KALAMAZOO COUNTY PRE-K APPLICATION 2019-2020

"Will your child be 3-4 years old on or before December 1? (Refer to step 2a)"

"Can you provide proof of income for the last 12 months? (Refer to step 2b)"

"Do you reside in Kalamazoo County? (Refer to step 2c)"

Dear pre-kindergarten family, we're so excited to be a part of your child's next adventure! A valuable Pre-K experience makes for a great start and a major difference in a child's kindergarten readiness and success.

If you answered "Yes" to all the questions above, you are likely eligible for the Kalamazoo County Pre-K program. Please fill out the Kalamazoo County Pre-K application and submit it with all the required documents listed under the step-by-step instructions to determine eligibility.

If you answered "No" to any of these questions, you may still be eligible for the Kalamazoo County Pre-K program. We encourage you to fill out our Pre-K application. Please contact us by email at hsenroll@kresa.org if you have any questions.

EASY AS 1, 2, 3...

Turn in the following three items with your child's application:

- ☐ 1. Child's birth record
- ☐ 2. Proof of yearly family income: work earnings (W-2, tax return, or check stubs), child support, unemployment, SSI, cash assistance and any other proof of income.
- ☐ 3. Proof of current address: driver's license, rent receipt, utility bill, letter from shelter or host if between homes.

Check out the step-by-step instructions for more detailed information.

Kalamazoo RESA inspiring educational excellence | KALAMAZOO COUNTY PRE-K | KC Ready4s | Great Start Collaborative Kalamazoo County | Great Start Readiness Program Michigan's Nationally Recognized Pre-K Program | KALAMAZOO RESA Head Start

Step-by-Step Instructions

Step 1: Pre-K Application

- ☐ 1a Fill out the Kalamazoo County Pre-K application, completely. Application is available in both English and Spanish. You can download a copy or fill out a digital form at DreamBigStartSmall.org.

Step 2: Required Documents

All applicants must send the following items with the Kalamazoo County Pre-K application. Eligibility cannot be determined unless all of the following required documents have been submitted.

☐ 2a Proof of age. According to new guidelines, all children must be:

- 3-years-old on or before December 1* in order to be age eligible for the 3-year-old programs
- 4-years-old on or before December 1* in order to be age eligible for the 4-year-old programs

*Placement may be prioritized for children who will be 3 or 4 years old on or before September 1.

Submit one of the following:

- Birth certificate (preferred)
- Passport
- Affidavit of parentage/Hospital record
- Baptismal record
- Foster care emergency consent card
- Foster care placement letter
- Court order

☐ 2b Proof of income. **Income is a primary qualifying factor.** You can check the charts available on kresa.org/qualifications for more details. You must submit documents for all sources of income over the last 12 months. These documents may include:

- Last year's tax return (first page), or pay stub with year-to-date listed, W2's, or written statement from employer if tax return is not available
- TANF/FIP
- Social security/SSI check stub or monthly statement
- Unemployment check stub or statement
- Financial aid (grants/scholarships)
- Child support/Alimony/Pension statement

☐ 2c Proof of residency. Submit one of the following:

- Driver's license or County ID with correct address (preferred)
- Recent utility bill for your address
- Rental agreement/Mortgage/Deed to house
- Written letter from shelter, if between homes

☐ 2d Additional documents:

- Current immunization record (prior to the child's first day of class)
- Health appraisal/Physical/Well-child exam within the past year (due within the first 30 days of the program year)
- Medicaid, or insurance card for child

Step 3: Submitting Your Documents

☐ 3a Once you have filled out the application completely and gathered all the required documents:

- Submit application and required documents online at DreamBigStartSmall.org
- Submit paper application and required documents at:
  - » Kalamazoo RESA Head Start/GSRP Administration Office, 422 E. South St., Kalamazoo, MI 49007
  - » Kalamazoo RESA Early Childhood Office, GSRP, lower level of 4606 Croyden Ave., Kalamazoo, MI 49006
  - » Kalamazoo County Ready 4s Office, 259 E. Michigan Ave., Suite 409, Kalamazoo, MI 49007
  - » Any Kalamazoo County Ready 4s participating provider
  - » Check with your local school district for location

For assistance, please call (269) 250-9333, Monday–Friday, 8:00am–4:00pm.

