Great Start Readiness Program
Michigan's Nationally Recognized Pre-K Program

STRONG Beginnings
PRESCHOOL FOR 3 YEAR OLD CHILDREN

St. Clair County GSRP/STRONG BEGINNINGS
Parent Income Worksheet 2025-26

Name of Child:_____ Birthdate:_____

Please circle YES OR NO for each question below	IF YES > Provide copies of the following
Do the child's biological parents live separately and have **50/50 PHYSICAL CUSTODY?** NO YES>	BOTH parents income information is REQUIRED and the number of people in each family. **2024 State or Federal (1040); 1st two pages from both parents.**
In 2024, were the parent(s)/guardian eligible for:	**IF YES> Provide CURRENT copies of the following:**
CATEGORICAL ELIGIBILITY - SNAP, TANF, SSI, Foster care, Homelessness Eligibility in any of these areas makes a family **categorically eligible for Head Start services. They do not need to have their income verified. VERIFY ELIGIBILITY THEN STOP**	☐ SNAP - Eligibility letter or SNAP card and ID Number ☐ Public Assistance - Eligibility letter ☐ TANF - Eligibility letter ☐ SSI - Eligibility letter or deposit record ☐ Foster care - Placement letter from DHHS ☐ Homeless - Letter from parent or person with whom they are residing
In 2024, did the parent(s)/guardian receive money from:	**IF YES> Provide copies of the following:**
GROSS WAGES FROM EMPLOYER OR NET INCOME FROM SELF-EMPLOYMENT NO YES>	**W2s** from all jobs in 2024 **OR 2024 State or Federal (form 1040)**(1ST 2 PAGES ONLY) **OR One year (2024) of check stubs ONLY in absence of other listed forms.**
UNEMPLOYMENT NO YES>	**Unemployment Benefit form to show weekly/monthly/annual amount**
WORKERS' COMPENSATION NO YES>	**Compensation Benefits form** showing **weekly/monthly/annual amount**
CHILD SUPPORT NO YES>	**Friend of the Court** document showing amount **ordered** AND amount **paid for 2024**
SOCIAL SECURITY BENEFITS NO YES>	Documentation/award letter showing **monthly amount or amount received for 2024**
SOCIAL SECURITY DISABILITY NO YES>	Documentation/award letter showing **monthly amount or amount received for 2024**
ALIMONY NO YES>	Documentation/award letter showing **monthly amount or amount received for 2024**
ANY PENSION/RETIREMENT NO YES>	Documentation showing **monthly amount or amount received for 2024**
TRAINING STIPENDS NO YES>	Documentation showing **amount paid**
MILITARY FAMILY ALLOTMENT+ NO YES>	Documentation showing **monthly amount or amount received for 2024**
VETERAN'S BENEFITS NO YES>	Documentation showing **monthly amount or amount received for 2024**
REGULAR INSURANCE OR ANNUITY PAYMENTS NO YES>	Documentation showing **monthly amount paid**
COLLEGE SCHOLARSHIPS, FELLOWSHIPS, GRANTS Used for room/board/living expenses. **This does not** include those used only for qualified educational expenses. NO YES>	Documentation/award letter showing **amount received for 2024**
DIVIDENDS, INTEREST, NET RENTAL INCOME, NET ROYALTIES, ANY ESTATES OR TRUSTS NO YES>	Documentation showing **monthly amount or total annual amount received for 2024**
NET GAMBLING OR LOTTERY WINNINGS NO YES>	Documentation showing the **amount received in 2024**
ANY OTHER INCOME SOURCE/MONEY RECEIVED NO YES>	Documentation showing the **amount received in 2024**

If you have no income or do not have your own home, please complete below and provide documentation.

☐ I live with someone who pays for my housing, utility bills, etc. Name/relationship:_____
Attach a letter signed by this person noting the fact you live there and they pay all bills.

☐ I live in a shelter, motel, hotel, homeless or other living arrangements (describe):

Read and Sign: I certify that the information contained in this application is true and correct and that all income is being reported. I understand that this information is being collected to determine eligibility for the state of Michigan-funded GSRP program. I also understand this is an APPLICATION and DOESN'T GUARANTEE placement into the program.

_____ _____

Signature of Parent/Guardian **Date**

* If this form was completed on behalf of the parent/guardian, indicate who assisted the parent/guardian to complete the form. Form

completed by: _____ with info obtained from: _____ Date:_____

These materials were developed under a grant awarded by the Michigan Department of Education

Permission to Use Image on Classroom Webpage, School / District Media Sites, Electronic Newsletters and Social Media (School Facebook or Twitter)

Yale Public Schools likes to recognize students for their efforts and accomplishments in a variety of ways. One way to recognize students is to post group and individual photos on classroom webpages and other websites. Examples would be of photos of classroom projects, teamwork activities, students having fun while learning, and recognizing students for special awards! We would like your permission to post photos of your child so you can share in all memorable experiences. If names are included in a picture, only first names and/or last initial will be used to identify each child.

