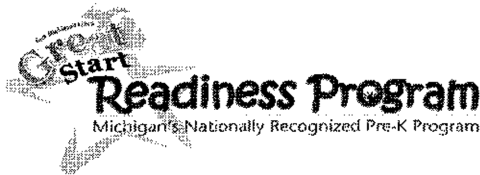


Kennedy Early Childhood Center
11333 Kaltz, Avenue
Warren, MI 48089
586 759-9406
FAX 586 758-7394

June, 2021

Enclosed is a registration packet for enrollment to the Our World of Fours program for the 2021-2022 School year.

In order to complete your child's student file we need the following documentation:

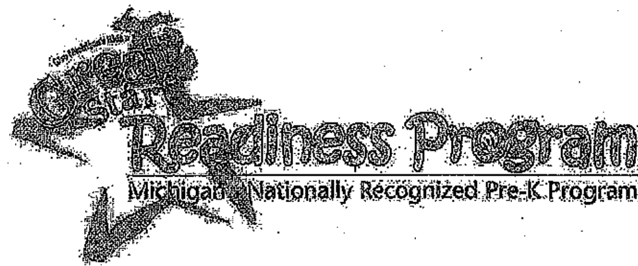
____ Birth Certificate*
____ Physical**
____ Immunization Record**
____ Income Information (3 current Pay Stubs, Tax return, SSI, DHS document)
____ Lease or Mortgage (must match address on utility bill & license)
____ Driver's License (address must match what is on lease & utilities)
____ Utility Bill (address must match what is on lease & driver's license)

*Please note: 100% of the above documentation must be returned with the registration packet. No child will be allowed to attend school until all paperwork is turned in.

Please feel free to contact me if you have any questions in regard to the above requested paperwork.

Sincerely,
Nikki Buckles
Kennedy Early Childhood Center
Our World of Fours Secretary

*We accept the Birth Verification but for Kindergarten you MUST have the original Birth Certificate with the seal.



Van Dyke GSRP Our World of Fours

Fact Sheet

- We are a state funded program.
- We are not Head Start. We are our own separate program.
- If your child has any medical or dietary issues, we must have all necessary physician completed paperwork on file before your child can start the program.
- We require two parent/teacher conferences and two home visits per school year. These are mandatory and are scheduled on non-school days.
- Throughout the school year, we host various events in the evenings and during school hours that require parent participation.
- We offer a play based learning environment that prepares your child for kindergarten.

Macomb County

EARLY CHILDHOOD PROGRAM OVERVIEW

All enrolled families receive the benefits of a high-quality early childhood program.

Highlight the following points when discussing program options with families.

PROGRAM DESCRIPTION

	Head Start	Great Start Readiness Program
Funding Source	Federally funded	State funded
Age Eligibility	3-5 years of age. Will be 3-5 by September 1	4 years of age by December 1
Income Eligibility	Family income is at or below 100% poverty level	90% of families meet low income requirements/risk factors or up to 250% of federal poverty level
Selection Criteria	Priority point system; 10% enrollment must be children with disabilities.	Eligibility based on income and risk factors are documented.
Hours of Operation	<u>Part Day program</u> – morning or afternoon 3 ½ hours M-Th <u>Full Day program</u> – 8:30-3:00 M-F	<u>Part Day program</u> – minimum 3 hours <u>School Day program</u> – minimum 6 ½ hours
Length of Program	September – mid June minimum of 128-160 days (30-32 weeks)	Minimum of 30 weeks/120 days
Average Class Size	15-17 children per session (based on ages of children in classroom)	16-18
Adult-Child Ratio	1:8	1:8

PROGRAM SERVICES

Head Start	Great Start Readiness Program
<u>PROVIDED SERVICES</u> • Early Childhood Education • Parent/Family Engagement and Education • Nutritious meals provided at no cost • Medical Records Assessment • Dental services including mobile dentist • Family needs assessment/community services • Special Needs/Disability Services	<u>PROVIDED SERVICES</u> • Early Childhood Education • Parent/Family Involvement and Education • Nutrition services • Free meals and/or snacks <u>REFERRAL SERVICES</u> • Medical • Dental • Health/Menth Health • Social Services • Special Needs

