

Dear Parent/Guardian,

Thank you for registering your child with Gaylord Community School's Preschool Program. This program is for children who will be FOUR years old on or before November 30th of the current year. It offers highly competitive rates, a safe and structured learning environment, and a focus on kindergarten readiness for your preschool student.

Please note:

- **A \$100 non-refundable deposit is required to ensure enrollment in the Preschool program.**
- Tuition is \$560 per month.
- Tuition is based on the 36-week GCS calendar year (39 weeks minus ONE week for Christmas Holiday and ONE week for Spring Break).
- It is a full-day, five-a-day-a-week program. Partial schedules cannot be accommodated.
- Full payment of tuition is expected based on full-day enrollment. There are no credits for weeks and/or months that run shorter than other months. There are no credits for days/weeks not attended due to personal/family vacations, illness, etc.
- DHS payment is accepted. Parents are responsible for balance of tuition that is not covered by DHS.
- The Preschool will run on the same calendar as Gaylord Community Schools K-12. It is closed on holidays, school breaks and other days as identified in the yearly GCS calendar. All dates and/or closures are subject to change, of which parents/students will be notified accordingly.
- Busing service is not provided by Gaylord Community Schools.

Please provide the following documents to complete the enrollment:

- **ORIGINAL BIRTH CERTIFICATE**
- **COMPLETE IMMUNIZATION** or Immunization Waiver
- **HEALTH APPRAISAL**
- **PARENT/GUARDIAN IDENTIFICATION** - Driver's license or state ID
- **POWER OF ATTORNEY** or **GUARDIANSHIP PAPERWORK** – if student doesn't live with parent


*** For more information about immunization clinics and health appraisals, contact the Health Department at 1-800-432-4121 or your child's physician

Please fill out the following forms:

- **STUDENT INFORMATION RECORD** (Emergency Card)
- **HEALTH & GENERAL INFORMATION FORM**
- **EARLY DISMISSAL FORM**
- **PARENT AGREEMENT SIGNATURE PAGE**
- **CONCUSSION AWARENESS ACKNOWLEDGMENT FORM**

VACCINES REQUIRED FOR CHILDCARE AND PRESCHOOL IN MICHIGAN

Whenever infants and children are in group settings, there is a chance for diseases to spread. Parents must follow state vaccine laws in order for their infants and children to attend childcare and preschool. These laws are the minimum standard for preventing disease outbreaks in group settings. The best way to protect a child from serious diseases is to follow the recommended vaccination schedule at www.CDC.gov/Vaccines. By following the recommended schedule, infants and children will be fully protected and vaccination requirements will be met.

	2-3 months	4-5 months	6-15 months	16-18 months	19 months – 4 years	5 years
 Diphtheria, Tetanus, Pertussis (DTaP)	1 DTaP	2 DTaP	3 DTaP	4 DTaP	4 DTaP	4 DTaP
	1	2	3 or age-appropriate complete series	4 or age-appropriate complete series	4 or age-appropriate complete series	None
H. influenzae type b (Hib)	1	2	2	1 at or after 15 months or age-appropriate complete series	None	None
Polio	1	2	2	3	3	3
Measles, Mumps, Rubella (MMR)¹	None	None	None	1 at or after 12 months	1 at or after 12 months	1 at or after 12 months
Hepatitis B¹	1	2	2	3	3	3
Varicella (Chickenpox)¹	None	None	None	1 at or after 12 months or current lab immunity or history of varicella disease	1 at or after 12 months or current lab immunity or history of varicella disease	1 at or after 12 months or current lab immunity or history of varicella disease

This is not a cumulative chart.
For example, a child 19 months to 5 years old is required to have 4 doses of DTaP to enter childcare or preschool and to be fully protected.