Step 4: Application Processing Time

☐ 4a Please allow two to four weeks for processing your application. Once your application is processed, you will receive a letter regarding eligibility.

KALAMAZOO COUNTY PRE-K APPLICATION 2019-2020

Complete this application OR apply online at DreamBigStartSmall.org

CHILD INFORMATION

Child's Legal Name: _____ (Last Name) _____ (First Name) _____ (Middle Initial) Date of Birth: ____ / ____ / ____ (mm / dd / yyyy)

Gender: ☐ Male ☐ Female Ethnicity: ☐ Hispanic or Latino ☐ Not Hispanic or Latino

Race (Check all that apply): ☐ Black or African American ☐ Asian ☐ White or Caucasian
☐ American Indian or Alaska Native ☐ Native Hawaiian or other Pacific Islander

Program Preference (Full day not available in all programs): ☐ Full Day ☐ Part Day (If part day, ☐ Morning ☐ Afternoon ☐ Either)

Based on availability, do you have a program location preference? _____

How did you hear about Kalamazoo County Pre-K? ☐ Radio ☐ Flyer ☐ Social Media ☐ Previous Experience (programs, home visits)
☐ Family/Friends — Full Name: _____

FAMILY INFORMATION

Child Lives with: ☐ Both Parents ☐ Mother ☐ Father ☐ Joint Custody (If joint, ☐ Physical or ☐ Legal) ☐ Legal Guardian
☐ Grandparent(s) ☐ Foster Care ☐ Other, Explain: _____

Family Language: Primary _____ Secondary _____ ☐ Family Needs an Interpreter

PARENT OR LEGAL GUARDIAN INFORMATION

Full Name: _____
Date of Birth: _____
Parent Address: _____
_____
Email: _____
Legally Responsible for Financial Support: ☐ Yes ☐ No

Phone Type: Phone Number with Area Code:
☐ Home ☐ Work ☐ Cell ☐ Text _____
☐ Home ☐ Work ☐ Cell ☐ Text _____

Relationship: ☐ Birth or Adoptive or Step Parent ☐ Foster Parent
☐ Grandparent ☐ Other Relative ☐ Other Caregiver

Education (Check the highest level):
☐ No High School Diploma or Highest Grade: ☐ 9 ☐ 10 ☐ 11
☐ High School Diploma or ☐ GED ☐ Associate Degree
☐ Bachelor's Degree ☐ Master's Degree ☐ Doctoral Degree

Employment or Other (Check all that apply):
☐ Employed Part-time (Less than 35 hours per week)
☐ Employed Full-time (More than 35 hours per week)
☐ Attends School or College ☐ Home by Choice ☐ Unemployed

PARENT OR LEGAL GUARDIAN INFORMATION

Full Name: _____
Date of Birth: _____
Parent Address: _____
_____
Email: _____
Legally Responsible for Financial Support: ☐ Yes ☐ No

Phone Type: Phone Number with Area Code:
☐ Home ☐ Work ☐ Cell ☐ Text _____
☐ Home ☐ Work ☐ Cell ☐ Text _____

Relationship: ☐ Birth or Adoptive or Step Parent ☐ Foster Parent
☐ Grandparent ☐ Other Relative ☐ Other Caregiver

Education (Check the highest level):
☐ No High School Diploma or Highest Grade: ☐ 9 ☐ 10 ☐ 11
☐ High School Diploma or ☐ GED ☐ Associate Degree
☐ Bachelor's Degree ☐ Master's Degree ☐ Doctoral Degree

Employment or Other (Check all that apply):
☐ Employed Part-time (Less than 35 hours per week)
☐ Employed Full-time (More than 35 hours per week)
☐ Attends School or College ☐ Home by Choice ☐ Unemployed

LIST OTHER CHILDREN AND OTHER FAMILY MEMBERS SUPPORTED BY INCOME (IF YOU NEED EXTRA SPACE, ATTACH A SHEET OF PAPER)

