Student name:_________________________________DOB:________

Date Entered:_________Before and After care:_____________Transportation:____________

Pre-Registration Forms and Check- Off Sheet for

Midland Public Schools

School Entrance Form

Immunization Information

*Birth Certificate

Original birth certificate must be verified and a copy will be made in the office. Passport is also acceptable. Any social security numbers that appear need to be redacted.

Child Information Card

$25 non-refundable registration fee.

**Checks Payable to Midland Public Schools.

Transportation

Health Appraisal

Please deliver to:

The Pre-Primary Center at Carpenter Street School

1407 West Carpenter Street

School Entrance Form

Midland Public Schools
Midland, MI
PLEASE PRINT

For School Use Only

Teacher Number	Room No.	Residency verified by	Resident Dist.	Student Number
Entrance Date	Grade	Date	Attendance Area	DOB Verified by

Student Information

Legal Name: First Name	Middle Name	Last Name
Preferred Name: First Name/Nickname	Middle Name	Last Name

Is this student Hispanic/Latino? ☐ Yes ☐ No | Gender ☐ Male ☐ Female ☐ Unspecified | Date of Birth | Multiple Birth (Twin, Triplet, etc)

What is the students' race?
- ☐ American Indian or Alaska Native
- ☐ Native Hawaiian or Pacific Islander
- ☐ Asian
- ☐ White
- ☐ Black or African American

Place of Birth
Country of Citizenship
Alien Registration Number | Entry date into U.S. (if within 12 months)

Home Language Information

1. Is your student's primary language a language other than English? ☐ No ☐ Yes, Please Specify ______
2. Is there a language other than English spoken regularly in the home? ☐ No ☐ Yes, Please Specify ______

Do you wish to have your student tested for potential tutoring in English as a second language? ☐ Yes ☐ No, we refuse ESL Services

Is there a current **Order of Protection, No Contact Order** or other safety factors concerning this student? ☐ Yes, please provide documentation ☐ No

Physical Address

Apt Number	Street
City	Zip

Mailing Address (if different than physical address)

Apt Number	Street	P.O. Box
City	State	Zip

If your student is experiencing a loss of housing, foreclosure, eviction, or has had to move due to hardship, he or she may be eligible for assistance. This program requires school districts to remove any barriers to the immediate enrollment, attendance, full participation, and success of students, preK-12th grade, who lack a "fixed, regular, and adequate overnight residence." If eligible, students protected under the McKinney-Vento Act are entitled to immediate enrollment into school even if they do not have the documents normally needed, such as proof of residency, school records, immunization records, or birth certificate. The federal McKinney-Vento Homeless Assistance Act, Title IX Part A, of the Every Student Succeeds Act of 2015 includes a definition of who is considered "homeless" or as more commonly referenced "in transition" for the purposes of the Act and, therefore, eligible for the rights and protections it provides.

- ☐ I am a student not living with a parent or legal guardian. ☐ Shelter: ☐ Shelterhouse ☐ Open Door
- ☐ Campground, park, camper or Car. Where:______
- ☐ Doubled-up or couch surfing due to economic hardship or loss of housing, residing with: ☐ Family ☐ Friends
- ☐ Motel/Hotel Where:______
- ☐ Abandoned apartment or building Where:______
- ☐ In a Foster Care Placement ☐ No ☐ Yes, Where:______

Custodial Guardian

First Name	Middle Name	Last Name
Relationship to student (father, mother, etc)	Employer	Email Address
Education Level Completed	Apt Number	Street
P.O. Box	City	State	Zip	Active Military? ☐ Yes
Home Phone	Work Phone	Extension	Cell Phone	Pager

Custodial Guardian

First Name	Middle Name	Last Name
Relationship to student (father, mother, etc)	Employer	Email Address
Education Level Completed	Apt Number	Street
P.O. Box	City	State	Zip	Active Military? ☐ Yes
Home Phone	Work Phone	Extension	Cell Phone	Pager

Non-Custodial Guardian

First Name	Middle Name	Last Name
Relationship to student (father, mother, etc)	Employer	Email Address
Education Level Completed	Apt Number	Street
P.O. Box	City	State	Zip	Active Military? ☐ Yes
Home Phone	Work Phone	Extension	Cell Phone	Pager