¹If the child has not received these vaccines, documented immunity is required. These rules apply to children who are the above ages upon entry into childcare or preschool. During disease outbreaks, incompletely vaccinated children may be excluded from childcare and preschool. Parents and guardians choosing to decline vaccines must obtain a certified non-medical waiver from a local health department. Read more about waivers at www.Michigan.gov/Immunize. All doses of vaccines must be valid (follow CDC Immunization Schedule for number of doses, correct spacing, and ages) for childcare and preschool entry purposes. The Michigan Department of Health and Human Services (MDHHS) does not discriminate against any individual or group on the basis of race, national origin, color, sex, disability, religion, age, height, weight, familial status, partisan considerations, or genetic information. Sex-based discrimination includes, but is not limited to, discrimination based on sexual orientation, gender identity, gender expression, sex characteristics, and pregnancy. MDHHS-Pub-1254 (Rev. 4-23)

GAYLORD COMMUNITY SCHOOLS

2024-2025 STUDENT INFORMATION RECORD

Please print clearly in ink and provide all information requested. Sign, date, and return to your student's school.

Student's Legal Last Name:	First Name:	Middle Name:	Preferred First Name:
Home Phone:	Gender: (M/F)	Grade	Date of Birth:
Student's Residence Address:		City:	Zip Code:
Mailing Address for Student Mailings:		City:	Zip Code:
School District of Residence:	County of Residence	Birthplace: (City / State / Country)	

Please note that if ethnicity and race information is not provided, the US Department of Education requires the school district to provide an answer on our behalf.

ETHNICITY (check one)	RACE (number all that apply)		
<input type="checkbox"/> Non-Hispanic	<input type="checkbox"/> African American	<input type="checkbox"/> American Indian / Alaska Native	<input type="checkbox"/> Asian
<input type="checkbox"/> Hispanic	<input type="checkbox"/> Native Hawaiian / Pacific Islander	<input type="checkbox"/> White	<input type="checkbox"/> Hispanic / Latino

LANGUAGE SPOKEN AT HOME:(select all that apply) English Spanish Other: (specify) _____

STUDENT LIVES WITH: (check one):

<input type="checkbox"/> Both Parents	<input type="checkbox"/> Mother Only	<input type="checkbox"/> Father Only	<input type="checkbox"/> Foster Parents	<input type="checkbox"/> Other (specify below)
<input type="checkbox"/> Joint Custody	<input type="checkbox"/> Mother / Step-Father	<input type="checkbox"/> Father / Step-Mother	<input type="checkbox"/> Host Family	_____
<input type="checkbox"/> Legal Guardian	<input type="checkbox"/> Mother / Other	<input type="checkbox"/> Father / Other	<input type="checkbox"/> Adult Student	_____

STUDENT'S RESIDENCE IS: (check one)

<input type="checkbox"/> Single Family Dwelling	<input type="checkbox"/> More than 1 family in house	<input type="checkbox"/> Motel / Car / Campsite
<input type="checkbox"/> With Friends / Family (other than parent/guardian)	<input type="checkbox"/> Shelter	<input type="checkbox"/> Other

PARENT INFORMATION

Mother Name:	Father Name:
Cell Phone:	Cell Phone:
Home Phone:	Home Phone:
Email:	Email:
Work Place/Phone:	Work Place/Phone:
Lives with Student (select one): <input type="checkbox"/> YES <input type="checkbox"/> NO	Lives with Student (select one): <input type="checkbox"/> YES <input type="checkbox"/> NO

If a parent does not live in the same household as the student, send school mailings to this address (Optional): _____

Is any parent a member of the **Armed Forces** and on active duty (select one): YES NO

If there are adults who are restricted from seeing this student OR if there is any other guardianship information **by order of a court**, please list them here.
WE CAN NOT RESTRICT A PARENT WITHOUT LEGAL DOCUMENTATION ON FILE AT THE SCHOOL

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OTHER ADULTS RESIDING IN THE HOME: (not including mother and father listed above)

Name (Last,First)	Relationship	Phone

OFFICE USE ONLY

STUDENT ID:	STUDENT UIC:	AM BUS ROUTE:
RESIDENT STATUS:	DISTRICT OF RESIDENCE:	PM BUS ROUTE:
K-8 HOMEROOM TEACHER:	DISTRICT ENTRY DATE:	Secondary Route Info - AM: PM:

OTHER CHILDREN RESIDING IN THE HOME:

Name (Last, First)	Birthdate	Grade	School Attending

MEDICAL INFORMATION

ALLERGIES:

