GSRP Preschool Checklist

Great Start Readiness Program (GSRP) is a school readiness program designed to prepare children for kindergarten and to pave the way for success in school. GSRP is funded through the State of Michigan grant and is free to families. Children must be 4 years old by September 1st. If your child has a birthdate between September 2nd and December 1st you may sIll apply. However, you will be put on a waitlist and will be considered after August 10th. Parent participation and home visits are also required.

Before we are allowed to enroll a student into Fraser Public Schools the State of Michigan requires the following documents:

- ☐ Fraser Public Schools Student Data Form
- ☐ CHILD INFORMATION RECORD
- ☐ Parent/Guardian ID (Driver's License, State ID, or Passport)
- ☐ Proof of Custody (when applicable)
- ☐ Original Birth Certificate
    - ☐ Order online at www.vitalcheck.com
    - ☐ Go to courthouse of the county where the child was born.
    - ☐ Contact State of Michigan Vital Records by phone at (517) 335-8656
- ☐ Current Immunization Records (students are not allowed to start at school without proof of immunizations)
- ☐ Current Physical (with physician's signature)
- ☐ Concussion Form
- ☐ Pesticide Form
- ☐ Program Measurement Form
- ☐ Parent Agreement

Great Start Readiness Program
Enrollment Form

Child's Legal Name:

Last _____ First _____ Middle Name_____

Birthdate _____/_____/_____ Sex: Male___ Female ___ Home Language: _____

Parent/Guardian Name_____ Parent/Guardian Name _____

Phone Number _____ Phone Number _____

Address _____ City _____ Zip _____

Resident School District_____

Email Address_____

Email Address_____

Race:

___ American Indian or Alaska Native
___ Asian American
___ Black or African American
___ Native Hawaiian or other Pacific Islander
___ White
___ Hispanic or Latino

LIST ALL PERSONS WHO LIVE IN THE HOME
For any children 17 and under, please also include birthdate

Name	Birthdate	Relationship

Please self-report your gross annual household income:	

Please check all that apply:

	PRIORITIZATION FACTORS
	Homeless
	Foster Care
	IEP (General Education Setting)

I hereby affirm the information provided in this form is true to the best of my knowledge and belief

_____ _____
Parent/Guardian Signature Date

Fraser Public Schools
Student Data Form

Please complete and return this enrollment form.

Student Information

Student's Full Legal Name Last Name First Name Middle Name		**Gender** ☐ M ☐ F
Home Street Address (with apt/suite)	**Home City & Zip**	**Primary Phone**
Mailing Address	**Mailing City & Zip**	**Secondary Phone**
Resident School District	**Race (Please choose one from list below, regardless of Ethnicity)** 1 ☐ Alaskan Native/American Indian 2 ☐ Asian American 3 ☐ Black or African American 4 ☐ Native Hawaiian/Other Pacific Islander 5 ☐ White 6 ☐ Hispanic or Latino 7 ☐ Multi-Racial – If Multi-Racial, please list two:	
Ethnicity (Please choose one) Hispanic/Latino ☐ Not Hispanic or Latino ☐		
Student's Date of Birth (MM/DD/YYYY)	**Student Order of Birth (if multiple)** Please check: ☐ 01 ☐ 02 ☐ 03 ☐ 04	**Birth City/State (if born in US)**

Fill in Section Below for Students not Born in US

U.S. Citizen ☐ Yes ☐ No	**Date Entered US (month & year)**	**First Attended School in US (month & year)**	**Country of Birth**

Fill in Sections Below for All Students

Primary Language	**Language Spoken in Home**

Services Received at Former School

☐ **IEP** ☐ 504	☐ **Title I**	☐ **ELL**	☐ **Social Work**	☐ **Other Services**

Please Describe Other Services ***Please provide copies related to any of the above checked boxes***

Forms Submitted

☐ **Birth Certificate**	☐ **Proof of Residency**	☐ **Immunization**	☐ **Physical**	☐ **Concussion Awareness**

Health-Fill Out the Medical Forms Packet for any Boxes Checked

Preferred Hospital	Names & Schedule for Medications
Emergency Medical Alerts, Allergies or Problems	Physical Limitations (Explain)

☐ Asthma	☐ Diabetes	☐ Vision Problem	☐ Hearing Problem	☐ Peanut Allergy	☐ Cystic Fibrosis ☐ Other