We thank you for your support, and hope you enjoy watching all the #GreathingshappingatYPSD!

Child's Name:_____ Teacher: _____

Parent Guardian's Name: _____

____ I will allow Yale Public Schools to post photos of my child on classroom webpages , school / district media sites, electronic newsletters and social media sites (School Facebook or Twitter).

Parent Guardian's Signature: _____

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 _____

Name of Child Care Center

Child(ren)'s Name(s):	

Parent Name _____

Parent Signature _____ Date _____

LARA is an equal opportunity employer/program.

Yale Public Schools
Great Start Readiness Program

Parent Handbook Acknowledgement

Child's Name_____

Parent/Guardian's Name_____

I have been provided a copy of the "Parent Handbook for Yale Public Schools Great Start Readiness Program", and agree to read and abide by all policies.

_____ _____ _____ _____

Parent/Guardian Signature Date Validating Signature Date

Yale Public Schools
Great Start Readiness Program
Nutrition Agreement

The Great Start Readiness Preschool Program follows the guidelines of the DHS Bureau of Children and Adult Licensing. Foods served reflect the home and community cultures and are high in nutrients and low in fat, sugar, and salt. Parents who choose to send a snack to school with their child should take into consideration the nutritional value of the foods they chose. If parents choose to send in a special occasion food, it is asked that consideration be given to special needs diets and allergies. Please check with the teacher before choosing a food item. Snacks are provided free of charge to the eligible GSRP children.

It is the parent's responsibility to inform staff of any and all allergies the child may have. If your child has food allergies or the need for a special diet, please provide the staff with a written plan from your child's doctor.

_____ _____

Parent/Guardian Signature Date

_____ _____

Validating Signature Date

Yale Public Schools
Great Start Readiness Program
Good Health Statement

I, _____, parent/guardian of _____,
certify that my child is in good health.

My child has the following physical restrictions:

_____

_____

My child's immunizations (waiver) are up to date and on file at the

_____ School in _____, Michigan.
(School Name)

_____ Date_____
Parent/Guardian Signature

_____ Date_____
Validating Signature

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

_____ / /
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	Visual Acuity			
			Muscle Imbalance			
		Date: / /	Other:			
☐	☐	HEARING	Audiometer			
			Other:			
		Date: / /				
☐	☐	URINALYSIS	Sugar			
			Albumin			
		Date: / /	Microscopic			
☐	☐	BLOOD LEAD LEVEL	Level _____ ug/dl ⇨			
		Date: / /				

No	Yes	Was child tested for:	Test results:	Normal	Referred	Under Care
☐	☐	HEIGHT & WEIGHT	Height			
			Weight			
☐	☐	Other: _____	Other			
☐	☐	HEMOGLOBIN / HEMATOCRIT	⇨			
☐	☐	BLOOD PRESSURE	Reading: _____			
☐	☐	TUBERCULIN	Type: _____			
		Date: / /	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 _____ 's teeth. As a result of this examination, my recommendation for treatment is: _____

child's name

_____ ___/___/___

Dentist's Signature Date

PHYSICIAN'S SIGNATURE

_____ ___/___/___ _____ _____

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

_____ _____ MI _____ (_____) _____

Number & Street City 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.

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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.

YALE PUBLIC SCHOOLS - GREAT START READINESS PROGRAM
TRANSPORTATION

I, _____, the parent/ guardian of:

_____ allow him/her to ride the bus to/from school. I understand that while they are on the bus they are the responsibility of Yale Public Schools and not the Yale GSRP. This means that any of the state licensing rules WILL NOT APPLY while they are on the bus. They will be Yale Public Schools responsibility until they are signed in/out of Yale GSRP.

_____ _____

PARENT/GUARDIAN SIGNATURE DATE

"These materials were developed under a grant awarded by the Michigan Department of Education."

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.)							

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 6-17may be used.

YALE PUBLIC SCHOOLS – VOLUNTEER FORM

198 School Drive, Yale Michigan 48097 Phone: 810-387-3231 Fax: 810-387-4418

As part of our continuing Safe Schools Initiative, individuals who will serve in the capacity of an official school chaperone or classroom volunteer will need to provide a valid Michigan Driver's License and this completed form in order for the school district to complete a background check through the Michigan State Police.

Yale Public Schools will not approve chaperones with the following:

- Felony conviction(s)
- Misdemeanor conviction(s) listed under the Michigan Sex Offender Registration Act
- Misdemeanor conviction(s) involving drugs, weapons, or anything that could endanger students

If you wish to volunteer/chaperone, please provide this completed form and a copy of your driver license to the building secretary at least one week prior to the event.

Print Name: _____ _____ _____
First Name Middle Initial Last Name

Maiden Name / Names Previously Used: _____

Race: _____ Sex: _____ Month of Birth: _____ Day of Birth: _____ Year of Birth: _____

I authorize the Yale Public School District to contact law enforcement agencies to complete a criminal background records check. I further consent to the release of this information by the law enforcement agencies to the Yale School District.

