

Welcome

To enroll for Preschool in the Troy School District, please fill in this ENTIRE Preschool Enrollment Packet, Print and Bring to your Registration/Enrollment appointment.

If you have any questions, please call the Enrollment office at [\(248\) 823-3000](tel:2488233000)

Thank you

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
Parent/Legal Guardian's Name			Home Phone ()	Parent/Legal Guardian's Name (Optional)
Home Address (if not child's address)			Cell Phone ()	Home Address (if not child's address)
City	State	Zip Code	City	State
Email Address (optional)			Email Address	
Employer Name			Work Phone ()	Employer Name
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. 7-18) Previous edition 6-17 may be used.

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 treatment 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 Citation.	

BCAL-3731 (Rev. 7-18) Previous edition 6-17 may be used.

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?	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	1 Allergies or Reactions (for example, food, medication or other)	Birth History: Are there any current or past diagnosis(es) <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, please describe: If yes, list medications: Was the health history reviewed by a health professional? <input type="checkbox"/> Yes <input type="checkbox"/> No Examiner's Initials: _____
<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 _____	

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 Other: _____	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 Date: / /	Type: _____ Neg.: <input type="checkbox"/> Pos.: <input type="checkbox"/> _____ mm			
<input type="checkbox"/>	<input type="checkbox"/>	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		VACCINES (Circle Type)	DATE ADMINISTERED MM/DD/YYYY	
Hepatitis B (HepB)	1	3	Hepatitis A (HepA)	1	2
	2		Influenza (IIV/LAIV)	1	3
				2	4
DTaP/DTP/DT/Td	1	4	Meningococcal (MCV4 / MPSV4)	1	2
	2	5			
	3	6	Human Papillomavirus (HPV9/HPV4/HPV2)	1	3
Tdap	1			2	
<i>Haemophilus Influenzae</i> type b (HIB)	1	3	OTHER Vaccines Specify Date & Type	Type of Vaccine(s)	Date of Vaccine(s)
	2	4		1	
Polio (IPV/OPV)	1	3		2	
	2	4	3		
Pneumococcal Conjugate (PCV7/PCV13)	1	3	<i>Indicate and attach physician diagnosis or laboratory evidence of immunity as applicable</i>		
	2	4	*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.		
Rotavirus (RV1/RV5)	1	3			
	2		Parent/Guardian refused immunizations: <input type="checkbox"/>		
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					
_____			_____		____/____/____
<i>Health Professional's Signature</i>			Title		Date

SECTION IV - RECOMMENDATIONS

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

No	Yes	
<input type="checkbox"/>	<input type="checkbox"/>	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"/>	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

_____ / _____ / _____
Date

_____ *Dentist's Signature*

PHYSICIAN'S SIGNATURE

_____ *Examiner's Signature* _____ / _____ / _____ *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.



Troy School District Preschool
Family and Social History

The following information is confidential. The information included will give the preschool staff a head start on getting to know your child. Thank you for taking the time to complete this valuable form.

Name of Child _____ Birthdate _____

Mother (Guardian) _____ Age _____

Father (Guardian) _____ Age _____

Home Elementary School for Kindergarten _____

Parent work hours: _____

Marital Status of Parents:

Living Together _____ Steppather _____

Parent work hours _____ Stepmother _____

If child is adopted:

Age at Adoption _____

Does child know he/she is adopted? _____

Separated _____ Divorced (remarks) _____
how long?

Custody/Living Arrangements: _____

Brothers/Sisters of Child:

Name _____ Age _____

Name _____ Age _____

Name _____ Age _____

Name _____ Age _____

Other members of the household (include relationship/age): _____

What is your child's native language? _____ Does your child speak English? _____

Does the child have a room alone? _____ If not, with whom? _____

Who has cared for child other than parents? _____ How many people live in your home? _____

Has your child had any group play experience? Where? _____

Does child have neighborhood friends? Specify. _____

Average number of hours per day spent on IPAD/computer/phone/TV. _____

Child's favorite indoor activities: _____

Child's favorite outdoor activities: _____

Please complete reverse side of this form.



Developmental History of Child:

Age at which child:

Crept on hands and knees _____

Sat alone _____

Walked alone _____

Named simple objects _____

Repeated short sentences _____

Slept through night _____

Began toilet training _____

Word child uses for: Urination _____ Bowel movement _____

Usual time for B.M. _____ Dietary Restrictions? _____

Does child dress self? _____ Undress self? _____

What time does your child go to bed at night? _____ Does she/he sleep well? _____

What time does your child usually awaken? _____ Any medical concerns/diagnosis? _____

Has your child ever been serviced by/ or participated in any other programs sponsored by the Troy School District? (ECP, Head Start, Early On, speech/language, etc) If so, when/by whom?