Physician Name	Physician Phone

Contact 1 (Parent/Guardian)

First & Last Name	Relationship to Student	Contact Emergency Priority
Street Address, City, State & Zip	Home Phone	Cell Phone
	Email Address	Resides with Student? ☐ Yes ☐ No
Employer	Work Phone (with extension)	Receives Letter Mailings? ☐ Yes ☐ No

Contact 2

First & Last Name	Relationship to Student	Contact Emergency Priority
Street Address, City, State & Zip	Home Phone	Cell Phone
	Email Address	Resides with Student? ☐ Yes ☐ No
Employer	Work Phone (with extension)	Receives Letter Mailings? ☐ Yes ☐ No

Contact 3

First & Last Name	Relationship to Student	Contact Emergency Priority
Street Address, City, State & Zip	Home Phone	Cell Phone
	Email Address	Resides with Student? ☐ Yes ☐ No
Employer	Work Phone (with extension)	Receives Letter Mailings? ☐ Yes ☐ No

Contact 4		
First & Last Name	**Relationship to Student**	**Contact Emergency Priority**
Street Address, City, State & Zip	**Home Phone**	**Cell Phone**
Cell Phone 2/Pager	**Email Address**	**Resides with Student?** ☐ Yes ☐ No
Employer	**Work Phone (with extension)**	**Receives Letter Mailings?** ☐ Yes ☐ No

Siblings Enrolled in Fraser Public Schools		
Name	**Date of Birth**	**School Attended**
Name	**Date of Birth**	**School Attended**
Name	**Date of Birth**	**School Attended**
Name	**Date of Birth**	**School Attended**

INTERNET ACCEPTABLE USE POLICY PRESS / VIDEO RELEASE

Fraser Public Schools has my permission to use photographs and/or videos of my child to show school activities to the public. I understand that the personally identifiable information may be used at the discretion of the media, involving no financial compensation to Fraser Public Schools, the student, or family of the student.

Press/Video Release ☐ Yes ☐ No

I understand that I have the right to deny consent to the release of photographs, information and/or Internet accessibility specified above by notifying the principal of my child's school.

_____ _____

Parent/Guardian Signature Date

If permission is denied, please write "DENIED" on the signature line.

INTERNET USE

All students are able to use the Internet in accordance with Fraser Public Schools Internet acceptable use policy, available at each school. If you do not want your child to use the Internet, please contact his/her school principal.

MEDICAL ASSISTANCE

In the event that my child is injured or may need medical assistance and I cannot be reached, school personnel of this district are hereby authorized to take whatever action that is necessary to provide medical emergency care for my child. I agree to assume all expenses.

I certify that the information on this form is true and correct to the best of my knowledge.

_____ _____

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.)					

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.

Medical/Allergy Questionnaire

Child's Name _____Class_____

Birthdate _____/_____/ 20___ Doctor _____ Phone (____) _____-_____

Does your child have any medical conditions? (Diabetes, seizures, heart condition, etc.)

_____Yes _____No

If yes, please list:

1. _____
2. _____
3. _____

Does your child have asthma? _____Yes _____No

If yes, please list any medications:

	NAME	AMOUNT	FREQUENCY
1.			
2.			
3.			

Does your child have any allergies?

- ☐ My child has NO CURRENT ALLERGIES (Skip to Parent Permission on next page)
- ☐ My child has allergies. Please answer the questions below.

Has your child been diagnosed by a doctor for his/her allergies? _____Yes _____No

When/How was your child diagnosed with allergies?

_____

When was the last time your child had an allergic reaction?

_____

How many times has your child been treated in the ER or hospitalized for an allergic reaction?

_____

FOOD ALLERGIES: Check all that apply. Name the specific food causing the reaction.