Last Name	First Name	Attended Head Start?	Date of Birth (mm/dd/yyyy)	Gender	Relationship	If child, age of parent when child was born
		☐ Yes ☐ No		☐ M ☐ F		
		☐ Yes ☐ No		☐ M ☐ F		
		☐ Yes ☐ No		☐ M ☐ F		
		☐ Yes ☐ No		☐ M ☐ F		

Please list school(s) where siblings currently attend: _____

FAMILY'S CURRENT LIVING SITUATION

The family currently lives:
☐ in a home you rent or own
☐ in a home owned or rented by someone else
☐ in a temporary housing situation
☐ without a fixed nighttime residence
☐ in a hotel/motel
☐ in a shelter

ADDRESS INFORMATION (INCLUDE APARTMENT COMPLEX NAME, IF APPLICABLE.)

Address: _____ (Street, Apt) _____ (City) _____ (State) _____ (Zip Code) County: _____

Child's Pick-up Address (If different): _____ Child's Drop-off Address (If different): _____

What school district do you live in: ☐ Climax-Scotts ☐ Comstock ☐ Galesburg-Augusta ☐ Gull Lake ☐ Kalamazoo ☐ Parchment ☐ Portage ☐ Schoolcraft ☐ Vicksburg ☐ Other: _____

INCOME OF FAMILY MEMBERS LEGALLY RESPONSIBLE FOR CHILD'S SUPPORT

Name: _____ Total Annual Income: $ _____

Name: _____ Total Annual Income: $ _____

Please select **ALL** sources of family income received in the last 12 months:

☐ Full-time Employment ☐ Cash Assistance (FIP) ☐ SSI ☐ Other: _____

☐ Part-time Employment ☐ Unemployment ☐ Child Care Reimbursement _____

☐ Social Security ☐ Child Support _____

SUPPLEMENTAL QUESTIONS

Emergency Contact Name: _____ Phone Number with Area Code: _____

Address: _____ (Street/ Apt.) _____ (City) _____ (State) _____ (Zip Code)

Before or after School care needed? (Not available in all programs) ☐ Yes ☐ No Are you able to self transport? ☐ Yes ☐ No

Please list any program or childcare that your child is currently attending: _____

CHILD (APPLICANT) DISABILITY STATUS

Does the child have an identified developmental delay? ☐ No ☐ Yes – Please describe: _____

Has your child participated with any of the following programs? ☐ Early On ☐ PET ☐ Home Visits – Contact: _____

Has your child received services for: ☐ Vision or Hearing ☐ Speech ☐ Early Childhood Special Education ☐ Occupational Therapy ☐ Physical Therapy ☐ IEP or IFSP

OTHER CONFIDENTIAL INFORMATION THAT MAY PRIORITIZE PLACEMENT

Does child's behavior ever prevent participation in other group settings?	☐ Yes	☐ No
Does anyone in the household speak a primary language other than English?	☐ Yes	☐ No
Has someone in the household been abused or neglected?	☐ Yes	☐ No
Does child live with one adult as result of divorce, separation, incarceration, military service or death?	☐ Yes	☐ No
Does child have a chronic illness or medical considerations (asthma, feeding tube, allergies, frequent ear infections, etc.?)	☐ Yes	☐ No
Is the child in foster care?	☐ Yes	☐ No
Does any sibling have a chronic illness, behavior issue, disability or has died?	☐ Yes	☐ No
Was either parent under 20 years old when first child was born?	☐ Yes	☐ No
Is family without stable housing or is family homeless?	☐ Yes	☐ No
Does family live in high-risk neighborhood? (Unsafe due to crime, drug abuse, pollution, insect infestation, etc.)	☐ Yes	☐ No
Was child exposed to toxic substances before or after birth? (Alcohol, drugs, lead poisoning, nicotine, etc.)	☐ Yes	☐ No

PARENT/GUARDIAN SIGNATURE

Information on this application is confidential. Your child's pre-kindergarten program will not discriminate against any family or student on the basis of race, color, national origin, gender, or handicap.