Macomb County Referral Form for the Great Start Readiness Program to Head Start

____ **Birth Date:** ______________
(Print) Child's Last Name **First Name**

____ **Phone Number:** ______________
(Print) Parent/Guardian's Last Name **First Name**

Address: ____________________ **City:** ________________ **Zip:** ________

Home School District: __________________________ **Enrolling for School Year:** ________

Have you previously applied for Head Start or been enrolled? ____________________________

I understand my child may be eligible for Head Start and that Head Start programs have a higher level of funding that may provide more services to my child/family. However, the Great Start Readiness Program best meets the needs for our family due to the following reasons:

Check all that apply:

- ☐ Zero Available Slots
- ☐ Transportation/Distance
- ☐ Schedule (parent working/ in school)
- ☐ Sibling was in Program
- ☐ Hours of Operation
- ☐ Sibling Attends Same School
- ☐ Other: Explain ____________________

Parent/Guardian Signature: ______________________ **Date:** __________

By signing I agree this information may be shared with appropriate early childhood agencies.

I have discussed this family's eligibility for Head Start and the family services they provide. As indicated, the family chooses to be enrolled in GSRP. **(Type or print all information below)**

GSRP Location: Kennedy ECC **Email:** buckles.nikki@vdps.net

Phone Number: 586-759-9406 **Contact Person:** Melissa Pluszczynski

School District of GSRP Program: Van Dyke

Head Start Use Only

I have reviewed the above information, and/or parent's documentation.

____ **Head Start releases this child to be enrolled in GSRP** ____ **Child is enrolled in Head Start for 2021-2022 school year**

Head Start Representative Signature: ______________________ **Date:** ________

VAN DYKE PUBLIC SCHOOLS – ENROLLMENT FORM

STUDENT INFORMATION

Last Name: ______________________________

First Name: ______________________________

Middle Name: ______________________________

Address: ______________________________

City: ________________ Zip Code: __________

Sex: *Male* __________ *Female* __________

Date of Birth: MO______ DAY________ YEAR________

City & State *or* Place of Birth: ______________________

Date of First DPT Booster: ______________________

Home Telephone Number: (___) ______________________

Beeper/Pager Number: (___) ______________________

Cell Phone Number: (___) ______________________

PARENT INFORMATION

Father: ______________________________
First Name *Last Name*

Address: ______________________________
Number *Street*

City: ________________ Zip Code: __________

Mother: ______________________________
First Name *Last Name*

Address: ______________________________
Number *Street*

City: ________________ Zip Code: __________

Step-Parent: ______________________________
First Name *Last Name*

Address: ______________________________
Number *Street*

City: ________________ Zip Code: __________

With whom does student reside? ☐ Father ☐ Mother ☐ Stepmother ☐ Stepfather ☐ Guardian ☐ Other__________

Is the student or has the student been in Special Education classes? ☐ Yes ☐ No

Does your child plan on playing any sports? ☐ Yes ☐ No

What, if any, special help or care does your child require? Please explain. ______________________________

____

____

____

I have received a copy of the Van Dyke Code of Conduct Book. __________
Initials

______________________________ __________
Signature of Parent/Guardian *Date*

SCHOOL INFORMATION

Name of last school attended: ______________________

Address: ______________________________
City *State* *Zip Code*

Name of last school district: ______________________

Did your child ever attend any other Van Dyke School?
☐ Yes ☐ No

If **YES**, what school and when?
Name of School: ______________________
School Year Attended: ______________________

-OTHER CHILDREN IN FAMILY-		
Name of Child	*Sex*	*Date of Birth*

Please check mother's highest grade-level completed?
High School: __09 __10 __11 __12
College: __01 __02 __03 __04

State Board of Education Approved Home Language Survey

The Van Dyke School District is collecting information regarding the language background of each of its students. This information will be used to determine the number of children who should be provided bilingual instruction according to Sections 380.1151-380.1158 of the School Code of 1976, Michigan's Bilingual Education Law.

1) Is your child's native language English? ☐ Yes ☐ No

What is the native language? ______________________

2) Is English used in your home most of the time? ☐ Yes ☐ No

What is the language used at home? ______________________

3) Is your child Multi-Racial? ☐ Yes ☐ No

If YES, mark with percentage, all categories that best describe your child's origin.
If NO, mark only one category 100%.