- ☐ Peanuts Specifically: _____
- ☐ Tree Nuts Specifically: _____
- ☐ Fish Specifically: _____
- ☐ Fruit Specifically: _____
- ☐ Dairy Specifically: _____

REACTION can occur by (check all that apply) ☐ Ingestion ☐ Contact ☐ Inhalation

SYMPTOMS of child's food allergy reaction/intolerance include:

- ☐ Nausea and vomiting
- ☐ Cramping and/or abdominal pain
- ☐ Facial swelling, itching, welts or hives
- ☐ Swelling of the lips, nose, tongue or throat.
- ☐ Respiratory changes difficulty breathing, wheezing or continuous coughing.
- ☐ Inability to speak or swallow.
- ☐ Flushed face
- ☐ Drooling
- ☐ Complains that the throat feels tight, scratchy, or different in some way.
- ☐ OTHER – Describe:

  _____

FOR PEANUT ALLERGY:

If a label indicates the food item is made in a facility that also processes peanuts, my child may consume. _____Yes _____No

Does your child have an Epinephrine Auto-injector prescribed? _____Yes _____No

MEDICATIONS: If your child takes any allergy medications please inquire about additional required forms.

- ☐ Non-Prescription Medication
- ☐ Prescription Medication
- ☐ Allergy & Anaphylaxis Emergency Care Plan

OTHER ALLERGIES: Please list any other allergies you child has.

1. _____
2. _____
3. _____

Does your child wear a Medic Alert to identify him/her as having allergies? ___Yes ___No

PARENT PERMISSION

I verify that the above information is correct. I give my permission to share this information with staff on a need-to-know basis. The information is valid for ONE SCHOOL YEAR. Annual parent signature is required.

Parent/Guardian Signature _____ Date _____

Mother _____Phone (_____) _____-_____

Father _____ Phone (_____) _____-_____

HEALTH APPRAISAL

Michigan Department of Health and Human Services

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, dentist, dental therapist, and dental hygienist.
(**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)	Today's Date (mm/dd/yy)
Parent/Guardian (Last, First, Middle)	Home/Cell Phone Number
Address (Number, Street, City, Zip Code)	Work Phone Number

SECTION I – HEALTH HISTORY

Yes	No	Resolved	#	Is your child having any of the problems listed below?	Birth History
☐	☐	☐	1	Allergies or Reactions (for example, food, medication or other)	
☐	☐	☐	2	Anaphylaxis	
☐	☐	☐	3	Does your child take any medication(s) regularly?	If yes, list medications
☐	☐	☐	4	Hay Fever, Asthma, or Wheezing	
☐	☐	☐	5	Eczema or Frequent Skin Rashes	
☐	☐	☐	6	Convulsions/Seizures	
☐	☐	☐	7	Heart Trouble	
☐	☐	☐	8	Diabetes	
☐	☐	☐	9	Frequent Colds, Sore Throats, Earaches (4 or more per year)	Are there any current or past diagnosis(es) ☐ Yes ☐ No
☐	☐	☐	10	Trouble with Passing Urine or Bowel Movements	If yes, please describe
☐	☐	☐	11	Shortness of Breath	
☐	☐	☐	12	Speech Problems	
☐	☐	☐	13	Menstrual Problems	
☐	☐	☐	14	Dental Problems Date of Last Exam _____ **OR** Date of Last Assessment _____	
☐	☐	☐		Other (please describe) _____	

Reason for Medication		
Concussion History		
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

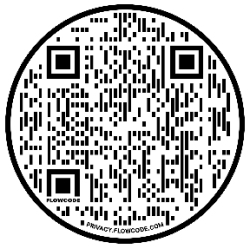
Test and Measurements

Yes	No	Was child tested for	Tests and results	Normal	Referred	Under care
☐	☐	Vision Date _____	Visual Acuity	☐	☐	☐
			Muscle Imbalance	☐	☐	☐
			Other	☐	☐	☐
☐	☐	Hearing Date _____	☐ Audiometer (R= Right, L=Left)	R/L	R/L	☐
			☐ OAE (R= Right, L=Left)	R/L	R/L	☐
			☐ Other (R= Right, L=Left)	R/L	R/L	☐
☐	☐	Urinalysis	Sugar	☐	☐	☐
			Albumin	☐	☐	☐
			Microscopic	☐	☐	☐
☐	☐	Blood Lead Level Date _____	Level _____ ug/dl	☐	☐	☐

Note: All children in Medicaid need to be tested at 1 and 2 years of age, or once between 3 and 6 years of age if not previously tested. All children, regardless of Medicaid status, should be tested at those same ages if they live in an area where lead risk is high.

