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

FOR GSRP PROGRAM STAFF ONLY:

FPL Calculator

	Percent of Federal Poverty Level
	0-50%
	51-100%
	101-150%
	151-200%
	201-250%
	251-300%
	301-350%
	351-400%
	401-450%
	451-500%
	500% +

This child is income-eligible to participate in:

☐ Head Start ☐ Great Start Readiness Program

	Documents Received (Required)
	Child Information Record
	Head Start Release Form (if applicable)
	Health Appraisal
	Immunization Record
	IEP (if applicable)
	Parent Notice of Program Measurement
	Verification of Birth

Additional Comments:

_____

_____

I verify I have reviewed the GSRP Enrollment form

_____ _____

Staff Signature and Title Date

Anchor Bay Schools Early Childhood Programs
Pre-K For All Program Overview

Research indicates that children who are provided with a high-quality preschool experience show significant positive developmental differences when compared to children from the same backgrounds that did not attend a preschool program. Michigan, through the Department of Education, provides funding for high-quality preschool programs through the Michigan Department of Lifelong Education, Advancement, and Potential (MiLEAP) program. The Great Start Readiness Program (GSRP) is for children who may be a risk of becoming educationally disadvantaged and who may have extraordinary need of special assistance.

A specific situation or condition is considered at risk factor if that situation puts the child at a direct risk of school failure. The primary question is in later grades, how does this particular factor have a negative impact on the child's development?

There are eight clusters of factors that may place children at educational risk. These must be documented in our files.

Community/financial factors
Child health factors
Child developmental factors
Parent/parenting factors
Family circumstance factors

In order to determine eligibility for the program the information on this application **MUST** be documented. Many of these questions will be very personal and sometimes sensitive. This information will only be viewed by those professionals who may be involved in screening or servicing your child should they be eligible. These may include: Program Director, Early Childhood Educational Specialist, Social Worker, School Psychologist, Special Education Director, Speech Therapist, and Teaching Staff. All applications will be reviewed by the Educational Specialist to determine eligibility.

Your child may qualify for other Early Childhood Programs. Every effort will be made to place your child in the most appropriate program based on their needs and developmental screening. By signing below, you give permission for us to share your application and child's screening results with other programs to determine the best placement. Placement into a different program will not occur without you first being contacted for consent, evaluation or registration. Other programs that may be considered are Head Start, ECSE and Traditional Tuition Based Preschool.

Parent/Guardian Signature_____Date_____

Staff Intake Signature _____Date_____

****

(For Office Use Only)

_____Income Eligible _____Head Start Referred _____FIA/DHS Eligible

_____Childcare Needed _____Transportation Requested (in district only) _____Parent Transportation

_____
Early Childhood Educational Specialist

Pre-K For All Policy Agreement

SCHOOL RELEASE FORM: Anchor Bay School District students may be photographed or videotaped, and their name and/or work displayed for educational and/or not-for profit use in various ways: newspaper articles, community newspaper articles, building videos, Channel 6 broadcasts, building video networks, program yearbook, as well as district, building and classroom newsletters, web pages, etc. If you do not want your child to participate in the above activities you must submit your request in writing to the Program Supervisor by the first day your child attends preschool.

Child's Full Name_____ **Date**_____
Parents: Please initial next to each statement and sign at the bottom.

