



Greenville Public Schools Preschool Enrollment



GSRP, Junior Jackets & Children's Corner

GSRP Contact: (616) 754-3641

Junior Jackets & Children's Corner Contact: (616) 754-1000 ext. 8700

Child's Name: _____

Enrollment Checklist- These materials must be turned in before your child will be enrolled

- Preschool Collaborative Application (preschool only)
- Income Verification: W-2, front page of last year's taxes or pay stub (preschool only)
- Copy of Birth Certificate (preschool only)
- Copy of Immunization Records
- Health Appraisal (students 4 and under) or Statement of Health (student 5 and older)
*required by the first day of school
- Enrollment Form
- Child Information Card
- Children's Corner Placement Contract (Children's Corner Before & After School Care only)
- Transportation Link Completed (GSRP only)
- Photo Release Form
- Authorization to Disclose Information Form
- Permission Form
- Licensing Notebook Signature Page
- Written Information Packet Documentation Form
- Substance Free Classroom Agreement
- Free & Reduced Meal Application/Household Survey (preschool only)
- Age Waiver (if applicable)
- Family Heritage Survey

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

SECTION I - HEALTH HISTORY

<table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <th style="width: 5%;">Yes</th> <th style="width: 5%;">No</th> <th style="width: 5%;">Reached</th> <th style="width: 85%;"># Is your child having any of the problems listed below?</th> </tr> <tr> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td>1 Allergies or Reactions (for example, food, medication or other)</td> </tr> <tr> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td>2 Hay Fever, Asthma, or Wheezing</td> </tr> <tr> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td>3 Eczema or Frequent Skin Rashes</td> </tr> <tr> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td>4 Convulsions/Seizures</td> </tr> <tr> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td>5 Heart Trouble</td> </tr> <tr> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td>6 Diabetes</td> </tr> <tr> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td>7 Frequent Colds, Sore Throats, Earaches (4 or more per year)</td> </tr> <tr> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td>8 Trouble with Passing Urine or Bowel Movements</td> </tr> <tr> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td>9 Shortness of Breath</td> </tr> <tr> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td>10 Speech Problems</td> </tr> <tr> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td>11 Menstrual Problems</td> </tr> <tr> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td>12 Dental Problems: Date of Last Exam / /</td> </tr> <tr> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td>Other (please describe): _____</td> </tr> <tr> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td>Does your child take any medication(s) regularly?</td> </tr> <tr> <td colspan="4">Reason for Medication _____</td> </tr> <tr> <td colspan="4" style="text-align: center;">Parent/Guardian Signature _____ Date / /</td> </tr> </table>	Yes	No	Reached	# Is your child having any of the problems listed below?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	1 Allergies or Reactions (for example, food, medication or other)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	2 Hay Fever, Asthma, or Wheezing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	3 Eczema or Frequent Skin Rashes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	4 Convulsions/Seizures	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	5 Heart Trouble	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	6 Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	7 Frequent Colds, Sore Throats, Earaches (4 or more per year)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	8 Trouble with Passing Urine or Bowel Movements	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	9 Shortness of Breath	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	10 Speech Problems	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	11 Menstrual Problems	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	12 Dental Problems: Date of Last Exam / /	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Other (please describe): _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Does your child take any medication(s) regularly?	Reason for Medication _____				Parent/Guardian Signature _____ Date / /				<p>Birth History:</p> <p>Are there any current or past diagnosis(es) <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>If yes, please describe:</p> <p>If yes, list medications:</p> <p>Was the health history reviewed by a health professional? <input type="checkbox"/> Yes <input type="checkbox"/> No Examiner's Initials: _____</p>
Yes	No	Reached	# Is your child having any of the problems listed below?																																																																		
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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
<input type="checkbox"/>	<input type="checkbox"/>	VISION Date: / /	Visual Acuity Muscle Imbalance Other: _____				<input type="checkbox"/>	<input type="checkbox"/>	HEIGHT & WEIGHT Height Weight Other: _____				
<input type="checkbox"/>	<input type="checkbox"/>	HEARING Date: / /	Audiometer Other: _____				<input type="checkbox"/>	<input type="checkbox"/>	HEMOGLOBIN / HEMATOCRIT BLOOD PRESSURE Reading: _____				
<input type="checkbox"/>	<input type="checkbox"/>	URINALYSIS Date: / /	Sugar Albumin Microscopic				<input type="checkbox"/>	<input type="checkbox"/>	TUBERCULIN Type: _____ Date: / / Neg.: <input type="checkbox"/> Pos.: <input type="checkbox"/> _____ mm				
<input type="checkbox"/>	<input type="checkbox"/>	BLOOD LEAD LEVEL Date: / /	Level _____ ug/dl				<p>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.</p>						