American Indian *or* Alaskan Native__________
Asian American__________
Black *or* African American__________
Hispanic *or* Latino__________
Native Hawaiian *or* Other Pacific Islander__________
White__________

Please identify your child's racial background, by percentages, in the spaces provided above.

REGISTERING AT: ______________________

CURRENT GRADE: ______________________

- OFFICE USE ONLY -

☐ IMMUN ☐ ORIG. B/C ☐ PROOF OF RES ☐ EMG CARD

☐ REQUEST FOR RECORDS

STUDENT #______________________

PERSON TAKING REGISTRATION______________________

PARENT NOTIFICATION OF THE LICENSING NOTEBOOK

Child Care Organizations Act, 1973 Public Act 116

Michigan Department of Licensing and Regulatory Affairs

All child care centers must maintain a licensing notebook which includes all licensing inspection reports, special investigation reports and all related corrective action plans (CAP). The notebook must include all reports issued and CAPs developed on and after May 27, 2010 until the license is closed.

- This center maintains a licensing notebook of all licensing inspection reports, special investigation reports and all related corrective action plans.
- The notebook will be available to parents for review during regular business hours.
- Licensing inspection and special investigation reports from at least the past two years are available on the Bureau of Community and Health Systems website at **www.michigan.gov/michildcare**.

I have read the above statement issued by ______________________________.
Name of Child Care Center

Child(ren)'s Name(s) ______________________________

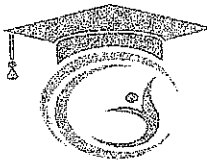
____

Parent Name ______________________________

Parent Signature ______________________ Date ____________

LARA is an equal opportunity employer/program.

BCAL-5053 (10-16) MS Word



It is the responsibility of the parent/legal guardian to provide Van Dyke Pubic Schools with all necessary documentation for enrollment and placement of the enrolling student(s).

STUDENT REGISTRATION - PLACEMENT AGREEMENT

PROVIDING FALSE INFORMATION WILL RESULT IN YOUR CHILD BEING DISENROLLED AND THE POSSIBILITY OF LEGAL ACTION DUE TO RESIDENCY FRAUD.

Student Name:____

I understand, due to the high standards of Van Dyke Public Schools, that my child will be registered and placed in classes, only if the following criteria are met. His/her registration and placement, is temporary and contingent upon verification of the following items:

- Academic achievement is determined by most recent report card
- That there are no previous actions taken toward expulsion
- Evidence that registrant a resident of Van Dyke Public School District
- Parent/Legal Guardian must provide a valid driver's license or State issued picture identification card
- Valid telephone number must be provided for emergency contact
- Proof of student's date of birth (Student's original Birth Certificate)
- Up-to-date Immunization Record (required)

PROOF OF RESIDENCY consists of:

- Purchase Agreement or closing papers or City of Warren Tax document
- Lease or Rental Agreement
- Current Driver's License or State I.D.
- Current Voter's registration
- Current Utility Bill(s)
- Notarized District Affidavit of Residency (if living with friend or relative)
- Court Order

Every parent/legal guardian registering a child must prove residency within our school district's boundaries.* It is the responsibility of the parent to provide proof of residency upon enrollment. You must provide three pieces of residency proof – of these one must be a purchase agreement, closing papers, City of Warren property tax documentation, lease or rental agreement. **The student must reside at this address.**

If a student is registering under the rules of Power of Attorney, all of the above stated requirements still govern registration. The student must reside at the home of the person assuming Power of Attorney. At any time, a home visit may occur. (Completed, notarized, district Power of Attorney is valid for 6 months from the date issued. Therefore, two are required per school year.)

I, ____, **certify that I have read, understand, and have**
Name of Parent/Legal Guardian
provided the above information. It is true and complete. Parents/Guardians providing false information for registration may have their child(ren) subject to disenrollment from Van Dyke Public Schools.

____ ____________________
Signature of Parent/Legal Guardian *Date*

* Macomb County students residing outside of our district's boundaries must submit an application to attend Van Dyke Public Schools during the open enrollment times. These students must have applications processed and approved through the Van Dyke Public Schools Administrative Service Center (Office for Curriculum and Instruction) under our district's Schools of Choice Plan.