☐	☐	Height & Weight	Height	☐	☐	☐
			Weight	☐	☐	☐
		Other _____	Other _____	☐	☐	☐
☐	☐	Hemoglobin/Hematocrit	⇨	☐	☐	☐
☐	☐	Blood Pressure	Reading _____	☐	☐	☐

Complete pediatric tuberculosis risk assessment available at:
https://www.michigan.gov/documents/mdhhs/4._MI_Pediatric_TB_Risk_Assessment_661537_7.pdf **OR** feel free to use the attached QR code instead of the full link text.



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 based on this information.*

Vaccines (Circle Type)	Date Administered mm/dd/yy		Vaccines (Circle Type)	Date Administered mm/dd/yy	
Hepatitis B (HepB)	1	3	Hepatitis A (HepA)	1	3
	2	4		2	
DTaP/DTP/DT/Td	1	4	Influenza (IIV/LAIV)	1	3
	2	5		2	4
	3	6	Meningococcal MenACWY (MCV4)	1	3
				2	
Tdap	1		Meningococcal B (Bexsero, Trumenba)	1	3
				2	
Haemophilus Influenzae type b (HIB)	1	3	Human Papillomavirus (9vHPV, 4vHPV, 2vHPV)	1	3
				2	
	2	4	Additional Vaccines Specify Date & Type	Type of Vaccine(s)	Date of Vaccine(s)
Polio (IPV/OPV)	1	4		1	
	2	5		2	
	3			3	
Pneumococcal Conjugate (PCV7/PCV13)	1	3	Indicate and attach physician diagnosis or laboratory evidence of immunity as applicable.		
	2	4			
Rotavirus (RV1/RV5)	1	3	***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.		
	2				
Measles, Mumps, Rubella (MMR/MMRV)	1	3			
	2				
Varicella (Chickenpox), (Var, MMRV)	1	2			
History of Chickenpox Disease? ☐ Yes ☐ No If yes, date _____			Parent/Guardian refused recommended immunizations at visit: ☐		
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)

Yes	No	
☐	☐	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 EXAM OR ASSESSMENT RECOMMENDATIONS (OPTIONAL)

Child's Name	Has received ☐ Dental Exam ☐ Dental Assessment
Findings and Recommendation (Check all that apply) ☐ No Urgent Needs ☐ Routine Care Needed ☐ Treated Decay ☐ Restorative/Urgent Needs for Dental Care ☐ Untreated Decay ☐ Further Referral for Specialist	
Signature	Date
Check One ☐ Dentist ☐ Dental Therapist ☐ Dental Hygienist	

PHYSICIAN'S SIGNATURE

Examiner's Signature	Date	Examiner's Name (Print)		Degree or License
Number & Street	City	MI	Zip Code	Telephone Number

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 preventative and primary health care, including medical, dental, and mental health. The schedule must incorporate the well-childcare 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.

The Michigan Department of Health and Human Services will not exclude from participation in, deny benefits of, or discriminate against any individual or group because of race, sex, religion, age, national origin, color, height, weight, marital status, partisan considerations, or a disability or genetic information that is unrelated to the person's eligibility.

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)

UNDERSTANDING CONCUSSION

Some Common Symptoms

Headache	**Balance Problems**	**Sensitive 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	**Sensitive to Light**	**Fogginess**	**"Feeling Down"**	**Sleep Problems**
		Grogginess		

WHAT IS A CONCUSSION?

A concussion is a type of traumatic 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 or 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 play on the day of the injury and until a health care professional says they are okay to return to play.

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 PLAY –** Concussions take time to heal. Don't let the student return to play the day of injury and until a heath care professional says it's okay. A student who returns to play 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. It is better to miss one game than the whole season.

3. **TELL THE SCHOOL ABOUT ANY PREVIOUS CONCUSSION –** 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 about assignment or position
- Forgets an instruction
- Can't recall events prior to or after a hit or fall
- Is unsure of game, score, or opponent
- 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. A student should receive immediate medical attention if after a bump, blow, or jolt to the head or body s/he exhibits any of the following danger signs:

- One pupil larger than the other
- Is drowsy or cannot be awakened
- A headache that gets worse
- Weakness, numbness, or decreased coordination
- Repeated vomiting or nausea
- Slurred speech
- Convulsions or seizures
- Cannot recognize people/places
- Becomes increasingly confused, restless or agitated
- Has unusual behavior
- Loses consciousness (even a brief loss of consciousness should be taken seriously.)