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		DATE ADMINISTERED MM/DD/YYYY
Hepatitis B (HepB)	1	3	2
	2		
DTaP/DTp/DT/d	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 Chickenpox Disease? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, date:			
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:
<input type="checkbox"/>	<input type="checkbox"/>	_____
<input type="checkbox"/>	<input type="checkbox"/>	Should the child's activity be restricted because of any physical defect or illness? If yes, check and explain degree of restriction(s): <input type="checkbox"/> Classroom <input type="checkbox"/> Playground <input type="checkbox"/> Gymnasium <input type="checkbox"/> Swimming Pool <input type="checkbox"/> Competitive Sports <input type="checkbox"/> Other

Other Recommendations		

SECTION V - DENTAL EXAMINATION AND RECOMMENDATIONS (OPTIONAL)
I have examined _____'s teeth. As a result of this examination, my recommendation for treatment is: _____ child's name
_____ Dentist's Signature
_____ Date

PHYSICIAN'S SIGNATURE			
_____ Examiner's Signature	_____ Date	_____ Examiner's Name (Print or Type)	_____ Degree or License
_____ Number & Street	_____ City	_____ MI	_____ 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 well-child care visit 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 at regular intervals based on age.

Developed in Cooperation with the Department of Health and Human Services, Education, 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.



Greenville Public Schools Preschool



Statement of Health

Child's Name: _____

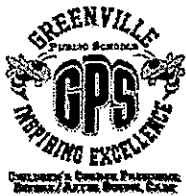
Child's School of Attendance: _____

Child's Age: _____ Child's Grade: _____

My Child is in good health with activity restrictions noted: _____

My child's immunizations are up to date. My child's immunization records or appropriate waiver is on file with my child's school. I assume responsibility for the state of my child's health while in this program. The appropriate Greenville Public School staff member has my permission to check/copy the health form if necessary (state law requires that the health form and/or this statement be on file and on site).

Dated: _____ Parent/Guardian Signature: _____



Greenville Public Schools Preschool Enrollment



Student Registration / Emergency Form

Student Information:

Last: _____ First: _____ Middle: _____

Address (no PO Boxes): _____

City: _____ State: Michigan Zip Code: _____ County: _____

Mailing Address (if different): _____

Home Phone: _____ Birth City & State: _____

Male Female Birth date: ___/___/___ Grade Entering: _____

Primary Language spoken in the home: _____ (Contact teacher if other than English)

Ethnicity

Is the student Hispanic/Latino (choose only one)

- No, not Hispanic/Latino
- Yes, Hispanic/Latino- (A person of Cuban, Mexican, Puerto Rican, South/Central American, or other Spanish culture or origin, regardless of race.

Race

The question to the left is about ethnicity, not race. No matter what you selected, please continue to answer the following by marking one or more boxes indicating what you consider your student's race to be.

- American Indian/Alaska Native Asian American
- Native Hawaiian/Pacific Islander Black/African Amer.
- White

Family Information:

Student Resides with: _____
Name _____ Relationship _____

Is this home your rent or own? Yes No

Father/Step-Father Name: _____ Birthdate: ___/___/___

Address (if different than primary residence): _____

City: _____ State: _____ Zip Code: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Employer & Occupation: _____ Email address: _____

Mother/Step-Mother Name: _____ Birthdate: ___/___/___

Address (if different than primary residence): _____

City: _____ State: _____ Zip Code: _____

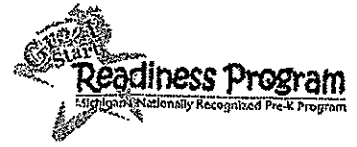
Home Phone: _____ Work Phone: _____ Cell Phone: _____