Does your child have an IEP? (Individualized Educational Plan) _____

Do you have any concerns about your child's developmental progress? _____

Does your child have any learning challenges that might influence their development? _____

Has your child had any prior screenings completed relating to their development? _____

Does your child have any special fears you are aware of? _____

What method of behavior control is used in your home? _____

What is your child's usual reaction? _____

Who does your child behave well for? _____ Who does your child not behave well for? _____

How would you describe your child's personality? _____

Has your family experienced changes at home in the past year (move, illness, loss of loved one or pet, etc.) that might affect your child during preschool? _____

Is there any special information that would help the teaching team caring for your child?



Dear Preschool Families,

Troy School District preschool collaborate with Oakland Schools by using the developmental screening tool the ASQ-3rd edition, Ages & Stages Questionnaire. Parents & professionals rely on ASQ for the best developmental and social-emotional screening for children from one month to 5 ½ years. Highly reliable and valid, ASQ looks at strengths and trouble spots, educates parents about developmental milestones, and incorporates parents' expert knowledge about their children.

The ASQ is widely used in homes, early childcare programs, schools, and clinical settings. The ASQ is easy for parents and educators to use and takes less than 15 minutes to complete.

Please take 15 minutes for your child and complete the ASQ3 screening tool @ <https://www.asqonline.com/family/a4a4bf>

You may also complete the ASQ-SE2(social-emotional development) screening tool to see if your child's social-emotional development is on schedule @ <https://www.asqonline.com/family/8e80fb>.

** If your child has a diagnosis, please do not complete this screening.*

If you prefer to complete a paper copy of the screening tool, please contact your child's teacher.

Once the ASQ3 or ASQ-SE2 is completed & scored, parents & teachers are given an individual child report. Information from the report will help identify developmental delays, strengths and milestones, and the need for additional screening or support. This provides families and teachers with a tool which establishes information on the child's development.

Because developmental and social-emotional delays can be subtle and can occur in children who appear to be developing typically, most children who would benefit from early intervention are not identified until after they start school. It is our goal to help identify and provide support with early intervention through the use of this assessment tool.

Thank you for taking the time to complete the ASQ-3 and the ASQ-SE2 for your child. We highly regard your expertise on your child's development and look forward to providing you with an excellent parent/teacher partnership for the education and development of your child.

Please complete the back of this form and submit at enrollment.



Screening Consent Form 2020-21

Dear Preschool Families,

The first 5 years of life are very important for your child(ren) because this time sets the stage for success in school and later in life. During infancy and early childhood, your child(ren) will gain many experiences and learn many skills. It is important to ensure that each child's development proceeds well during this period.

Please read the text below and select the desired option to indicate whether you will participate in the screenings/monitoring programs.

_____ I have read the provided information about the Ages & Stages Questionnaire (ASQ-3) and the ASQ-SE2. I wish to have my child(ren) participate in the monitoring program.

_____ I understand and give my consent for my child(ren) to participate in hearing and vision screening provided by the Oakland County Health Department. Screening is available to 4 year old students only.

_____ I do not wish to participate. I have read the provided information about the Ages & Stages Questionnaires (ASQ-3) and the ASQ-SE2 and understand the purpose of this program.

_____ I do not wish to participate. I have read the provided information about the hearing & vision screening and understand the purpose of this program.

Please return this form at enrollment

My child _____, attends the Troy School District preschool program.

X

Parent or Guardian's Signature

Date _____

Preschool 2020-21 Parent Agreement

Please read and sign the reverse side of this form.



Child's Name (please print clearly) _____

Please read each statement below, and then sign the bottom of this agreement. Return this form at the time of enrollment. I, _____, have been provided information pertaining to the Preschool policies and procedures via the Parent Handbook. I have received a printed copy at the time of enrollment.

- I have read the Preschool Parent Handbook and agree to abide by all policies and procedures described including the following: admission and withdrawal, schedule of operation, tuition/fees, late pick-up fees, typical daily routine, program philosophy, food provided by the parent, child illness exclusion policy, notification for accidents, injuries and incidents, discipline policy, pest management, volunteer policy.

I understand and agree to the following:

- The policies regarding fees.
- Fees for the upcoming month are posted to my account on the first (1st) of each month. **Invoices are not mailed.** Fees/tuition are due the first of each month.
- Payment options available are one full payment for the year tuition in August, 5 installment payments beginning August 1 through Dec, 2020 or 10 installment payments from August 1st through May 1st 2021.
- Payment method is limited to either online payment <https://squareup.com/store/troyschools> by using a VISA, MasterCard, Discover, or American Express debit or credit card or by participation in the Authorization for Automatic Credit Card/Debit Payment option.
- Payments received after the due date will be assessed a \$45 late charge on the current balance.
- **If my account is more than 30 days past due it will be turned over to a collection agency.**
- Credits/refunds are not given for any missed days of school. (including, but not limited to: illness, travel, emergency closings, weather, etc.)
- Unused portions of the yearly tuition will not be refunded after December 1, 2020 due to withdrawal from preschool.
- Written notice to the Troy School District Preschool is required to withdraw my child from the program. **The withdrawal becomes effective two (2) weeks after the notice is received in the preschool office, 205 W. Square Lake Rd.** If, after withdrawing my child I want to reinstate, I may do so space permitting.
- I understand the late pick up fee policy.
- My child's photo may be used in Troy School District publications, general news articles, social media, or on the district website.
- I may review the licensing reports (past 5 years), located in the Licensing Notebook available at the TSD preschool building, where my child attends. The Licensing Notebook is available during the center's daily hours of operation (8-4pm), Monday – Friday.
- I have received information on Concussion Awareness.
- Half-Day Preschools ONLY – I must provide my child with a healthy snack each day. I must label the snack bag with my child's first and last name and record the date on the bag daily.
- Full Day Preschools ONLY – I must provide my child with a lunch and two snacks each day. I understand lunch may be purchased at school or I may pack lunch. When I send snack/lunch from home I must label the snack/lunch bag with my child's first and last name and record the date on the bag daily.
- I have been provided with a list of activities (Daily Routine) that will be offered during the preschool hours. I understand that not all activities will be offered daily.
- I understand that if a serious injury or accident occurs with my child, I will be notified first, unless the injury is life-threatening. If life threatening, 911 will be called for medical evaluation and possible transport to the hospital.
- I understand the Pest Management Application notification will be provided to me by email, a posting in the center, or in person by staff prior to applications. The handbook explains application methods used.