Please Sign: _____

Check the schools you would like to have notified of your willingness to volunteer and/or chaperone:

	First & Last Name of Student(s)	Grade	Relationship to Student
☐ Avoca Elementary			
☐ Farrell-Emmett			
☐ Yale Elementary			
☐ Yale Junior High			
☐ Yale High School			

Thank you for supporting Yale Public Schools!

Please Note: ***Volunteer/chaperone form must be renewed every school year (complete a new form and provide current driver's license).***

Building Secretary: Please provide a copy of the completed form and driver's license copy to Central Office immediately upon receipt of this information to complete the background check.

Central Office Use Only:

Date Form Received: _____ ICHAT Ran: _____ Added to Drive: _____

YPS Pre School
Transportation Request Form

Preschool Students:

Pre School Students Name: _____ School of Attendance: _____ DOB: _____

PICK UP: Home address Alt. Address_____ ***AM Transportation Is Not Required***

DROP OFF: Home address Alt. Address_____ ***PM Transportation Is Not Required***

Pre School Students Name: _____ School of Attendance: _____ DOB: _____

PICK UP: Home address Alt. Address_____ ***AM Transportation Is Not Required***

DROP OFF: Home address Alt. Address_____ ***PM Transportation Is Not Required***

Responsible Sibling:

Responsible Siblings Name: _____ Grade: _____

Alternate Responsible Siblings Name: _____ Grade: _____

By signing below, I understand that my preschool student's sibling or alternate, will be responsible to get my preschooler to and from the preschool classroom and to and from their assigned bus. I also understand that I must have all of my emergency contact information up to date for my preschool student should we be approved for bus transportation.

Parent/Guardian Contact Information:

Last Name _____ First Name _____

Street Address: _____ E-mail_____

Home Tel: _____ Cell Ph: _____

Signature of Parent/Guardian: _____ ***Date:*** _____

THIS FORM MUST BE SUBMITTED FOR TRANSPORTATION SERVICES:

Yale Public Schools – Transportation Department ~ 253 School Drive ~ Yale, MI 48097 ~ Phone: 381-387-3231 ext. 6271 ~ Fax: 810-387-9074

TRANSPORTATION OFFICE ONLY

_____	_____	_____	_____
Date Received	Date Approved	Date Parent Notified	Bus# & Driver Name

EDUCATION BENEFITS FORM SY 2024 - 2025

District: _____ School: _____

Part A: STUDENT INFORMATION - Complete for each student Pre-K through 12th Grade

Student's Last Name	Student's First Name	Grade Level	School	Identify H if Homeless M if Migrant R if Runaway F if Foster

Part B: BENEFITS RECEIVED (if applicable)

If any member of your household receives Food Assistance Program (FAP), Family Independence Program (FIP), or FDPIR, provide the name and case number for the person who receives benefits. Bridge Card Numbers and Medicaid Numbers are NOT ACCEPTABLE case numbers.

Name: _____ Case Number: ___ ___ ___ ___ ___ ___ ___ ___ ___

Part C: HOUSEHOLD SIZE	Part D: ANNUAL HOUSEHOLD INCOME - Select the appropriate range of combined annual income for all people in the household (Include all income before taxes)		
☐ 1 ⟶	☐ At or below $19,578	☐ Between $19,579 and $27,861	☐ At or above $27,862
☐ 2 ⟶	☐ At or below $26,572	☐ Between $26,573 and $37,814	☐ At or above $37,815
☐ 3 ⟶	☐ At or below $33,566	☐ Between $33,567 and $47,767	☐ At or above $47,768
☐ 4 ⟶	☐ At or below $40,560	☐ Between $40,561 and $57,720	☐ At or above $57,721
☐ 5 ⟶	☐ At or below $47,554	☐ Between $47,555 and $67,673	☐ At or above $67,674
☐ 6 ⟶	☐ At or below $54,548	☐ Between $54,549 and $77,626	☐ At or above $77,627
☐ 7 ⟶	☐ At or below $61,542	☐ Between $61,543 and $87,579	☐ At or above $87,580
☐ 8 ⟶	☐ At or below $68,536	☐ Between $68,537 and $97,532	☐ At or above $97,533

*** Special Instructions for households with more than 8 people: DO NOT check the boxes above. Instead, fill in items below:**

Household size (# people): _____ Total annual income: _____

Part E: CERTIFICATION - The head of household or adult designee who completed this form must complete this certification section

I certify (promise) that all information on this form is true and that all income is reported to the best of my knowledge. I understand that this form may impact the amount of State or Federal funding allocated to my local school district. I understand that the information I have provided may be verified.

(Signature) _____ (Printed Name) _____ (Date) _____

(Address) _____ (City) _____ (Zip) _____

(Email Address) _____ (Home Phone) _____ (Work Phone) _____

Do NOT fill out this section. This is for school use only.

Status: F _____ R _____ N _____ Determining Official's Signature: _____ Date: _____