HOW TO RESPOND TO A REPORT OF A CONCUSSION:

If a student reports one or more symptoms of a concussion after a bump, blow, or jolt to the head or body, s/he should be kept out of athletic play the day of the injury. The student should only return to play with permission from a health care professional experienced in evaluating for concussion. During recovery, rest is key. Exercising or activities that involve 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 rests breaks, be given extra help and time, spend less time reading, writing or on a computer. After a concussion, returning to sports and school is a gradual process that should be monitored by a health care professional.

Remember: Concussion affects people differently. While most students with a concussion recover quickly and fully, some will have symptoms that last for days, or even weeks. A more serious concussion can last for months or longer.

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 Concussion Fact Sheet for Parents and/or the Concussion Fact Sheet for Students provided by _____

Sponsoring Organization

_____	_____
Participant Name Printed	Parent or Guardian Name Printed
_____	_____
Participant Name Signature	Parent or Guardian Name Signature
_____	_____
Date	Date

Return this signed form to the sponsoring organization that must keep on file for the duration of participation or age 18.

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

Dear Parent/Guardian:

Key Points Related to Claiming a Nonmedical Immunization Waiver for Children Attending Michigan Schools and Licensed Childcare Programs

In early 2015, Michigan instituted an administrative rule change on nonmedical waivers for childhood immunizations. Parents/guardians seeking to obtain a nonmedical immunization waiver for their child/children who are enrolled in school or licensed childcare programs are required to attend an educational session, where they are provided with information about vaccine-preventable diseases and vaccinations.

Key Points

- The rule applies to parents/guardians seeking a nonmedical immunization waiver for their child/children enrolled in public or private:
    - Licensed childcare, preschool, and Head Start programs
    - Kindergarten, 7th grade, and any newly enrolled student into the school district
- This rule preserves your ability to obtain a nonmedical waiver.
- Nonmedical waivers (religious or philosophical/other objections) are available at your county health department and cannot be found at schools/childcare programs or physician offices.
- Parents/Guardians are required to follow these steps when seeking a nonmedical waiver:
    1. Contact your county health department for an appointment to speak with a health educator.
    2. During the visit, immunization-related questions and concerns of the parents/guardians can be brought up for discussion. The staff will present evidence-based information regarding the risks of vaccine-preventable diseases and the benefits/potential risks (risks consisting mostly moderate side effects) of vaccination.
    3. Schools/childcare programs will only accept the current, un-altered, official State of Michigan form (Any new waivers issued should have the revision date of January 10, 2021.)
        - A county health department will not issue a waiver without both signatures as it would be considered an incomplete and invalid waiver.
        - Forms cannot be altered in any way (this includes crossing information out).
    4. Take the current, certified waiver form to your child's school or childcare program.
- If your child has a medical reason (that is, a true medical contraindication or precaution) for not receiving a vaccine, a physician (MD/DO) must sign the State of Michigan Medical Contraindication Form.
- Based on the public health code, a child without an up-to-date immunization record, a certified nonmedical waiver form, **or** a physician (MD/DO)-signed medical waiver shall be excluded from school/childcare.

For more information, please visit www.michigan.gov/immunize > click on *Local Health Departments* > click on *Immunization Waiver Information.* This website will provide you with a link to all the county health departments, along with their addresses and phone numbers.

*County Health Department includes the City of Detroit

May 3, 2021

Health Department

Statement of Varicella Disease
CHICKENPOX

The Michigan Public Health Code Act 368 of 1978 Part 92 Immunization and Macomb County Immunization Regulations require all children admitted to any public, private, parochial, special education, alternative education, adult education, career/technical education, homeschool cooperative, virtual school or charter academy, childcare center, nursery school, preschool, camp, or any other organized care or educational facility operating in Macomb County to present a certificate indicating dates of all required immunizations.

Complete the portion below **only** if your child has had varicella (chickenpox) disease. **This form must be signed and witnessed at your child's school/childcare program.**

I certify my child: _____
Last Name First Name M.I.

_____
Birth Date Grade Date of School Enrollment

Has had varicella disease _____
(When did varicella occur: Age or Date?)