Other children in household (please begin with oldest child)

Full Name (Last, First, Middle)	Gender	Date of Birth	Age	Grade
Full Name (Last, First, Middle)	Gender	Date of Birth	Age	Grade
Full Name (Last, First, Middle)	Gender	Date of Birth	Age	Grade
Full Name (Last, First, Middle)	Gender	Date of Birth	Age	Grade

Emergency Contact

First Name | Middle Name | Last Name

Relationship to student (uncle, aunt, family friend, etc) | Apt Number | Street

P.O. Box | City | State | Zip

Home Phone | Work Phone | Extension | Cell Phone | Pager

Emergency Contact

First Name | Middle Name | Last Name

Relationship to student (uncle, aunt, family friend, etc) | Apt Number | Street

P.O. Box | City | State | Zip

Home Phone | Work Phone | Extension | Cell Phone | Pager

Emergency Contact

First Name | Middle Name | Last Name

Relationship to student (uncle, aunt, family friend, etc) | Apt Number | Street

P.O. Box | City | State | Zip

Home Phone | Work Phone | Extension | Cell Phone | Pager

Health/Medical Information

Family Doctor | Phone

Immunizations:

Please attach current immunization records. We must have current immunization information or a waiver to complete your students registration.

Allergies or reactions to:

- ☐ Medication ______
- ☐ Insect Stings ______
- ☐ Foods ______
- ☐ Seafood
- ☐ Other ______

Does student use Epi-Pen or other emergency medications? ☐ Yes ☐ No

If Yes, will it be at school? ☐ Yes ☐ No

Medical devices:

- ☐ Brace
- ☐ Contact Lenses
- ☐ Glasses
- ☐ Hearing Aide
- ☐ Other ______

Health alerts, Please explain:

Does student have any chronic health problems?

☐ Asthma	☐ Blood	☐ Cardiac	☐ Cancer	☐ Convulsions/Seizures	☐ Cystic Fibrosis
☐ Diabetes	☐ Hearing	☐ Immuno-Deficiency	☐ Neurological	☐ Orthopedic	☐ Psychological
☐ Sickle Cell Anemia	☐ Speech	☐ Vision	☐ Other ______		

Is this condition potentially life threatening? ☐ Yes ☐ No If yes, please describe below

A history of mental health concerns; worries, anxiety, fears, depression? ☐ Yes ☐ No If yes, please describe below

Medical Notes, Descriptions, Diagnosis

Last School Attended

School Name		Street Address		
City	State	Zip	Withdraw Date	Type of School ☐ Public ☐ Private

3 year old preschool setting

Name of preschool/Daycare	How many days a week	Name of preschool/Daycare	How many days a week

4 year old preschool setting

Name of preschool/Daycare	How many days a week	Name of preschool/Daycare	How many days a week

Young 5 setting

Name of preschool/Daycare	How many days a week	Name of preschool/Daycare	How many days a week

Enrollment

Has this student ever received any special education services or attended special education classes? ☐ Yes ☐ No

Is this student currently receiving special education services? ☐ Yes ☐ No

Does the student currently receive services under Section 504? ☐ Yes ☐ No

Has the student ever had a mental health or behavioral residential placement? ☐ Yes ☐ No

If yes to any of the above, please provide a copy of the current documentation.

Discipline

Public Act 328 (effective January 1, 1995) requires public school districts to expel any student who possesses a dangerous weapon in a weapon-free school zone or commits either arson or rape in a school building or on school property (including school buses and/or other school transportation).

A dangerous weapon is defined as "a firearm, dagger, dirk, stiletto, knife with blade over three (3) inches in length, pocket knife opened by a mechanical device, iron bar, or brass knuckles or other devices designed to or likely to inflict bodily harm, including, but not limited to, air guns, and explosive devices."

Please Check One:

☐ Student has not been expelled from another school.

☐ Student has been expelled from another school or has expulsion charges pending. Please explain below.

☐ Is currently or previously been suspended from another school. Please explain below.