☐ *I certify that the information, including income, provided in this application is accurate and truthful to the best of my knowledge. I understand that it is my responsibility to inform my child's pre-kindergarten program if I move, or if I have any other changes in circumstances that could affect my child's enrollment or placement. I understand that by participating in the pre-kindergarten program, my child's learning and development will be assessed and monitored to support further growth; and that some results may be reported as scores and combined with other children's scores for future research related to the general level of impact of kindergarten readiness across the county.*

☐ *I understand that this information will be entered into a confidential central database system that may be accessed by Kalamazoo RESA Head Start, Great Start Readiness Programs, Kalamazoo County Ready 4s, and Homer Stryker M.D. School of Medicine in an effort to correctly place my child into a Kalamazoo County Pre-K Program and effectively analyze Kalamazoo County services to families and children. My signature below constitutes a consent to disclose the information on this application to the listed entities.*

Signature* of Parent/Guardian: _____ Date (mm/dd/yyyy): _____

** If information is given verbally, staff will print the parent/guardian name above with the date, check this box, and initial* ☐ _____

(Revised 1/14/2019)

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.

Parchment Early Learning Center
AND SCHOOL AGE CHILDCARE

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

"These materials were developed under a grant awarded by the Michigan Department of Education."

Child's Name: _____

Please initial ALL that apply

_____ I verify that I received a written information packet containing information regarding:

- Criteria for admission and withdrawal
- Schedule of operation, denoting hours, days, and holidays that the center provides services to families
- Billing and fee policy
- Discipline policy
- Food service policy
- 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

_____ I agree to provide all meals for our child in one of the following ways: purchasing through Chartwell's Food Service *or* packing and sending a lunch from home. If my student is in GSRP, I understand that breakfast and lunch are provided at no additional cost to me.

_____ I give permission for my GSRP student to ride the school bus daily (or as otherwise scheduled) from our pick up location to arrive at PELC at 8:10 AM or at 3:15 PM from PELC to our drop off location.

_____ I give permission for PELC staff to administer any topical, nonprescription medication to my child that is labeled with my child's name and that I have provided.

_____ I agree to allow PELC to use my child's photo or video in any of the following places: classroom or center wide books, albums, and newsletters, the website, Panther Press, and the Kalamazoo Gazette. I understand that photos or videos posted outside of the center will not have my child's name attached to them.

_____ I agree to allow our School Age child who is enrolled in PELC's Summer Camp to participate in swimming activities. My child is a ____ swimmer ____ non-swimmer.

_____ I understand that a door entry code will be activated for my family. I agree to keep the code confidential and not share it with others. The following 4 digits is my preferred entry code: _ _ _ _

Date: _____

Parent/Guardian printed name: _____

Parent/Guardian signature: _____

Parchment Early Learning Center
AND SCHOOL AGE CHILDCARE

Great Start Readiness Program
Michigan's National Accredited Pre-K Program

"These materials were developed under a grant awarded by the Michigan Department of Education."

Life Experiences Form

This form assists enrollment staff in finding all potential prioritization factors for the GSRP program. Please check all that apply. All information on this form will be kept confidential.

Family Information	Comments
☐ My child is eligible/been referred for special education services and/or has a diagnosed learning condition ☐ My child's developmental progress is less than that expected for their age ☐ A chronic health issue has caused development or learning problems ☐ I have concerns about my child's speech/ language, physical, academic, or social development	
☐ My child has been expelled from a preschool or childcare ☐ My child's behavior has prevented them from participating in a group setting ☐ My child has been referred to services/counseling for behavior problems ☐ I am concerned about school success due to severe or challenging behavior	
☐ Someone in my child's household has experienced domestic, sexual, emotional, or physical abuse ☐ Someone in my child's household has experienced physical or emotional neglect ☐ Child Protective Services has been called to investigate concerns within my child's household	
☐ My child's situation has been negatively affected by issues related to a sibling: chronic illness, severe or challenging behavior, disability, death ☐ My family is currently living "doubled up" with other family members or friends ☐ My family has moved often, experienced homelessness, has had unsafe or crowded housing, or lack of utilities ☐ My child has resided in a high risk neighborhood which may have lead to any of the following: exposure to lead, rodents, insect infestations, high crime, violence, injury, or drug abuse ☐ My child does not have adequate play and/or living space ☐ My child had pre- or postnatal exposure to toxic substances	
☐ None of the above	

Signature of Parent/Guardian: _____ Date: _____

STUDENT ENROLLMENT FORM

Has this student previously attended school in Parchment? ☐ Yes ☐ No

Check the preferred building you want your student to attend. Final determination will be made by the building's principal.