Signature: _____ Date: _____
(Parent or Legal Guardian)

Witnessed by: _____ Date: _____
(School/Program Staff)

School District: _____

School/Childcare Program: _____

PLACE THIS FORM IN THE CHILD'S PERMANENT RECORD

Dooley Center
16170 Canberra
Roseville MI 48066
586-439-7600
Fax 586-439-7601
Melissa. Laseck – Director

Advisory To Parents / Guardians

Dear Parent or Guardian:

State of Michigan law requires that schools and day care centers that may apply pesticides on school or day care property must provide an annual advisory to parents or guardians of students attending the facility.

Please be advised that the Fraser Public Schools district utilizes an Integrated Pest Management (IPM) approach to control pests. IPM is a pest management system that utilizes all suitable techniques in a total pest management system with the intent of preventing pests from reaching unacceptable levels or to reduce an existing population to an acceptable level. Pest management techniques emphasize sanitation, pest exclusion, and biological controls. One of the objectives of using an IPM approach is to reduce or eliminate the need for chemical applications of pesticides. However, certain situations may require the need for pesticides to be utilized.

Please be advised that parents or guardians of children attending Fraser Public Schools may review the district's Integrated Pest Management program and records of any pesticide application upon request.

If you have questions regarding the district's pest management procedures, please contact:

Fraser Operations & Maintenance
33499 Klein Road
Fraser, MI 48026
(586) 439-7114
enviromental@fraserk12.org

Child's Name _____

Parent's Signature _____Date ____/_____/_____

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Parent Notice of Program Measurement*

The Dooley Center is required to work with the Michigan Department of Education (MDE) to measure the effect of the state-wide Great Start Readiness Program (GSRP). Information is sometimes collected about GSRP staff, enrolled children, and their families. Program staff or a representative from MDE might:

- Ask parents questions about their child and family.
- Observe children in the classroom.
- Measure what children know about letters, words, numbers, etc....
- Ask teachers how children are learning and growing.

Information from you and about your child will not be shared with others in any way that you or your child could be identified. It is protected by law.

If you have any questions, please contact:

- The Dooley Center at (586) 439-7600
  Or
- The MDE Office of Great Start Preschool and Out-of-School Time Learning at
  - Mde-gsrp@michigan.gov
  - (517) 241-7004
  - 608 W Allegan, PO Box 30008, Lansing, MI 48909

Child's Name _____

Parent's Name _____
_
Parent's Signature _____Date _____/_____/_____

Provided to parents upon enrollment and/or included in the GSRP Parent Handbook

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Roseville MI 48066
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Fax 586-439-7601
Melissa Laseck - Director

GSRP Parent Agreement

Child's Name _____

_____ I understand that my child will attend school on a regular basis as he/she is in good health.

_____ I understand that I must notify the school office and bus garage (If using transportation) if my Child will be absent.

_____ I understand that I must make sure that my child's immunizations are up to date in the school office to continue to attend preschool.

_____ I understand I will make my child's teacher aware of any changes with phone numbers, addresses, email address and information pertaining to my child.

_____ I understand that I must provide local emergency contact information.

_____ I understand I must make my child's teacher aware of any allergies, medications, and special needs that my child may have.

_____ I understand the toilet-trained policy and procedure.

_____ I understand that my child may be photographed or videotaped during their time in the program. These photos or tapes may be used in newsletters, FPS website or FPS TV channel.

_____ I understand that the GSRP class may take short walks around the school area without prior notice.

_____ I am being made aware of a Licensing Notebook. I understand that: (i) The licensing notebook is available for parents to review during regular business hours. (ii) The licensing notebook contains all the licensing inspection reports, special investigation reports and related corrective action plans for the last 5 years, (iii) Licensing inspection reports, special investigation reports and related corrective action plans for at least the last 3 years are available on the department's child care licensing website at www.michigan.gov/michildcare.

_____ I understand that all preschool employees of Dooley-Fraser Public Schools have had a comprehensive background check.

_____ I understand that all Dooley classrooms are peanut and tree nut restricted. I will not send to school items that contain peanut or tree nut products.

_____ I have received and read the GSRP Parent Handbook, and I agree to the policies described within the handbook. Another GSRP Parent Handbook will be given if requested.

Parent/Guardian's
Signature: _____Date: _____/_____/_____