Walled Lake Schools Preschool Program
Early Childhood Center
40839 W 13 Mile Road
Novi, MI 48377
248-956-5080

# Tuition Session Choice Form

**Child Name** _____

**Parent/Guardian Name** _____

**Parent/Guardian Email** _____

| Session | Site | Time | Age | Days | Annual Cost | Monthly Payment |
|---|---|---|---|---|---|---|
| 3 | ECC | 8:30-11:30 | 3 years | T/TH | $1,786 | $178.60 |
| 4 | ECC | 8:00-3:00 | 3 years | M-F | $9,079 | $907.90 |
| 5 | ECC | 8:30-11:30 | 4 years | M/W/F | $2,572 | $257.20 |
| 6 | ECC | 8:20-3:20 | 3 years | T/TH | $3,720 | $372.00 |
| 7 | ECC | 8:20-3:20 | 3 years | M/W/F | $5,426 | $542.60 |
| 8 | ECC | 8:00-3:00 | 4 years | T/TH | $3,633 | $363.30 |
| 9 | ECC | 8:00-3:00 | 4 years | M/W/F | $5,347 | $534.70 |
| 10 | ECC-Blend | 8:10-11:20 | 3 & 4 years | M-TH | $3,501 | $350.10 |
| 11 | ECC-Blend | 12:05-3:15 | 3 & 4 years | M-TH | $3,501 | $350.10 |

***Class times may be subject to change slightly***
****Tuition fee subject to board approval***

**PLEASE INDICATE YOUR SESSION CHOICE BY PREFERENCE:**

**(Session #)** **1st** _____ **2nd** _____ **3rd** _____

**I am interested in Prime Time Care: Yes**_____ **No**_____ (Prime Time Care is available for 4 year old's, and for 3/4 year old's at the ECC only.) For more information, call Prime Time Care at 248-956-5002.

_____ _____

**Signature** **Date**

**Registration is on a first come, first served basis.** Your child will be placed in one of the sessions you have indicated according to availability.

***Your child must be 3 years old on or before September 1, 2025 for a 3 year-old class and 4 by September 1, 2025 for a 4 year-old class.* If your child was born between September 2, and December 1, you must fill out a Preschool Age

Waiver Request form and return it with your forms. ***All age waivers will be reviewed by administration***. (Keeping your child in their age cohort is highly recommended for success now and in the future.)

In order to reserve a spot for your child, you must complete the following 2 steps:

1) Register your child using the Gateway system: https://psreg.wlcsd.org/login Please upload your Child's birth certificate to this program.

2) Submit the following documents to the ***Walled Lake Early Childhood Center 40839 W. 13 Mile Rd, Novi, MI 48377*** by mail or in person:

- Tuition Session Choice Form (page 1 only)
- ***Non-refundable*** registration fee of $125 per child or $175 per family via check, cash or money order (please put your child's name on the check)
- Health Appraisal – signed by Doctor ***by 8/1/25***
- Asthma/Allergy Action Plan ***by 8/1/25*** *If needed (will NOT impact placement)
- Preschool Age Waiver Request Form *If applicable
- Child Information Record
- Parent Notification of Licensing Notebook
- Written Information Documentation
- COR Photo Sharing Form
- IEP *If applicable (will NOT impact placement)

***Failure to disclose or share information is considered falsifying of documents and may result in withdrawal from the program.***

Once all documents are received, processed, and your child has been placed in a classroom, you will receive a confirmation email with a **tuition contract.** The tuition contract will show your child's scheduled days and tuition fee. The contract must be signed and returned to the preschool office via mail, email or in person ***within 2 weeks*** or we reserve the right to remove your child from the class and place them on the waiting list.

If you have any questions or problems with submitting any documentation, please call the preschool office 248-956-5080 or email *KimberlyBobola@wlcsd.org* or *LisaMetcalf@wlcsd.org*

# CHILD INFORMATION RECORD

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

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 | Primary Phone ( ) | Parent/Legal Guardian's Name (Optional) | Primary Phone ( ) |
|---|---|---|---|
| Home Address (if not child's address) | 2nd Phone (if applicable) ( ) | Home Address (if not child's address) | 2nd Phone (if applicable) ( ) |
| 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/or Special Instructions? Yes ☐ No ☐ If yes, explain: (Attach additional sheets, if necessary.) | |

CCL-3731 (Rev. 3/17/2022) Previous editions 7-18 & 4-21 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 WLCSD Preschool, 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.

CCL-3731 (Rev. 3/17/2022) Previous editions 7-18 & 4-21 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 | Remarks | # 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 _____ 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.

