



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
2	ECC	8:00-3:00	3 years	M-F	\$9,079	\$907.90
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

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)		TODAY'S DATE (mm/dd/yy)
(City)	(ZIP Code)	
PARENT/GUARDIAN (Last, First, Middle)		HOME TELEPHONE NUMBER
ADDRESS (Number & Street)		WORK TELEPHONE NUMBER
(City)	(ZIP Code)	

SECTION I - HEALTH HISTORY

<p>Is your child having any of the problems listed below?</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> 1 Allergies or Reactions (for example, food, medication or other)</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> 2 Hay Fever, Asthma, or Wheezing</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> 3 Eczema or Frequent Skin Rashes</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> 4 Convulsions/Seizures</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> 5 Heart Trouble</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> 6 Diabetes</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> 7 Frequent Colds, Sore Throats, Earaches (4 or more per year)</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> 8 Trouble with Passing Urine or Bowel Movements</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> 9 Shortness of Breath</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> 10 Speech Problems</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> 11 Menstrual Problems</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> 12 Dental Problems: Date of Last Exam / /</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Other (please describe): _____</p> <p><input type="checkbox"/> <input type="checkbox"/> Does your child take any medication(s) regularly?</p> <p>Reason for Medication: _____</p> <p>Parent/Guardian Signature _____ Date / /</p>	<p>Birth History:</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>Are there any current or past diagnosis(es) <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>If yes, please describe: _____</p> <p>_____</p> <p>_____</p> <p>If yes, list medications: _____</p> <p>_____</p> <p>Was the health history reviewed by a health professional?</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No Examiner's Initials: _____</p>
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SECTION II - PHYSICAL EXAMINATION, INSPECTION, TESTS AND MEASUREMENTS

Required for Child Care and Head Start / Early Head Start

Tests and Measurements

Was child tested for:	Test results:	Normal	Referred	Under Care	No	Yes	Was child tested for:	Test results:	Normal	Referred	Under Care
VISION	Visual Acuity						HEIGHT & WEIGHT	Height			
	Muscle Imbalance							Weight			
	Other: _____							Other: _____			
HEARING	Audiometer						HEMOGLOBIN / HEMATOCRIT				
Other: _____							BLOOD PRESSURE	Reading: _____			
URINALYSIS	Sugar						TUBERCULIN	Type: _____			
Other: _____	Albumin						Date: / /	Neg: <input type="checkbox"/> Pos: <input type="checkbox"/> _____ mm			
Other: _____	Microscopic						<p>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.</p>				
BLOOD LEAD LEVEL	Level _____ ug/dl										
Date: / /											

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)
Hepatitis B (HepB)	1	3	Hepatitis A (HepA)
	2		
DTaP/DTP/DT/Td	1	4	Influenza (H1N1)
	2	5	
	3	6	Meningococcal (MCV4 / MPSV4)
Tdap	1		
Haemophilus Influenzae type b (HIB)	1	3	Human Papillomavirus (HPV9/HPV4/HPV2)
	2	4	
Polio (IPV/OPV)	1	3	OTHER Vaccines
	2	4	Specify Date & Type
Pneumococcal Conjugate (PCV7/PCV13)	1	3	Type of Vaccine(s)
	2	4	Date of Vaccine(s)
Rotavirus (RV1/RV5)	1	3	1
	2		2
Measles, Mumps, Rubella (MMR)	1	2	3
Varicella (Chickenpox)	1	2	
History of Chickenpox Disease? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, date:		Indicate and attach physician diagnosis or laboratory evidence of immunity as applicable	
I certify that the immunization dates are true to the best of my knowledge		NOTE: According to Public Act 308 of 1970, 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.	
Health Professional's Signature		Parent/Guardian refused immunizations: <input type="checkbox"/>	
Title		Date	

SECTION IV - RECOMMENDATIONS (Required for Child Care and Head Start/Early Head Start)	
<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"/>	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 _____ child's name	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.

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)		2 nd Phone (if applicable) ()	Home Address (if not child's address)		2 nd 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 <input type="checkbox"/> No <input type="checkbox"/> 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

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 WLCSD Preschool
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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):	
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Parent Name _____

Parent Signature _____ Date _____

LARA is an equal opportunity employer/program.

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: _____



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,

A handwritten signature in cursive script that reads "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)