____

____

____

Directory Information

The Board designates as student "directory information" a student's name, address, telephone number, date and place of birth, photograph, year book pictures, video and/or electronic images, major field of study, participation in officially recognized activities and sports, height and weight, if a member of an athletic team, dates of attendance, date of graduation, awards received, honor rolls, and scholarships. If you have any objections regarding the release of this information about your child, please notify the school your child will be attending in writing.

Parent Consent

In case of illness, accident, or injury serious enough to warrant immediate medical attention, I hereby give permission to transport the above named child to the nearest hospital. I understand I am responsible for any and all costs incurred.

The Board may establish online access for the parents or the eligible student to the student's confidential academic and attendance records. Please be reminded that the account and confidential information about the student is only as secure as the parents or student keeps their information. The parent, eligible student, or unauthorized party will hold neither the District nor its employees responsible for any breech of this information.

I understand, for the health, safety, and/or educational needs of my child, information may need to be shared with individuals working with my child. Typically, this would include the building administrator, secretary, teachers, aides, counselors, school social workers, noon duty staff, transportation staff, technology staff, school nurse, truancy program coordinator, and school resource officer.

I understand that Midland Public Schools will release my child's immunization record and personally identifiable information to the Michigan Department of Health and Human Services and Local Health Department. I understand this information will be used to improve the quality and timeliness of immunization services and to help schools comply with Michigan Law. You may withdraw your consent to share this information by notifying your child's school in writing at any time.

There may be an occasion for enrollment in a virtual class. I hereby give permission to allow my child to enroll in a class that is taught in that format.

I understand that:

1. **Midland Public Schools will request records for this student from previous school(s); and**
2. **enrollment is conditional until records are received and reviewed by the district; and**
3. **If student records received from the previous school(s) are not as represented, this student may be excluded from Midland Public Schools immediately without further recourse.**

Parent/Guardian Signature	Date

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.)					

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 minorchild 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.

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 ⇨

Birth History:

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

If yes, please describe:

If yes, list medications:

_______________ / /

Parent/Guardian Signature Date

Was the health history reviewed by a health professional? ☐ Yes ☐ No ***Examiner's Initials:*** ____________

SECTION II - PHYSICAL EXAMINATION, INSPECTION, TESTS AND MEASUREMENTS

Required for Child Care and Head Start / Early Head Start

Tests and Measurements

No	Yes	Was child tested for:	Test results:	Normal	Referred	Under Care
☐	☐	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 ______ (child's name) 's teeth. As a result of this examination, my recommendation for treatment is: ______

Dentist's Signature ______ Date ___/___/___

PHYSICIAN'S SIGNATURE

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

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.

TRANSPORTATION FORM

Student Name: ____

Parent/GuardianName: ____

Contact Telephone: ____

Will you need your student to ride the Midland Public Schools bus?

☐ Yes (If checked, please complete remainder of form)

☐ No (If checked, you have completed the form)

If yes, where will your student need to be picked up from in the morning?

Home Address: ____

Alternate Location:

Individual/Daycare Name: ______________________________

Street Address: ______________________________

Contact Telephone Number: ______________________________

If yes, where will your student need to be dropped off at in the afternoon?

Home Address: ____

Alternate Location:

Individual/Daycare Name: ______________________________

Street Address: ______________________________

Contact Telephone Number: ______________________________

For office use only:

Building:______________________________Teacher: ______________________________

MIDLAND PUBLIC SCHOOLS
Administration of Medication Policy

Medication Definition: Medication includes prescription, nonprescription and herbal medications and includes those taken by mouth, taken by inhaler, injected (epi-pen), applied as drops to eye or nose, or applied to the skin.
Administration of medication (prescription, nonprescription, and herbal) to a student by a school administrator or an employee designated by the school administrator is allowed if:

- ☐ The request to administer the medication should be completed and signed by the student's parent or guardian.
- ☐ The request for medicine must include the written instructions for the medication signed by the prescribing physician. The prescribing physician must authorize any changes in medication.
- ☐ Administration of medication by a school staff member must be done in compliance with a physician's written instructions and signed by a parent or guardian, for either prescription or nonprescription medicine. Administration of the medicine shall be done in the presence of another adult and a log of the medication administration shall be maintained. In a life-threatening emergency an individual may administer the medication, record this into the log and notify the school administrator.
- ☐ Parental or guardian request/permission and physician's instructions shall be renewed annually, or more often if necessary.
- ☐ Medication shall be stored in a secure location in a labeled container as prepared by the pharmacy, physician or pharmaceutical company and include the pupil's name, the name of the medication, dosage and frequency of administration. This container will be kept at the school for the duration of the administration.
- ☐ Non-prescription medications will not be given for more than the amount listed on the package without a note from a physician.
- ☐ All controlled-substance medications will be counted and recorded in the medication administration log upon receipt from the parent/guardian. The medication will be recounted on a regular basis (monthly or bi-weekly) and be reconciled with the medication administration log.

Self-Administration

Self-Administration means that the pupil is able to consume or apply prescription, non-prescription and herbal medication in the manner directed by a physician without additional assistance or direction. Self-possession means that the pupil may carry medication on his/her person to allow for immediate and self-determined administration

- ☐ The student's parent/guardian must provide written permission and request the school to allow student to self-possess and self-administer medication (prescription and/or nonprescription), except when prohibited by law.
- ☐ The request must include the written instructions for the medication and state that the student may self-possess and/or self-administer the medication. This request must be signed by the prescribing physician.
- ☐ Medication that a pupil possesses must be labeled and prepared by a pharmacy or pharmaceutical company and include the dosage and frequency of administration
- ☐ The parental or guardian request/permission and physician's instructions shall be renewed annually, or more often if necessary.
- ☐ Sharing of prescribed or non-prescribed medication is prohibited.
- ☐ Controlled substances (e.g., Ritalin or codeine) shall not be self-administered.
- ☐ Non-prescription medications will not be given for more than the amount listed on the package without a note from a physician.

The *Administration of Medications* policy and procedure plan shall be communicated to parents, guardians and physicians on an annual basis.

Additional Information

- ☐ If there is a question on the appropriateness of administering a particular type of medication or procedure, the involved employee should contact the building administrator who will seek further clarification.
- ☐ Medication should be brought to school by the parent/guardian unless other safe arrangements are necessary and possible.
- ☐ The school may set a designated time for administration of medication. The parent/guardian should be informed of this designated time and communicate this to the family physician when he/she writes instructions for administration of the medication. Exceptions to the designated time will be dealt with on an individual basis.
- ☐ Dividing a dose of medication is not the responsibility of the school personnel (e.g., pill-splitting, liquid dosage).
- ☐ Expiration dates on prescription medications, epi-pens, and inhalers shall be checked at least twice a year.

Medication Log

- ☐ A log of Medication administration shall be kept in the school office and filed in a pupil's permanent record at the end of each school year.
- ☐ The Medication Log shall include the pupil's name and the name and dosage of the medication. It should also include a place for the individual administering medication to record the date and time, the signature of individual administrating the medication and the signature of the adult witness.
- ☐ Prescription Accounting should be included on the Medication Log.
- ☐ If an error is made in recording, the individual who administered the medication shall cross out, initial the error, and make the correction in the log.

School Staff Training

- ☐ Training will be provided in the following situations:
  - When new staff is assigned to administer medications,
  - When special circumstances require procedures that fall outside the regular procedures,
  - When requested by building personnel.

600 E. Carpenter St., Midland MI 48640
Phone: (989)923-5001 Fax(989)923-5003

Parent Notification Regarding Child Custody

As per State and Federal law (MCL 722.30 & FERPA), please be advised, Midland Public Schools recognizes the legal rights of parents and guardians as indicated on a certified birth certificate or legal court order.

In cases where parents/guardians are legally separated, divorced and/or those parents who simply have ongoing custody issues between them, the parental rights of both parties will be equally recognized by your child's school, unless and until a parent/guardian has a legal court order that specifically restricts or denies the non-custodial parent's access to the child at school, the child's school records, or other protective order.

To accommodate a custodial parent's request to deny non-custodial parent's rights to access or information on a child, the school must have a copy of the most recent court order on file that indicates one parent's access and information rights are inhibited. Otherwise, either parent, with proper identification, may have access to the child at school, request and receive information and be included in the child's educational process.