- — I understand that a Permanent School Record will be started for my child and passed along to their Anchor Bay Elementary School when they enter Kindergarten.
- — I understand that there may be up to 8 Professional Development Days built into the school calendar. The exact dates for these Professional Development Days have not yet been determined but will be provided to me as soon as they become available. Every attempt will be made to align these dates with the district elementary calendar.
- — I understand that whenever Anchor Bay Schools close for inclement weather and/or building problems preschool classes are also cancelled.
- — I understand that if my child receives transportation, I agree to have my child ready at least 15 minutes before his/her scheduled pick up time. I also agree that an adult on my child's emergency card or myself will be available at the designated drop off location at least 15 minutes prior to the scheduled time.
- — I understand that transportation is a privilege for my child and that unacceptable or unsafe behavior will not be tolerated. I will be made aware of. any situations on the bus that involve my child. Failure to abide by bus safety rules may result in my child being removed from the bus route.
- — I understand that if on any given day I will be picking my child up from school instead of riding the bus home, I will send in a note indicating the date and my signature and contact Transportation.
- — I understand that if my child does not ride the school bus, I am to arrive at the school and wait with my child in the designated area until the other children are escorted off the bus. I understand that I must sign my child in with one of my child's teachers.
- — I understand that if my child does not ride the school bus, it is my responsibility to pick my child up on time at the end of each class and understand that a late pick-up penalty of $1.00 per minute may be imposed. Chronic or habitual late pick-ups may result in my child being dropped from the class. I will be required to sign my child OUT of class.
- — I understand that school is important and that regular attendance helps my child to grow and mature in all areas of development and teaches them the value of education. I will make every attempt to assure that my child is in school every day and on time unless they are ill.
- — In the event that my child is sick, I understand that I must call into the school to notify the office of their absence and reason for absence. This phone number will be provided to me during Home Visits. I must also contact Transportation.
- — I understand that a requirement of the Great Start Readiness Program is parent participation. I agree to participate in my child's education by attending parent meetings or activities, reading to my child every day, reading the teacher's weekly newsletters, returning and/or responding to teacher's notes when requested. I also understand that I will be asked to attend field trips with my child and to volunteer to assist in the classroom from time to time. I may also be asked to be a class representative for the Parent Advisory Committee.
- — I understand that two other requirements of the Great Start Readiness Program are that our family agrees to two Home Visits lasting approximately 45 - 60 minutes and two Parent Teacher Conferences lasting approximately 45 minutes.
- — A complete Parent Handbook will be available for download @ www.anchorbay. misd.net by the first day of school.
- — I am being made aware that a Licensing Notebook of all licensing inspection reports, special investigation reports, and all related corrective action plans are available for review at each preschool location. I understand that this notebook will be available for parents 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/childcare.
- — I understand that all Preschool classrooms are PEANUT and NUT FREE. Teachers should be made aware of any special dietary restrictions or allergies that my child may have. Homemade treats are not permissible due to allergy situations.
- — I understand that this is a School Day program and that my child will be served breakfast, lunch and a snack while at school. I agree to complete the Free/Reduced Lunch Application and return to school the first week attending.
- — I understand that because this is a School Day program, my child will be provided with a quiet rest time in the afternoon. It is my responsibility to launder their naptime bedding each week.

Parent's Signature:_____ Date:_____ Staff Initials:_____

Pre-K For All Programs - School Day Schedule 4 year-old
FREE Preschool Education Application (586) 648 - 2522 or
(586) 716 - 7862 Fax (586) 727 - 0967

Child must be 4 years old on or by September 1st (Children whose birthday falls between 9/2 – 12/1 may be considered)
Pleases return this application in person with required documentation. We must see the Original Birth Certificate. Applications without complete documentation cannot be considered. This is an application only.

Actual approval and registration will not occur until allocations are announced by the State.

Child's Name	Date of Birth	Birth Weight	Current Weight
Child's Address	City	Gender M I F	Current Height
Has your child attended Preschool?	Y N	Where?	
Is your child's primary language English?	Y N	If NO, what is the primary language?	