Screening Consent Form

The first 5 years of life set the stage for success
in school and for a life time.

The Ages & Stages Questionnaire-3 {ASQ-3} and the Ages & Stages-Social Emotional {ASQ-SE) are screening tools that ask questions about your child's overall and social emotional development, looking at how children are doing in the important areas of communication, physical ability, social skills and problem-solving skills.

These screens can help identify your child's strengths as well as any areas where your child may need support. The screening should take about 10-20 minutes to answer questions about your child.

Your individual information is protected to ensure confidentiality. Information is entered on a web based database that is secure and password protected. Identifying information from the screen will be seen only by the developmental screening specialist, who scores your screening and provides the results to you.

General information about the ages and results of children's screening scores are compiled at the Macomb Intermediate School District in order to better understand the strengths and challenges of the children living in Macomb County.

I have read the above description and give Great Start Macomb and Van Dyke Schools consent to screen my child.

___ Yes, I do wish to participate

___ No, I do NOT wish to participate

Parent/Guardian Signature	Date
Child's Name	Child's Birth Date

Great Start Readiness Program
Michigan's Nationally Recognized Pre-K Program

Macomb Intermediate School District

Parent Notice of Program Measurement

Kennedy Early Childhood Center is required to work with the Michigan Department of Education (MDE) to measure the effect of the statewide Great Start Readiness Program (GSRP). Information is sometimes collected about GSRP staff, enrolled children, and their families. Program staff or a representative from MDE might:

- Ask parents questions about their child and family.
- Observe children in the classroom.
- Measure what children know about letters, words and numbers.
- Ask teachers how children are learning and growing.

Information from you and your child will not be shared with others in any way that you and your child could be identified. It is protected by law.

Questions? Contact mde-gsrp@michigan.gov or 517-373-8483
Or
MDE, Office of Early Childhood Education and Family Services,
608 W. Allegan, P.O. Box 30008, Lansing, MI 48909

*Provided to parents upon enrollment.

______________________ ______________

Parent Signature Date

______________________ ______________________ ______________

GSRP Staff Signature Position/Title Date

Kennedy Early Childhood Center
11333 Kaltz Avenue
Warren, MI 48089
586 759-9406

Dear Parents:

Sometimes children may soil their clothing at meal time or during a preschool activity. In this instance this form will give the Our World of Fours staff permission to help change your child's clothing.

Please send in a change of clothes to school in the bag provided. Include socks, underwear, pants and a top. Clothing will be returned at the end of the school year.

Please remember your child must be toilet trained. We understand that due to illness, some children might have a bathroom accident. Please check below if the Our World of Fours staff has your permission to clean your child and change the soiled clothing. We will change a bathroom accident one (1) time. The next time you will be called to come in.

* *

Please check the appropriate response:

______ Yes, I give my permission for the Our World of Fours staff to clean my child if she/she has soiled their clothing.

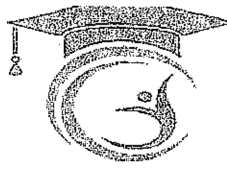
______ No, I do not give permission for the staff to clean my child, if he/she soiled their clothing. I wish to be called. I WILL COME TO SCHOOL IMMEDIATELY AND CLEAN MY OWN CHILD OR TAKE HIM/HER HOME. (PLEASE GIVE A TELEPHONE NUMBER WHERE YOU MAY BE REACHED DURING SCHOOL HOURS.)

Child's Name ____

Parent's Signature ____

Phone Number ____

Date ____________________



Van Dyke Public Schools
Warren, MI 48089

Social and Public Media Release Form

Photos and video are taken in the district on an ongoing basis. The Van Dyke Public Schools likes to showcase its staff and students, and some of this information may occasionally end up featured in the school buildings, in local newspapers, or on social media.

This form will allow your student to be photographed or video recorded with the purpose of sharing activities with our school community and/or in the media, including social media (See below.).**

This form releases the Van Dyke Public School District from any and all claims for libel and invasion of privacy arising from said recording regardless of nature.