- Food (List below) (Contact cafe for special diets)
- Animals (List below)
- Medications (List below)
- Other (List below)

CONDITIONS:

- Asthma - Parent providing inhaler to office? YES NO
- Diabetes
- Convulsions / Seizures (Explain below)
- Other Medical Information (Explain below)

Parent providing Epipen? YES NO

Please list any allergies and/or provide specific information on conditions checked above:

Please provide any additional information regarding your child's health or medical issues you would like the school to be aware of:

Medical Authorizations and Authorization to Transport in Case of Emergency

In case of an accident or serious illness, I request the school to contact me. If the school cannot reach me, I hereby authorize the school to call the physician indicated and follow his/her instructions. If the physician cannot be reached, the school may make necessary arrangements for the well-being of my child.

Doctor Name:

Doctor Phone:

PERSONS AUTHORIZED TO PICK UP CHILD FOR EMERGENCY PURPOSE ONLY

If your child is injured, ill, etc., and needs to leave school, we will first contact the parents listed on the front of this card. If parents are unavailable, we will contact the following individuals authorized to pick up your child from school for emergency purposes only. Your child should know the person. ID may be requested.

YOUR CHILD WILL NOT BE RELEASED TO ANY UNAUTHORIZED PERSON

Name (Last, First)	Relationship	Phone

I affirm that as the parent/legal guardian, all information provided is true and accurate and that my child and I reside at the listed address. I understand that any false information provided by me may subject me to legal penalties for perjury.

Signature of Parent / Guardian

Date

Gaylord Community Schools Preschool Program

Health and General Information Record

Student's Name: _____

What is your child's favorite:

Food: _____ Outdoor Activity: _____

Book: _____ Indoor Activity: _____

Toy: _____

Toilet Training:

Does your child need help using the toilet? Yes _____ No _____

Does your child wear diapers or pull-ups? Yes _____ No _____

Comments: _____

If child is on a special diet, please specify: _____

Do you have any concerns that your child is delayed in any areas (speech/language, motor skills, self-help skills, etc.) or may have a health problem? _____

Does your child have an IEP? Yes _____ No _____

HAS CHILD HAD:

<input type="checkbox"/> Chicken Pox ___/___/___ Date	<input type="checkbox"/> Whooping Cough	<input type="checkbox"/> Sickle Cell Disease
<input type="checkbox"/> The Varicella Vaccine	<input type="checkbox"/> Liver Disease	<input type="checkbox"/> Anemia
<input type="checkbox"/> Scarlet Fever	<input type="checkbox"/> Heart/Blood Vessel Disease	<input type="checkbox"/> High Lead Levels
<input type="checkbox"/> Measles	<input type="checkbox"/> Bleeding Tendencies	<input type="checkbox"/> Epilepsy
<input type="checkbox"/> German Measles	<input type="checkbox"/> Rheumatic Fever	<input type="checkbox"/> Mumps
<input type="checkbox"/> Eczema	<input type="checkbox"/> Asthma	<input type="checkbox"/> Diabetes
<input type="checkbox"/> Other		

FAMILY HEALTH HISTORY

Does any other household member have health concerns? _____

CONCERNS:

1. Does your child have difficulty separating from you? _____ YES _____ NO
2. What things cause your child to worry or be afraid? _____

3. Please list any concerns you have regarding your child's behavior: _____

ADDITIONAL INFORMATION FOR THE PRESCHOOL STAFF:

PREGNANCY/BIRTH HISTORY	YES	NO	SPECIFY
Was child born more than 3 weeks early?			
Did mother have any health problems during this pregnancy or delivery?			
Did child or mother stay in hospital for medical reasons longer than usual?			
Is mother pregnant now?			Due Date:
What was child's weight at birth?	_____ pounds _____ ounces		
HOSPITALIZATION AND ILLNESSES			
Has child ever been hospitalized or operated on?			
Has child ever had a serious accident? (broken bones, head injuries, falls, burns, poisoning, etc)			
Has child ever had a serious illness?			

By enrolling my child, _____, in the Gaylord Community Schools
Preschool Program, I agree to comply with the following health requirements:

- Up to date immunizations
- Complete physical exam (including all follow-ups and referrals)
- Dental exam (including all follow-ups and referrals)

I give permission for my child to participate in any observations and/or developmental assesments.