School district in which child lives: ____ Anchor Bay ____ Other: _____ District	Child's Ethnicity and Race: Hispanic (Latino) _____Y_____N _____ American Indian or Alaskan Native _____ Asian _____ Black or African American _____ White _____ Native Hawaiian or Pacific Islander _____ Multi-racial A child's race / ethnicity is not considered when determining a family's eligibility

Anchor Bay Residents ONLY: Bus or Drive						
Will you be needing Childcare either before or after class? $5 per hour M – Th Before Class _____ After Class _____						
Mother / Guardian name			**Mother's Date of Birth**			
Employed (Circle one) Yes No			Highest level of Education completed			
Address (If different than child)		City		State Ml	Zip	
Home Phone:	Cell Phone:			Work Phone:		
Marital status: (circle one):	Single	Married	Separated	Divorced	Re-Married	Widowed
Mother's Income (last 12 months):$			Proof of Income:			
Father / Guardian name			**Father's Date of Birth**			
Employed (Circle one) Yes No			Highest level of Education completed			
Address {If different than child)			City	State Ml	Zip	
Home Phone:	Cell Phone:			Work Phone:		
Marital status: (circle one)	Single	Married	Separated	Divorced	Re-Married	Widowed
Father's Income (last 12 months}: $			Proof of Income:			
Proof of current income is required and must be turned in with this application before final eligibility determination. Proof of income includes: Previous Years Federal Tax Form, W-2s, Current DHS Cash Statement, Current SS/ Statements or previous 3 months of pay stubs.						
Who does the child live with?	Mother	Father	Both	Other:		
Does the mother reside in home?		YES	NO			
Does the father reside in home?		YES	NO			
If either parent was marked NO for residing in home do they have:						
Joint custody		YES	NO	Explain:		
Regular visitation		YES	NO	Explain:		
Are there any Legal Court Papers?		YES	NO	Against who?		
Number of Children:_____ & Adults _____ in the household that the child primarily resided (this means sleeps at night)						
List anyone else ho lives in the household besides the child:				Relationship to Child		Monthly Income

For questions on the back page, please attach additional explanation or documentation whenever you answer YES.

Please mark NO or YES for each question. Provide an explanation if directed to do so. Documentation may be required.

Risk #	Risk Factors: Answer all of the following questions by placing an X in the Yes or No box	NO	YES
HS	Is the child in Foster Care or Ward of the Court?		
	Is the family Homeless, living in a shelter, a motel or with other family members?		
	If yes, please explain:		
	Is the family currently receiving Cash Assistance from OHS?		**$**
	Does the family currently receive Supplemental Security Income?		**$**
Low or no earned income/income not adequate for meeting basic needs		**NO**	**YES**
1	Annual income is below 250% of Federal Poverty Guidelines Proof of current income is required before final eligibility determination		**$**
Diagnosed Disability or Identified Developmental Delay		**NO**	**YES**
2	Does your child have a referral or diagnosis from a physical or mental health system or provider?		
	Does your child have an Early On transition referral?		
	Does your child have a Special Education referral; with developmental concerns, noted but not diagnosed?		
	Is your child independently toilet trained?		
	If you answered No to the above question, please provide appropriate medical documentation of a disability.		
	Does your child have an Individualized Education Plan from the school district {IEP) or an Individualized Family Service Plan from Early On (IFSP)?		
Severe or Challenging Behavior		**NO**	**YES**
3	Has your child been expelled from preschool or a child care center?		Where
	Does your child demonstrate intense anger or aggression, hit, pinch, bite or throw things when he/she is angry?		Describe
	Has your family participated in Family Counseling or any other program to help your child's behavior?		Where
Primary Home Language other than English?		**NO**	**YES**
4	Is your child entering school not able to speak English?		
	Do you speak another language in your home other than English? Specify:		
Parent/Guardian with Low Educational Attainment		**NO**	**YES**
5	Did either parent not graduate from High School or need special education in school?		
	Does either parent have trouble reading?		
Physical/ Sexual Abuse/ Neglect of Child or Parent/ Substance Abuse/ Addiction		**NO**	**YES**
6	Has your child been abused physically or sexually?		Explain
	Is or has there been domestic or spousal abuse of a parent or sibling?		Explain
	Has your child ever been removed from home for Neglect or has a Parent been charged with neglect?		Explain
	Has there been abuse of alcohol, prescription or non-prescription drugs by any family members who live in the home?		Explain
	Has anyone in your household been arrested and charged with a DUI?		Explain
	If yes, please explain:		
Environmental Risk		**NO**	**YES**
7	Has this child lost a parent or sibling by death?		When
	Does this child have a parent in jailor prison with whom they have a current relationship with?		Who/Where
	Is this child living with a relative or person other than the biological parent?		Who
	Has this child lost a parent to separation or divorce?		When
	Does this child have a parent who is currently away due to active military service?		Where - How Long
	Is this a single parent family?		
	Does the child or any family members in the home suffer from mental illness? •specific documentation from a physician or mental health provider is required. {bi-polar, mania, Schizophrenia Clinical Depression, Personality Disorder, etc.)		Documentation
	Does the child or family member in the home suffer from chronic illness or life-threatening diseases? •specific documentation from a physician or health provider is required. {i.e. Cancer, Dialysis, Heart Failure, Seizures Sickle Cell, etc.)		Documentation
	Age or mother at lime of this child's birth.		
	Has this child ever been diagnosed as failure to thrive?		
	Was this child exposed to toxic substances known to cause learning or developmental delays; such as Fetal Alcohol Syndrome, Drugs, or exposed to lead?		
	Is your family currently without stable housing? {home in foreclosure, living with another family because you have no other choice, or have you moved 3 or more limes this year).		