Parent's Signature _____ Date _____



Preschool 2020-21 Parent Agreement

Please read and sign the reverse side of this form.

BEHAVIOR EXPECTATIONS

We believe that children learn best in a well-ordered environment that is free from disruptions. To promote such an environment, the Early Childhood department, teachers and staff work together to help children to:

- Respect all persons & property
- Act in a courteous and cooperative manner.
- Use acceptable and appropriate language.
- Be safe & learn to act responsibly.

These student rules are described in the Troy School District's Student's Rights and Responsibilities Code of Conduct booklet and apply to all schools in the district. This can be found on the Troy School District's website at www.troy.k12.mi.us/about/codeofconduct.pdf.

Teachers will handle the majority of discipline within the classroom. Repeated and/or harmful behavior to others or self, will be called to the attention of the Early Childhood Director and/or Coordinator and parents will be notified.

Behavior will be monitored, with daily communication with the family.

1. If significant behavior changes do not occur, teaching team, director, and family, meet to discuss alternative options, strategies, classroom supports, next steps.
2. If the placement in the preschool classroom/CARE is not the recommended environment for the safety of the child, students and staff, and all intervention measures have been implemented without improvement in behavior, a final recommendation for permanent suspension from program may occur.
3. A child who has not been able to adjust to behavioral recommendations may be dismissed from the preschool/CARE program.

- I have read the behavior expectations and reviewed them with my child.

PROGRAM DISMISSAL

The following circumstances may result in a child being dismissed from the preschool.

- **Incomplete forms.**
- Dropping off a child before the start of class.
- Late pick-up (after class ends) more than three (3) times.
- Physical or verbal abuse/harm to another child or staff member, according to developmental expectations.
- Physical or verbal abuse/harm to another child or staff member by either a child or a parent.
- A child who does not adjust to behavioral recommendations as stated in the discipline procedures.
- Failure to sign a child in or out of the program more than three (3) times.

Accounts more than five (5) working days overdue may be dropped from the program

Parent's Signature _____

Date _____

WRITTEN INFORMATION PACKET DOCUMENTATION

Michigan Department of Human Services
Bureau of Children and Adult Licensing

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.

Department of Human Services (DHS) will not discriminate against any individual or group because of race, religion, age, national origin, color, height, weight, marital status, sex, sexual orientation, gender identity or expression, political beliefs or disability. If you need help with reading, writing, hearing, etc., under the Americans with Disabilities Act, you are invited to make your needs known to a DHS office in your area.

Troy School District

Pesticide/Herbicide Pre-Application Notification Form

Dear Parent/Guardian:

The Troy School District has adopted an Integrated Pest Management Plan. If a pesticide/herbicide is applied during the year, including the summer months when school is not in session a public notice will be posted at the common entrances of the school buildings at least 48 hours prior to the application.

You have the right to be informed by U.S. mail postmarked at least three days prior to any pesticide application that might be needed in your school. If you would like to receive notification by U.S. mail, please notify the TSD Operations Office (pesticide notification) at 1140 Rankin Dr. Troy, MI in writing. In an emergency, pesticides may be applied without prior notice, but you will be provided notice following any such application. To receive notification, please complete the following information. **If the form is not returned, we will assume you do not want to be notified.** Should you have questions or concerns about pest management within your school/work place, please contact the Principal or the Superintendent's office.

(Please complete the following and return it to the school/work place – Please Print)

PRIOR NOTIFICATION REQUEST FOR PESTICIDE/HERBICIDE USAGE

School: _____

Parent/Guardian Name: _____

Student Name: _____

Address: _____

City: _____ Zip Code: _____

Home Phone: _____ Work Phone: _____

Email Address: _____

Please select one appropriate response:

- NO, I do not want to be notified
- YES, I want to be notified when there is a scheduled pesticide/herbicide application
- Notifications will be sent out via the U.S. Mail

Parent/Guardian Signature

Date