# WRITTEN INFORMATION PACKET DOCUMENTATION

Michigan Department of Licensing and Regulatory Affairs
Child Care Licensing Bureau

| Child(ren)'s Name(s) (Last, First) | Facility's Name and License Number<br>WLCSD Preschool |
|---|---|

A written information packet has been provided at the time of enrollment. The packet included all the following information *(R 400.8146 (1-2)):*

- 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, and illnesses.
- Transportation policy, if applicable.
- Medication policy.
- Exclusion policy for child illnesses.
- Notice of the availability of the center's licensing notebook. (CENTER MUST CHECK ONE)

  ☒ The center keeps a licensing notebook containing a summary sheet, all licensing inspections and special investigation reports, and related corrective action plans for the last 5 years. The licensing notebook is available to parents/guardians during regular business hours. Reports from at least the past three years are available at www.michigan.gov/michildcare.

  ☐ The center does not keep a licensing notebook, but internet is available onsite. Reports from at least the last three years are available at www.michigan.gov/michildcare.

- Other _____

I certify that I received all of the above items.

_____ _____

**Parent/Guardian Signature** **Date**

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

LARA is an equal opportunity employer/program.

## PARENT NOTIFICATION OF THE LICENSING NOTEBOOK

Child Care Organizations Act, 1973 Public Act 116
**Michigan Department of Licensing and Regulatory Affairs**
**Child Care Licensing Bureau**

CENTER MUST CHECK ONE

☒ The center keeps a licensing notebook containing a summary sheet, all licensing inspections and special investigations, and related corrective action plans for the last 5 years. The licensing notebook is available to parents/guardians during regular business hours. Reports from at least the past three years are available at www.michigan.gov/michildcare.

☐ The center does not keep a licensing notebook, but internet is available onsite. Reports from at least the last three years are available at www.michigan.gov/michildcare.

I have read the above statement issued by WLCSD Preschool (ECC, Dublin, Wixom)
Name of Child Care Center

| | |
|---|---|
| Child(ren)'s Name(s): | |

Parent Name _____

Parent Signature _____ Date _____

LARA is an equal opportunity employer/program.

# Walled Lake Consolidated Schools

Educational Services Center
850 Ladd Road, Building D
Walled Lake, MI 48390
Phone: 248/956-2000
Fax: 248/956-2124

Dr. Michael A. Lonze
Superintendent of Schools

Dear Parent:

Student directory information that is not considered to be an invasion of privacy can be disclosed to outside organizations without parental consent.

In accordance with the Family Educational Rights and Privacy Act 20 USC 1232(g), the Walled Lake Consolidated School District allows parents to retain privacy of student directory information.

**Please review the boxes below – however you are not required to make a selection.**

Please check the box below if you DO NOT WANT YOUR CHILD'S INFORMATION RELEASED.

☐ Do NOT release my child's name and photo for any reason

**(If you check this item, your child's name and photo will be excluded from such items as honor roll lists, athletic rosters and programs, music and fine arts programs, honors and commencement programs, school newsletters, school/district publications, district website, news releases to media, etc. It will be included in the school yearbook unless you check the line below)**

**Below are individual options if the all-inclusive box above is not checked above.**

The Walled Lake Consolidated School District allows parents to retain privacy of student directory information. Walled Lake Schools' staff often highlights our students using digital means.

☐ Do NOT release my child's name and photo for the school yearbook

☐ Do NOT release or use my child's image or name on school and District social media (Twitter, Facebook or other)

☐ Do NOT release my child's address and telephone

While all other information concerning your child remains confidential, all student directory information will be released to a requesting party and/or may appear on a school-based website or publication unless you complete this form. If you have any questions or concerns about this information, please call the principal's office at your child's school.

Sincerely,

Michael A. Lonze

Dr. Michael A. Lonze
Superintendent of Schools

Date: _____ Parent's Signature: _____

| (Student's Name - please print) | (Grade) | (School) |
|---|---|---|
| (Student's Name - please print) | (Grade) | (School) |

# Photo Sharing and Communication Form

Our program uses COR Advantage, a private classroom assessment tool to share photos and school related content with our families. ***This is a secure system that allows your child's teacher to share material with only you and the other families in your child's classroom.*** In order for us to share your child's picture, we need to have consent from you.
Thank you for your participation

**Sharing preferences** (choose any)

- ☐ I allow my child's photo to be shared with me and other family members in my child's classroom through COR advantage
- ☐ I allow my child's photo to be used for content accessible to the entire school community, like newsletters, school-wide messages, etc.
- ☐ I allow my child's photo to be used for school promotional material and social media, all of which will be accessible to people outside of our school community.

Student Name: _____

Parent/Guardian Name: _____

Parent/Guardian Signature: _____ Date: _____