By returning this form, you are letting us know whether or not you grant consent for pictures of your child to be included in school correspondence and social or public media, which may include the following:

- Local newspapers, e.g. Warren Weekly, Macomb Daily
- Facebook for Van Dyke Public Schools or individual schools
- Van Dyke Public Schools Website
- Teacher Web Pages
- Other School-Related Social Media

Student's name: ______________________________

School: ______________________________ Grade: __________

Teacher's name if Elementary: ______________________________

Signature of parent or legal guardian: ______________________________

Date: ______________________________

______ **Yes, I grant my consent to use photograph/film of my child as stated above.**

______ **No, I do not consent to use photograph/film of my child as stated above.**

**If no form on file, do not use photograph or film of student.

July 2014

Educational Material for Parents and Students (Content Meets MDCH Requirements)

Sources: Michigan Department of Community Health, CDC and the National Operating Committee on Standards for Athletic Equipment (NOCSAE)

UNDERSTANDING CONCUSSION

Some Common Symptoms

Headache	Balance Problems	Sensitive to Noise	Poor Concentration	Not "Feeling Right"
Pressure in the Head	Double Vision	Sluggishness	Memory Problems	Feeling Irritable
Nausea/Vomiting	Blurry Vision	Haziness	Confusion	Slow Reaction Time
Dizziness	Sensitive to Light	Fogginess	"Feeling Down"	Sleep Problems
		Grogginess		

WHAT IS A CONCUSSION?

A concussion is a type of traumatic brain injury that changes the way the brain normally works. A concussion is caused by a fall, bump, blow, or jolt to the head or body that causes the head and brain to move quickly back and forth. A concussion can be caused by a shaking, spinning or a sudden stopping and starting of the head. Even a "ding," "getting your bell rung," or what seems to be a mild bump or blow to the head can be serious. A concussion can happen even if you haven't been knocked out.

You can't see a concussion. Signs and symptoms of concussions can show up right after the injury or may not appear or be noticed until days or weeks after the injury. If the student reports any symptoms of a concussion, or if you notice symptoms yourself, seek medical attention right away. A student who may have had a concussion should not return to play on the day of the injury and until a health care professional says they are okay to return to play.

IF YOU SUSPECT A CONCUSSION:

1. SEEK MEDICAL ATTENTION RIGHT AWAY – A health care professional will be able to decide how serious the concussion is and when it is safe for the student to return to regular activities, including sports. Don't hide it, report it. Ignoring symptoms and trying to "tough it out" often makes it worse.

2. KEEP YOUR STUDENT OUT OF PLAY – Concussions take time to heal. Don't let the student return to play the day of injury and until a heath care professional says it's okay. A student who returns to play too soon, while the brain is still healing, risks a greater chance of having a second concussion. Young children and teens are more likely to get a concussion and take longer to recover than adults. Repeat or second concussions increase the time it takes to recover and can be very serious. They can cause permanent brain damage, affecting the student for a lifetime. They can be fatal. It is better to miss one game than the whole season.

3. TELL THE SCHOOL ABOUT ANY PREVIOUS CONCUSSION – Schools should know if a student had a previous concussion. A student's school may not know about a concussion received in another sport or activity unless you notify them.

SIGNS OBSERVED BY PARENTS:

- Appears dazed or stunned
- Is confused about assignment or position
- Forgets an instruction
- Can't recall events prior to or after a hit or fall
- Is unsure of game, score, or opponent
- Moves clumsily
- Answers questions slowly
- Loses consciousness (even briefly)
- Shows mood, behavior, or personality changes

CONCUSSION DANGER SIGNS:

In rare cases, a dangerous blood clot may form on the brain in a person with a concussion and crowd the brain against the skull. A student should receive immediate medical attention if after a bump, blow, or jolt to the head or body s/he exhibits any of the following danger signs:

- One pupil larger than the other
- Is drowsy or cannot be awakened
- A headache that gets worse
- Weakness, numbness, or decreased coordination
- Repeated vomiting or nausea
- Slurred speech
- Convulsions or seizures
- Cannot recognize people/places
- Becomes increasingly confused, restless or agitated
- Has unusual behavior
- Loses consciousness (even a brief loss of consciousness should be taken seriously.)