☐ Central Elementary
☐ North Elementary
☐ Northwood Elementary
☐ Parchment Middle School
☐ Parchment High School
☐ Barclay Hills Education Center

FOR OFFICE USE ONLY
Verification of Birth Certificate ☐ Yes ☐ No
Verification of Immunizations ☐ Yes ☐ No
Verification of Residency ☐ Yes ☐ No
Locker Number Comb.
Homeroom/Teacher
Bus # (Pickup) Bus # (Drop-off)
Date Application Received
Date/Time 1st Day of Attendance

STUDENT INFORMATION

Student Name: _____ **Nickname:** _____
(FromBirth Certificate) (LAST) (FIRST) (MIDDLE) (OPTIONAL)

Gender: ☐Male ☐Female **Birthdate:** ___/___/____ **Age:**_____ **Grade:** _____ **Student Email Address:** _____

ETHNICITY (Part A) and RACE (Part B)

Race and Ethnicity (Both Part A and Part B) of the question must be answered. If either part is not answered, the US Department of Education requires the district to supply an answer on your behalf.

Part A:Ethnicity (*choose only one*)	**Is this student Hispanic/Latino?** (A person of Cuban, Mexican, Puerto Rican, South or Central American or other Spanish culture or origin, regardless of race.) ☐ Yes ☐ No
Part A refers to ethnicity, not race. No matter which box you selected above, please continue to answer Part B (below) by marking one or more boxes to indicate what you consider your student's race to be.	
Part B:Race (*choose one or more*) When choosing more than one, enter % for each ethnicity	%____ ☐ American Indian or Alaska Native (Origins from any of the original peoples of N, S, or Central America) %____ ☐ Asian (Origins from any of the original peoples of the Far East, Southeast Asia, or the Indian subcontinent) %____ ☐ Black or African American (Origins from any of the black racial groups of Africa) %____ ☐ Native Hawaiian / Other Pacific Islander (origins from any of the original peoples of any Pacific Island) %____ ☐ White (Origins from any of the original peoples of Europe, the Middle East or N Africa)

PRIMARY HOUSEHOLD INFORMATION

Home Phone Number:(___)_____**Unlisted ( )Phone Number for Attendance Calls:**(___)_____**Unlisted ( )**

Primary Email Address: _____

Is the primary language used in your child's home or environment a language other than English? ☐ Yes ☐ No

If yes, what is that language? _____ Resident District _____

Current Physical Address: _____
(STREET ADDRESS) (CITY) (STATE) (ZIP) (COUNTY)

Current Mailing Address: _____
(*if different*) (STREET ADDRESS or PO BOX) (CITY) (STATE) (ZIP)

PRIMARY HEAD(S) OF HOUSEHOLD (With whom does the child reside?)

☐ Adoptive Parents
☐ Birth Parents
☐ Father/Stepmother
☐ Mother/Stepfather
☐ Father Only
☐ Mother Only
☐ Legal Guardian
☐ Emancipated Minor
☐ Foster Home
☐ Relative (_____)
☐ Shelter
☐ Doubled-Up
☐ Hotel/Motel
☐ Other (_____)

Primary Household Data:	Primary Head of Household 1	Primary Head of Household 2
Head of Household Name/Title (Last, First)		
Relationship Type		
Occupation/Employer		
Employer Phone		
*Additional Notes for above Phone Number		
Cell Phone / Pager		
*Additional Notes for above Phone Number		
Email Address		

Color: Canary Yellow

1/20/2015

SECONDARY HEAD(S) OF HOUSEHOLD

Does the child have a second parent/second residence? ☐ Yes ☐ No **If yes, with whom?**

☐ Mother Only ☐ Stepmother/Father ☐ Other:_____

☐ Father Only ☐ Stepfather/Mother Joint Custody? ☐ Yes ☐ No

Current Physical Address: _____

(STREET ADDRESS) (CITY) (STATE) (ZIP) (COUNTY)