Employer & Occupation: _____ Email address: _____

Please complete both sides of form



Greenville Public Schools Preschool Enrollment



Non-Custodial Parent Name: _____ Birthdate: ____/____/____

Address (if different than primary residence): _____

City: _____ State: _____ Zip Code: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Employer & Occupation: _____ Email address: _____

If the child does not reside with parents, please fill in the following information

Guardian Name: _____ Birthdate: ____/____/____

Address (if different than primary residence): _____

City: _____ State: _____ Zip Code: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Employer & Occupation: _____ Email address: _____

In the case that a parent can not be contacted, please list the name of at least two emergency contacts below

Contact Name: _____ Phone Number: _____

Contact Name: _____ Phone Number: _____

Contact Name: _____ Phone Number: _____

Contact Name: _____ Phone Number: _____

CHILD INFORMATION RECORD

State of Michigan - Department of Licensing and Regulatory Affairs - Child Care Licensing

Instructions: Unless otherwise indicated, all requested information must be provided. If the information is not known or does not apply, "unknown" or "none" is the required response. A blank field, a line through a field or "N/A" are not acceptable responses.

For Provider Use Only	Date of Admission	Date of Discharge
-----------------------------	-------------------	-------------------

Name of Child (Last, First, Middle Initial)						Child's Date of Birth		
Address (Number and Street, Building/Apartment Number)				City		State	Zip Code	
Parent/Legal Guardian's Name		Home Phone ()		Parent/Legal Guardian's Name (Optional)		Home Phone ()		
Home Address (if not child's address)		Cell Phone ()		Home Address (if not child's address)		Cell Phone ()		
City		State	Zip Code		City		State	Zip Code
Email Address (optional)				Email Address				
Employer Name		Work Phone ()		Employer Name		Work Phone ()		
Name of Child's Physician or Health Clinic				Physician's or Health Clinic's Phone Number ()				
Hospital Preferred for Emergency Treatment (optional)								
Allergies, Special Needs and Special Instructions (Attach additional sheets, if necessary.)								

BCAL-3731 (Rev. 6-17) Previous editions 4-16, 6-15 and 7-12 may be used until September 30, 2018.

See Reverse Side

Emergency Contact & Release of Child: List all individuals, including parents/legal guardians, in order of preference, to be contacted in an emergency. If possible, include at least one person other than the parents/legal guardians to be contacted in an emergency and to whom the child can be released. The second phone number column can be left blank. (If more individuals, attach additional sheets.)

1.	()	()
2.	()	()
3.	()	()

Release of Child Only: List all individuals, other than the parents/legal guardians, to whom the child may be released. (If more individuals, attach additional sheets.)

1.	()	2.	()
3.	()	4.	()

Parent/Legal Guardian Initials:

_____ I give permission to _____, licensed by the Department of Licensing and Regulatory Affairs to secure emergency medical for the above named minor child while in care.

I certify that I accurately completed this form and if anything changes, I will notify the provider by updating this form.

Signature of Parent or Guardian _____ Date Signed _____

Date Card Reviewed	Parent or Legal Guardian Initials	Date Card Reviewed	Parent or Legal Guardian Initials	Date Card Reviewed	Parent or Legal Guardian Initials	Date Card Reviewed	Parent or Legal Guardian Initials
LARA is an equal opportunity employer/program.						AUTHORITY: 1973 PA 116 COMPLETION: Required PENALTY: Rule Violation	

BCAL-3731 (Rev. 6-17) Previous editions 4-16, 6-15 and 7-12 may be used until September 30, 2018.



CHILDREN'S CORNER

CHILD PLACEMENT CONTRACT

PART 1: CONTRACT PROVISIONS PROVIDED BY CHILD CARE FACILITY:

Children's Corner, as a licensed child care facility, will provide the following provisions of the Michigan Administrative Code:

R400.8110 Licensee.

Rule 110. (1) The Licensee shall do all of the following:

- (a) Be of good moral character
 - (b) Be suitable to meet the needs of children.
 - (c) Comply with requirements for criminal history check, criminal background check, and check for history of substantiated abuse and neglect for all staff and volunteers.
- (2) A licensee shall have administrative capability to operate the center in order to provide the services and facilities that are conducive to the welfare of children.