HOW TO RESPOND TO A REPORT OF A CONCUSSION:

If a student reports one or more symptoms of a concussion after a bump, blow, or jolt to the head or body, s/he should be kept out of athletic play the day of the injury. The student should only return to play with permission from a health care professional experienced in evaluating for concussion. During recovery, rest is key. Exercising or activities that involve a lot of concentration (such as studying, working on the computer, or playing video games) may cause concussion symptoms to reappear or get worse. Students who return to school after a concussion may need to spend fewer hours at school, take rests breaks, be given extra help and time, spend less time reading, writing or on a computer. After a concussion, returning to sports and school is a gradual process that should be monitored by a health care professional.

Remember: Concussion affects people differently. While most students with a concussion recover quickly and fully, some will have symptoms that last for days, or even weeks. A more serious concussion can last for months or longer.

To learn more, go to www.cdc.gov/concussion.

PARENT & STUDENT CONCUSSION INFORMATION SHEET ACKNOWLEDGMENT OF RECEIPT

By my name and signature below, I acknowledge that I have received and reviewed the Concussion Information Sheet for parents and students provided by Van Dyke Public Schools.

____
(Student Name)

____
(Parent Name)

____
(Parent Signature)

____
(Date)

Return this signed form to your child's school.

HEALTH APPRAISAL

Dear Parent or Guardian: The following information is requested so that the school can work with the parent to meet the physical, intellectual and emotional needs of the child. Fill out the information requested in Section I. Section III may be certified by the transcription of information from the certificate of immunization. The remaining sections are to be completed by a doctor, nurse and dentist. (**BE SURE TO BRING YOUR CHILD'S IMMUNIZATION RECORDS TO THE EXAMINATION.**)

PERSONAL

CHILD'S NAME (Last, First, Middle)			DATE OF BIRTH (mm/dd/yy) / /
ADDRESS (Number & Street)	(City)	(ZIP Code) MI	TODAY'S DATE (mm/dd/yy) / /
PARENT/GUARDIAN (Last, First, Middle)			HOME TELEPHONE NUMBER ( )
ADDRESS (Number & Street)	(City)	(ZIP Code) MI	WORK TELEPHONE NUMBER ( )

SECTION I - HEALTH HISTORY

Yes	No	Resolved	# Is your child having any of the problems listed below?	Birth History:
☐	☐	☐	1 Allergies or Reactions (for example, food, medication or other)	
☐	☐	☐	2 Hay Fever, Asthma, or Wheezing	
☐	☐	☐	3 Exzema or Frequent Skin Rashes	
☐	☐	☐	4 Convulsions/Seizures	
☐	☐	☐	5 Heart Trouble	
☐	☐	☐	6 Diabetes	
☐	☐	☐	7 Frequent Colds, Sore Throats, Earaches (4 or more per year)	Are there any current or past diagnosis(es) ☐ Yes ☐ No
☐	☐	☐	8 Trouble with Passing Urine or Bowel Movements	If yes, please describe:
☐	☐	☐	9 Shortness of Breath	
☐	☐	☐	10 Speech Problems	
☐	☐	☐	11 Menstrual Problems	
☐	☐	☐	12 Dental Problems: Date of Last Exam / /	
☐	☐	☐	Other (please describe):	
☐	☐		Does your child take any medication(s) regularly?	If yes, list medications:
			Reason for Medication ⇨	
			Parent/Guardian Signature Date / /	Was the health history reviewed by a health professional? ☐ Yes ☐ No ***Examiner's Initials:***

SECTION II - PHYSICAL EXAMINATION, INSPECTION, TESTS AND MEASUREMENTS

Required for Child Care and Head Start / Early Head Start

Tests and Measurements

No	Yes	Was child tested for:	Test results:	Normal	Referred	Under Care	No	Yes	Was child tested for:	Test results:	Normal	Referred	Under Care
☐	☐	VISION	Visual Acuity				☐	☐	HEIGHT & WEIGHT	Height			
			Muscle Imbalance							Weight			
		Date: / /	Other:				☐	☐	Other:	Other			
☐	☐	HEARING	Audiometer				☐	☐	HEMOGLOBIN / HEMATOCRIT	⇨			
		Date: / /	Other:				☐	☐	BLOOD PRESSURE	Reading:			
☐	☐	URINALYSIS	Sugar				☐	☐	TUBERCULIN	Type:			
			Albumin										
		Date: / /	Microscopic						Date: / /	Neg.: ☐ Pos.: ☐ ____ mm			
☐	☐	BLOOD LEAD LEVEL Date: / /	Level ____ ug/dl ⇨						**NOTE:** Blood lead level required for all children enrolled in Medicaid must be tested at one and two years of age, or once between three and six years of age if not previously tested. All children under age six living in high-risk areas should be tested at the same intervals as listed above.				