Current Mailing Address: _____

(if different) (STREET ADDRESS or PO BOX) (CITY) (STATE) (ZIP)

Should this household be included in all mailings? ☐ Yes ☐ No **Okay to release student to second household parent** ☐ Yes ☐ No

If you answered "No" to either of these questions, please attach legal documentation; specific to this child

Secondary Household Data:	Secondary Head of Household 1	Secondary Head of Household 2
Head of Household Name/Title (L,F,M)		
Relationship Type		
Occupation/Employer		
Employer Phone		
*Additional Notes for above Phone Number		
Cell Phone / Pager		
*Additional Notes for above Phone Number		
Email Address		

Other Contacts

Transportation to a location other than home	Name:	Address:	Phone
Childcare Contact	Name:	Phone #1:	Phone #2:

ADDITIONAL EMERGENCY CONTACT INFORMATION (NOT PARENTS)

Calling Order	Name	Relationship Type	Work Phone	Cell Phone	Home Phone
1)					
2)					
3)					
Doctor		Doctor		If a medical emergency exists, the school will take appropriate action on behalf of the child. The family will assume all medical costs.	

OTHER SIBLINGS LIVING AT HOME

Name	Gender	Birthdate	School	Grade
	☐M ☐F	/ /		
	☐M ☐F	/ /		
	☐M ☐F	/ /		

HEALTH INFORMATION

Medical information is confidential and will be shared with personnel on a need to know basis.

Special Health Conditions ☐ Diabetes ☐ Heart ☐ Asthma ☐ Seizures ☐ Other (Explain) _____

Allergies ☐ Insects/Beestings ☐ Medication ☐ Food ☐ Environmental (Explain all) _____

Is student currently taking any prescription medications? Please list: _____

SPECIAL NEEDS INFORMATION

Special Program Received at Prior School: ☐ Special Education ☐ Speech & Language ☐ 504 Plan ☐ Title 1 Services ☐ Other (Explain) _____

Has the student been previously suspended or expelled? ☐ Yes ☐ No **If Yes, which district?** _____

If Yes, please explain _____

Parent/Guardian Signature: _____ **Date** _____

Color: Canary Yellow

1/20/2015

Return this completed form to: ***(Insert institution's name, address & telephone number)***

Household Income Eligibility Statement – Child Care Institutions

Part 1 – Households Receiving Food Assistance Program (FAP), Family Independence Program (FIP), or Food Distribution Program on Indian Reservations (FDPIR)

If any member of your household receives FAP, FIP, or FDPIR, provide the name and case number for the person who receives the benefits.

Name:_____ **Case Number:** __ __ __ __ __ __ __ __ __

Part 2 – Household Information

First and Last Names of All Household Members, Related and Unrelated	Enrolled for Child Care (x)	Age	Birth Date	Foster Child (x)	Amount of Earnings from Work (before deductions)	How Often? (x)					Amount of Welfare, Child Support, or Alimony	How Often? (x)					Amount of All Other Income (Indicate source and amount)	How Often? (x)					Mark if No Income (x)
						Annually	Monthly	2x Month	Bi Weekly	Weekly		Annually	Monthly	2x Month	Bi Weekly	Weekly		Annually	Monthly	2x Month	Bi Weekly	Weekly	

Part 3 – All Households: Signature and Last Four (4) Digits of Adult Social Security Number (Adult household member MUST sign and date)

I certify that all information on this form is true and that all income is reported. I understand that the center or day care home will receive federal funds based on the information I give. I understand that CACFP officials may verify the information. I understand that if I purposely give false information, the participant receiving meals may lose the meal benefits, and I may be prosecuted.

Signature: _____ Print Name: _____ Date: _____

Last four digits of Social Security Number: XXX-XX-_ _ _ _ ____ I do not have a Social Security Number

For Institution Use Only:

For Institution Use Only			
Total Household Members:	**Total Income: $**	___ Annually ___ Monthly ___ 2x Month ___ Bi-Weekly ___ Weekly	**APPROVED CATEGORY** **Categorical Eligibility (A/Free):** Foster FIP FAP FDPIR **Other Household Children:** A (Free) B (Reduced) C (Paid)
Institution Official Signature: _____ **Approval Date:** _____			

This form is valid for 12 months from the date of institution signature. Approval date and institution signature are required.