I give my permission to forward health records, observations, and evaluations from preschool staff,
educational service district staff and local mental health professionals to the appropriate school at the
completion of the preschool program.

Parent/Guardian Printed Name

Parent/Guardian Signature

Date

EARLY DISMISSAL PLAN

In the event of an emergency or early dismissal, GCS Preschool needs a transportation plan for your children.

- If school is closing early for any reason, you will be contacted at the phone number(s) below.
- If an early dismissal does occur, and your child normally rides the Otsego County Bus System, you will be contacted at the phone number(s) below, and you will need to make arrangements with the bus system for pick-up change or cancellation.

You are responsible for alerting the GCS Preschool staff, after school daycare providers and if applicable, Otsego County Bus System, of any changes in your child's schedule or transportation.

In the event of an early dismissal (select one):

I will pick my child up

Please contact:

Name: _____ Relationship: _____ Phone No: _____

Name: _____ Relationship: _____ Phone No: _____

I give permission for my child to take the Otsego County Bus System to this address:

Daycare provider name: _____

Address: _____

Phone Number: _____

If I change my selected early dismissal plan above, I understand that I will communicate any transportation changes to the GCS Preschool Staff at 989-731-2648. It is also my responsibility to notify my child's daycare providers, and if applicable, the Otsego County Bus System.

Parent / Guardian Name

Parent / Guardian Signature

Today's Date

PARENT AGREEMENT SIGNATURE PAGE

Preschool Student Name: _____ Parent/Guardian Name: _____

➤ PARENT NOTIFICATION FOR THE LICENSING NOTEBOOK REQUIREMENT

All child care centers must maintain a licensing notebook which includes all licensing inspection reports, special investigation reports and all related corrective action plans (CAP). The notebook must include all reports issued and CAPs developed on or after May 27, 2010 until the license is closed.

- This center maintains a licensing notebook of all licensing inspection reports, special investigation reports and all related corrective action plans.
- The notebook will be available to parents for review during regular business hours.
- Licensing inspection and special investigation reports from the past two years are available on the Bureau of Children and Adult Licensing website at: www.michigan.gov/michildcare.

I have read the above statement issued by Gaylord Community Schools Preschool.

Signature of Parent / Guardian

Date

➤ TOPICAL LOTION, CREAM or OINTMENT PERMISSION

I give permission to GCS Preschool staff to apply topical medicine or lotion necessary to my child.

Example: hand lotion, antibiotic ointment

Circle one: YES NO

Signature of Parent / Guardian

Date

➤ ACKNOWLEDGMENT OF PARENT HANDBOOK

I have received and read the Parent Handbook. I understand the rights and responsibilities pertaining to parents and students, and agree to support and abide by the rules, guidelines, procedures, and policies of the School District. We also understand that this handbook supersedes all prior handbooks and other written material on the same subjects.

Signature of Parent / Guardian

Date

UNDERSTANDING CONCUSSIONS

Educational Material for Parents and Students

(Content Meets MDCH Requirements)

Sources: Michigan Department of Community Health, CDC and the National Operating Committee on Standards for Athletic Equipment (NOCSAE), National Athletic Trainers Association

Some Common Symptoms				
Headache	Balance Problems	Sensitivity to Noise	Poor Concentration	Not "Feeling Right"
Pressure in the Head	Double Vision	Sluggishness	Memory Problems	Feeling Irritable
Nausea/Vomiting	Blurry Vision	Haziness	Confusion	Slow Reaction Time
Dizziness	Sensitivity to Light	Fogginess	"Feeling Down"	Sleep Problems
		Grogginess		

WHAT IS A CONCUSSION?

A concussion is a type of brain injury that changes the way the brain normally works. A concussion is caused by a fall, bump, blow, or jolt to the head or body that causes the head and brain to move quickly back and forth. A concussion can be caused by a shaking, spinning for a sudden stopping and starting of the head. Even a "ding," "getting your bell rung," or what seems to be a mild bump or blow to the head can be serious. A concussion can happen even if you haven't been knocked out.