R400-8125 Staff and Volunteers

Rule 125. (1) All staff and volunteers shall provide appropriate care and supervision of children at all times

(2) All staff shall be of responsible character and suitable to meet the needs of children.

- (a) A written screening policy for all staff and volunteers, including parents shall be developed and implemented.

R400.8179 Program.

Rule 106. (1) A center shall implement a program plan which includes daily learning experiences appropriate to the developmental level of the children. Experiences shall be designed to develop all of the following:

- (a) Physical development, including large and small muscle activities.
 - (b) Social development, including communication skills.
 - (c) Emotional development, including positive self-concept.
 - (d) Cognitive development.
- (2) The center shall provide a flexible balance of all the following experiences:
- (a) Quiet and active.
 - (b) Individual, small groups and large groups.
 - (c) Large and small muscle activities.
 - (d) Child initiated and staff initiated.
- (3) Developmentally appropriate experiences shall be designed so that throughout the day each child has opportunities to do all the following:
- (a) Feel successful and feel good about him/herself and develop independence.
 - (b) Practice social interaction skills.
 - (c) Use materials and take part in activities which encourage creativity.
 - (d) Learn new ideas and skills.
 - (e) Participate in imaginative play.
 - (f) Participate in developmentally appropriate language and literacy experiences.
 - (g) Participate in early math and science experiences.
 - (h) Be physically active.

- (4) A school-age program shall supplement the areas of development not regularly provided for during the school day.
- (5) A typical daily routine shall be posted in a place visible to parents.
- (6) When media are used with children 2 years of age and older, all of the following apply:
- (a) Activities shall be developmentally appropriate.
 - (b) Interactive media shall be used to support learning and to expand children's access to content and shall be suitable to the age of the child in terms of content and length of use per session.
 - (c) Media with violent or adult content are prohibited which children are in care.
 - (d) Use of non-interactive media shall not exceed 2 hours per week per child.
 - (e) When media are available for children's use, other activities shall also be available to children.
- (7) Parents may visit the program during hours of operation for the purpose of observing their children.
- (8) A center operating with children in attendance for 3 or more continuous hours per day shall provide for daily outdoor play, unless prevented by inclement weather conditions.
- (9) A center shall provide each child under school age in attendance for 5 or more continuous hours a day with an opportunity to rest. A cot or a mat of appropriate size shall be provided.
- (10) Center will provide reasonable accommodations unless the accommodation would fundamentally alter the program, pose a direct threat to the child or others, or otherwise impose an undue burden on the center.

PART 2: PARENT AGREES TO THE FOLLOWING:

- *to pay a \$15.00 nonrefundable registration fee per family per year.
- *to pay all fees by Friday of the following week of service. Late payment charge is \$10.00 per week. There is a \$20.00 charge for insufficient funds.
- *to pay for the number of days signed up for unless one (1) week notice is given.
- * **We require 2 or more days each week. A waiting list will be maintained.**
- *No discount is given for illness (unless 3 consecutive class days) or change of plans.
- ***Monthly Colanders must be turned in prior to the 1st of each month**
- *Credit will be given if Center is **canceled**.
- *Any past due balance of \$200 will be immediate grounds for dismissal.
- * Late pick-up fee as follows: \$15.00 for each portion of 15 minutes late after 6:00. (\$15.00 from 6:00-6:16; \$30.00 from 6:15-6:30 etc.). Each charge will be per family per occurrence and will be billed to statement of parents.

*My/our child is in good health, immunizations are up-to-date, and my child can participate in all activities at Children's Corner. I assume responsibility for the state of his/her health while in this program. I will provide outdoor clothing, tennis shoes, change of clothing, and a blanket for rest time.

*Be advised that the 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 on the Children's Corner desk. Licensing inspection and special investigation reports from the past two years are available on the Bureau of Children and Adult licensing website:

www.michigan.gov/michildcare.

CHILDREN'S CORNER agrees to provide child care services for the following named children:

Name of Parent: _____ Home phone: _____

Address: _____ Work Phone: _____

Name of Children: _____ School _____ Birth Date _____ Grade _____

* FIELD TRIP: I hereby give my permission to Children's Corner for the above named child(ren) to be transported in a vehicle and/or participate in field trips.