Return this completed form to: (*insert institution's name, address & telephone number)*

Participant Enrollment Form

Instructions:

1. List full name of participant enrolled in care
2. Circle the typical days each participant is in care
3. List times each participant is in care
4. Circle the meals and snacks each participant typically receives while in care
5. Select the ethnicity of each participant using the following codes: H = Hispanic or Latino, N = Not Hispanic or Latino*
6. Select one or more racial designations of each participant using the following codes: A/I = American Indian or Alaskan Native, A = Asian, B = Black or African American, H/PI = Native Hawaiian or Pacific Islander, W = White*
7. Sign and date the form and return to your care center

Participant's First and Last Name	Typical Days in Care (circle all that apply)	List Times in Care	Meals/Snacks Received (circle all that apply)	Ethnicity	Race
	Mon Tues Wed Thu Fri Sat Sun		Breakfast AM Snack Lunch PM Snack Supper Evening Snack		
	Mon Tues Wed Thu Fri Sat Sun		Breakfast AM Snack Lunch PM Snack Supper Evening Snack		
	Mon Tues Wed Thu Fri Sat Sun		Breakfast AM Snack Lunch PM Snack Supper Evening Snack		
	Mon Tues Wed Thu Fri Sat Sun		Breakfast AM Snack Lunch PM Snack Supper Evening Snack		

* This information is voluntary. This will assist us in assuring the Child and Adult Care Food Program is administered in a nondiscriminatory manner.

Adult/Parent/Guardian's Address

Adult/Parent/Guardian's Phone Number

Signature of Adult/Parent/Guardian

Date Signed

Non-Discrimination Statement

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MICHIGAN Education

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?
☐	☐	☐	1 Allergies or Reactions (for example, food, medication or other)
☐	☐	☐	2 Hay Fever, Asthma, or Wheezing
☐	☐	☐	3 Eczema or Frequent Skin Rashes
☐	☐	☐	4 Convulsions/Seizures
☐	☐	☐	5 Heart Trouble
☐	☐	☐	6 Diabetes
☐	☐	☐	7 Frequent Colds, Sore Throats, Earaches (4 or more per year)
☐	☐	☐	8 Trouble with Passing Urine or Bowel Movements
☐	☐	☐	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?

Reason for Medication

_____ / / *Parent/Guardian Signature* Date

Birth History:

Are there any current or past diagnosis(es) ☐ Yes ☐ No

If yes, please describe:

If yes, list medications:

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
☐	☐	VISION Date: / /	Visual Acuity			
			Muscle Imbalance			
			Other:			
☐	☐	HEARING Date: / /	Audiometer			
			Other:			
☐	☐	URINALYSIS Date: / /	Sugar			
			Albumin			
			Microscopic			
☐	☐	BLOOD LEAD LEVEL Date: / /	Level _____ ug/dl ⇨			

No	Yes	Was child tested for:	Test results:	Normal	Referred	Under Care
☐	☐	HEIGHT & WEIGHT	Height			
			Weight			
☐	☐	Other: _____	Other			
☐	☐	HEMOGLOBIN / HEMATOCRIT	⇨			
☐	☐	BLOOD PRESSURE	Reading: _____			
☐	☐	TUBERCULIN Date: / /	Type: _____ Neg.: ☐ Pos.: ☐ _____ mm			

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 (HepB)	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 Chickenpox Disease? ☐ Yes ☐ No If yes, date:

VACCINES (Circle Type)	DATE ADMINISTERED MM/DD/YYYY	
Hepatitis A (HepA)	1	2
Influenza (IIV/LAIV)	1	3
	2	4
Meningococcal (MCV4 / MPSV4)	1	2
Human Papillomavirus (HPV9/HPV4/HPV2)	1	3
	2	

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 provider office for medical waiver forms and through your local health department for nonmedical waiver forms.

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 _____ '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

_____ _____ 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 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.

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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.