Examinations and/or Inspections

Essential Findings Deviating from Normal:

Exam Date: / /

SECTION III - IMMUNIZATIONS

Statements such as "UP TO DATE" or "COMPLETE" will not be accepted. Admission to school may be denied on the basis of this information.*

VACCINES (Circle Type)	DATE ADMINISTERED MM/DD/YYYY	
Hepatitis B (Hep B)	1	3
	2	
DTaP/DTP/DT/Td	1	4
	2	5
	3	6
Tdap	1	
Haemophilus Influenzae type b (HIB)	1	3
	2	4
Polio - IPV / OPV	1	3
	2	4
Pneumococcal Conjugate (PCV7/PCV13)	1	3
	2	4
Rotavirus (RV1/RV5)	1	3
	2	
Measles,Mumps, Rubella (MMR)	1	2
Varicella (Chickenpox)	1	2

History of Clckenpox Disease? ☐ Yes ☐ No If yes, date:

VACCINES (Circle Type)	DATE ADMINISTERED MM/DD/YYYY	
Hepatitis A (Hep A)	1	2
Influenza TIV/LAIV	1	3
	2	4
Meningococcal MCV4 / MPSV4	1	2
Human Papillomavirus (HVP4/HPV2)	1	2
	2	3
OTHER Vaccines Specify Date & Type	Type of Vaccine(s)	Date of Vaccine(s)
	1	
	2	
	3	

Indicate and attach physician diagnosis or laboratory evidence of immunity as applicable

*NOTE: According to Public Act 368 of 1978, any child enrolling in a Michigan school for the first time must be adequately immunized, vision tested and hearing tested. Exemptions to these requirements are granted for medical, religious and other objections, provided that the waiver forms are properly prepared, signed and delivered to school administrators. Forms for these exemptions are available at your child's school or local health department.

Parent/Guardian refused immunizations: ☐

I certify that the immunization dates are true to the best of my knowledge

______________________ ______________ ___/___/___
Health Professional's Signature Title Date

SECTION IV - RECOMMENDATIONS

(Required for Child Care and Head Start/Early Head Start)

No	Yes	
☐	☐	Is there any defect of vision, hearing or other condition for which the school could help by seating or other actions? If yes, please explain:
☐	☐	Should the child's activity be restricted because of any physical defect or illness? If yes, check and explain degree of restriction(s): ☐ Classroom ☐ Playground ☐ Gymnasium ☐ Swimming Pool ☐ Competitive Sports ☐ Other

Other Recommendations

SECTION V - DENTAL EXAMINATION AND RECOMMENDATIONS (OPTIONAL)

I have examined ______________ (child's name) 's teeth. As a result of this examination, my recommendation for treatment is: ______________

______________________ ___/___/___
Dentist's Signature Date

PHYSICIAN'S SIGNATURE

______________ ___/___/___ ______________ ______________
Examiner's Signature Date ***Examiner's Name (Print or Type)*** Degree or License

______________ ______________ MI ______ (____)______
Number & Street City ZIP Code Telephone

Information required for:

Early On - Hearing and Vision Status; Diagnosis; Health Status

Child Care Licensing - Physical Exam, Restrictions, Immunizations

Head Start/Early Head Start - Determination that child is up-to-date on a schedule of age-appropriate preventive and primary health care, including medical, dental, and mental health. The schedule must incorporate the schedule of well-child care required by EPSDT and the latest immunizations schedule recommended by the Centers for Disease Control and Prevention, State, tribal, and local authorities. An EPSDT well-child exam includes height, weight, and blood tests for anemia and regular intervals based on age.

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Developed in Cooperation with the Departments of Human Services, Education, Community Health, Michigan American Association of Pediatrics, Early Childhood Investment Corporation, Child Care Licensing, Head Start, Michigan State Medical Society, Michigan Association of Osteopathic Physicians and Surgeons.