*PHOTOS: I hereby grant GPS permission to take my child's picture. These pictures could be used in advertising, or publicity press releases.

*All snacks and meals will be provided by the parent unless otherwise stated

***I/we have read the Parent Handbook at www.greenville.k12.mi.us; Department-Children's Corner and this Child Placement Contract and agree to abide by these policies.**

Upon signing this agreement, the parent, legal guardian or responsible adult and the child care facility agrees to abide by all the provisions contained in this contract.

.....
In witness whereof, the parties hereto have executed this contract as of the date:

Parent/Legal Guardian or Responsible Adult

CHILDREN'S CORNER

(Signature)

BY: _____
(Signature)

(Printed Name)

(Relationship to Children)

DIRECTOR

(Dated)

(Dated)

RESIGN: _____

REDATE: _____

RESIGN: _____

REDATE: _____

RESIGN: _____

REDATE: _____



PHOTO RELEASE FORM

GREENVILLE PUBLIC SCHOOLS PRESCHOOL PROGRAM PHOTOGRAPHY/ VIDEOTAPE PERMISSION FORM

Consent is hereby given to the Greenville Public Schools Preschool Programs to photograph/video the following members of my family:

Name: _____ Birthdate: _____

Name: _____ Birthdate: _____

Name: _____ Birthdate: _____

Name: _____ Birthdate: _____

These photographs/videos may be used for the purpose of:

- Parent/Staff Training
- PowerPoint/Videotape presentation
- Scrapbooks
- Newspaper
- MCGSC website
- Brochures -- To be distributed through Montcalm and neighboring counties
- Social Networking
- All of the above**

I recognize I have the rights to request to review any photographs or video before they are released to the media or used in a presentation.

Parent/Guardian Signature

Date



Greenville Public Schools



Authorization to Disclose Information

Student: _____ Date of Birth: _____

I understand that services provided to my child may come from different agencies. In order to plan for and provide the best possible care for my child and our family, various professionals may need to share information about my child. This form is an authorization, or permission from me, for those professionals to share the information I would like shared. I understand that this information may be used to help decide if my child is eligible for services, how best to coordinate and provide those services, and the services for which we qualify. The agencies and persons I have initialed below have my permission to share the information about my child and family that I have listed. This could be electronic, verbal, or written. I understand that information will NOT be shared without my authorization with anyone who does not have a valid reason for it or unless authorized under applicable federal and state laws. I understand that this information will not be shared with anyone who has not agreed to meet applicable confidentiality standards. I am aware that I can, without penalty, at any time, cancel this consent and not share information with these persons or agencies. My authorization to share information is voluntary and is good for 12 months. At any time I may, in writing, cancel this authorization to share information form.

Agencies Authorized to Exchange Information (initial those that apply)

Info Code (see back)	Initial	Agency/Person	Info Code (see back)	Initial	Agency/Person
		Montcalm Area Intermediate School District (MAISD)			Physician Name/Address:
		MAISD Local Education Agencies/Districts			Physician Name/Address:
		SMMLES Dental Support			Physician Name/Address:
		EightCAP			Daycare Provider:
		Other:			Other:
		Other:			Other:

Consent for Authorization to Disclose Information (Initial one of the two statements.)

My signature below is my consent and agreement to the following:

- I have read and understand this consent form (or it has been read to me in a language I understand).
- I understand that my authorization or consent to allow the sharing of information about my child is voluntary and I may deny or revoke consent at any time, without penalty. Revocation of consent is not retroactive.
- I understand that information about my child will also be kept on a database that is subject to the same confidentiality provisions.
- I understand the confidentiality of information about my child is protected by state and federal law, including the Individuals with Disabilities Education Act (IDEA), the Family Educational Rights and Privacy Act (FERPA), and the Health Insurance Portability and Accountability Act (HIPAA). The protected health information (PHI) or personally-identifiable information (PII) in my child's records cannot be disclosed, given, sold, or transferred in any way to any other agency/program (and its contractors or authorized representatives) not specified in this release unless otherwise specifically authorized by federal or state laws.
- I understand that authorizing the disclosure of health information is voluntary. I also understand that I may refuse to sign this authorization and that my refusal to sign will not affect my ability to obtain treatment or services, payment for services, or eligibility for benefits unless the information is necessary to demonstrate that I meet eligibility or enrollment criteria.
- I authorize the agencies designated and their representatives to engage in verbal or written communication in order to share records and information as indicated above.