You can't see a concussion. Signs and symptoms of concussions can show up right after the injury or may not appear or be noticed until days or weeks after the injury. If the student reports any symptoms of a concussion, or if you notice symptoms yourself, seek medical attention right away. A student who may have had a concussion should not return to activity on the day of the injury and not until a health care professional says they are okay to return to activity.

IF YOU SUSPECT A CONCUSSION:

1. **SEEK MEDICAL ATTENTION RIGHT AWAY**-A health care professional will be able to decide how serious the concussion is and when it is safe for the student to return to regular activities, including sports. Don't hide it, report it. Ignoring symptoms and trying to "tough it out" often makes it worse.
2. **KEEP YOUR STUDENT OUT OF ACTIVITY**-Concussions take time to heal. Don't let the student return to activity the day of the injury and not until a health professional says it is okay. A student who returns to activity too soon, while the brain is still healing, risks a greater chance of having a second concussion. Young children and teens are more likely to get a concussion and take longer to recover than adults. Repeat or second concussions increase the time it takes to recover and can be very serious. They can cause permanent brain damage, affecting the student for a lifetime. They can be fatal.
3. **TELL THE SCHOOL ABOUT ANY PREVIOUS CONCUSSION(S)**-Schools should know if a student had a previous concussion. A student's school may not know about a concussion received in another sport or activity unless you notify them.

SIGNS OBSERVED BY PARENTS:

- Appears dazed or stunned
- Is confused or has trouble with homework or school assignments
- Forgets an instruction
- Can't recall events prior to or after a hit or fall
- Appears fatigued
- Moves clumsily
- Answers questions slowly
- Loses consciousness (even briefly)
- Shows mood, behavior or personality changes

CONCUSSION DANGER SIGNS:

In rare cases, a dangerous blood clot may form on the brain in a person with a concussion and crowd the brain against the skull. If a student sustains a bump, blow or jolt to the head or body and the following danger signs are present, **immediate medical attention** should be sought at the closest emergency department.

• One pupil larger than the other	• Repeated vomiting or nausea	• Becomes increasingly confused or agitated	• Is drowsy and cannot be awakened
• Slurred speech	• Has unusual behavior	• A headache that gets worse	• Convulsions or seizures
• Weakness, numbness or decreased coordination	• Cannot recognize people or places	• Loses consciousness (even briefly)	

WHAT SHOULD YOU DO?

If a student reports one or more symptoms of a concussion after receiving a bump, blow or jolt to the head or body, h/she should be immediately removed from activity (this includes but is not limited to, athletics, PE classes, band, dance, aerobics, theatre and choir.) The student should only return to activity with the permission of a health care professional experienced in evaluating concussions. Rest is key during recovery. Exercising or activities that require a lot of concentration (such as studying, working on the computer or playing video games) may cause concussion symptoms to reappear or get worse. Students who return to school after a concussion may need to spend fewer hours at school, take rest breaks, be given extra help and time, and spend less time reading, writing or on a computer or iPad. After a concussion, returning to sports and school is a gradual process and should be monitored by a health care professional. Concussions affect each individual differently. Some may recover quickly and fully while others may have symptoms that last for days, weeks or even months.

To learn more, go to www.cdc.gov/concussion

PARENTS AND STUDENTS MUST SIGN AND RETURN THE EDUCATIONAL MATERIAL ACKNOWLEDGEMENT FORM

CONCUSSION AWARENESS

EDUCATIONAL MATERIAL ACKNOWLEDGEMENT FORM

By my name and signature below, I acknowledge in accordance with Public Acts 342 and 343 of 2012 that I have received and reviewed the "Understanding Concussions: Education for Parents and Athletes" provided by Gaylord Community Schools.

Student Name Printed

Parent or Guardian Name Printed

Student Name Signature

Parent or Guardian Name Signature

Date

Date

Return this signed form to your school's athletic office or to your coach. The school must keep this on file until the student is age 18. We realize this may not be the first nor the last time you sign and submit this form, as each organization needs to have a copy. Thank you for your cooperation and understanding.

Students and parents please review and keep the educational materials available for future reference.