My signature below indicates that I do NOT authorize any information to be shared at this time:

Signature of Student or Parent/Guardian

Initials

Date Signed

Authorization Obtained By:

Witness

Date Signed



Permission Form

I give permission for my child, _____, to participate in the following:

Attend and participate in field trips:

By school transportation

Yes

No

Walking field trips

Yes

No

Be transported to school sponsored Activities by your local school district:

Yes

No

Participate in parties and holiday Celebrations (when scheduled):

Yes

No

Parent/Guardian Signature

Date



Greenville Public Schools



LICENSING NOTEBOOK

Greenville Public Schools GSRP and Junior Jackets Preschools maintain a licensing notebook for your review.

The notebook-

- 1) Includes all licensing inspection reports, special investigation reports and all related corrective action plans.
- 2) Will be available for your review during regular business hours

Licensing inspection and special investigation reports from the past two years are available on the Bureau of Children and Adult Licensing website at: www.michigan.gov/michildcare.

Please sign this document and return it to preschool so there will be a signed notification on file for each parent.

Signature

Date

WRITTEN INFORMATION PACKET DOCUMENTATION
Michigan Department of Licensing and Regulatory Affairs
Bureau of Community and Health Systems

Child(ren)'s Name(s) (Last, First)	Center Name
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A written information packet has been provided at the time of enrollment. The packet included all the following information:

- Criteria for admission and withdrawal.
- Schedule of operation, denoting hours, days, and holidays during which the center is open and services are provided.
- Fee policy.
- Discipline policy.
- Food service program.
- Program philosophy.
- Typical daily routine.
- Parent notification plan for accidents, injuries, incidents, illnesses.
- Exclusion policy for child illnesses.
- Notice of the availability of the center's licensing notebook.
 - The licensing notebook contains all the licensing inspection and special investigation reports and related corrective action plans since May 28, 2010.
 - The licensing notebook is available to parents during regular business hours.
 - Licensing inspection and special investigation reports from at least the past two years are available on the child care licensing website at www.michigan.gov/michildcare.
- Other _____

I certify that I received all of the above items.

Parent/Guardian Signature

Date

Note: A single BCAL-4340 form may be used for all children in the same family.

LARA is an equal opportunity employer/program.



Substance Free Classroom Agreement

A substance free classroom is defined as one where the following is prohibited: all use of cigarettes, cigars or burning tobacco in any form (including vaping), use and possession of alcohol and other drugs, which are prohibited by state law and/or Greenville Public Schools district policy. These requirements apply to all classroom guests in common areas as well as all school facilities and/or activities and include field trip activities.

Parents and staff are expected to abide by the Substance Free Classroom Agreement to the following standards:

1. The use or possession of alcohol and illegal drugs is not permitted within the substance free classroom. This policy applies to all areas of the substance free classroom, including, but not limited to the following: classrooms, hallways, bathrooms, stairwells, and field trip activities.
2. Parents and staff may not enter the classroom under the influence of alcohol or other drugs. Problematic behaviors that result from parents and staff being under the influence of alcohol and/or drugs are also prohibited. Such behaviors will be considered a violation of this agreement.
3. Classroom guests are aware of and abide by all classroom rules and regulations, including this agreement.
4. Substance Free, as defined above, is responsible for supporting a substance free classroom. Staff must express concerns to the building administrator about any classroom guest(s) who may be violating the substance free classroom standards.
5. Violations of the Substance Free Classroom agreement will be handled as follows:
 - a. An incident report will be filed with the building administrator.
 - b. Classroom guest(s) will not be allowed to participate in future classroom activities.

I have read, understand and agree to abide by the terms and conditions of the Substance Free Classroom Agreement. I understand that this agreement shall remain in effect through my child's participation in a Greenville Public Schools preschool program. I understand that any violation may result in administrative action, which may include my inability to participate in classroom activities.

Parent/Guardian Signature

Date

Staff Signature

Date