I certify that all the information provided in this application is true to the best of my knowledge and hereby release this information to be shared with Macomb County Head Start, St. Clair County Head Start and/or other Great Start Readiness Programs or other school professionals. I understand that upon review I may be required to provide verification for my child's file to participate in the program. I understand that placement in the program is based on a priority risk factor scale ad that just because my child qualifies; it does not mean that they will be placed into the program. I understand that I will be notified as soon as possible of acceptance in the program. If accepted, I further understand that I must agree to have two (2) Home Visits by the teaching team and to come to two (2) Parent Teacher Conferences. I must attend a Mandatory Parent Orientation Meeting and to fulfill my Parent Participation Agreement

Parent/Guardian Signature _____ Date _____ Staff Signature _____

Anchor Bay School District does not exclude any qualified person from its Early Childhood Programs on the basis of disability.

Anchor Bay School District - Student Emergency Card
Early Childhood and SACC Programs

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.

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.	Ph.	Ph.
2.	Ph.	Ph.
3.	Ph.	Ph.

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.	Ph.		Ph.
3.	Ph.		Ph.

Parent/Legal Guardian Initials:

_____ I give permission to Anchor Bay School District, 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.

Macomb County Referral Form for the Great Start Readiness Program to Head Start

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_____ **Birth Date:** _____
(Print) Child's Last Name **First Name**

_____**Phone Number:** _____
(Print) Parent/Guardian's Last Name **First Name**

Address: _____ **City:** _____ **Zip:** _____

Home School District: _____ **Enrolling for School Year:** _____

Child has a current IEP? ☐ **IEP**

Have you previously applied for Head Start or been enrolled? _____

I understand my child may be eligible for Head Start and that Head Start programs have a higher level of funding that may provide more services to my child/family. However, the Great Start Readiness Program best meets the needs for our family due to the following reasons:

Check all that apply:

☐ Zero Available Slots
☐ Hours of Operation
☐ Transportation/Distance
☐ Sibling Attends Same School
☐ Schedule (parent working/ in school)
☐ Other: Explain_____
☐ Sibling was in Program

Parent/Guardian Signature: _____ **Date:** _____
By signing I agree this information may be shared with appropriate early childhood agencies.

I have discussed this family's eligibility for Head Start and the family services they provide. As indicated, the family chooses to be enrolled in GSRP. **(Type or print all information below)**

GSRP Location: _____ **Email:** _____

Phone Number: _____ **Contact Person:** _____

School District of GSRP Program: _____

Head Start Use Only

I have reviewed the above information, and/or parent's documentation.

_____ **Head Start releases this child to be enrolled in GSRP** _____**Child is enrolled in Head Start for 2026-27 school year**

Head Start Representative Signature: _____ **Date:** _____

MACOMB INTERMEDIATE SCHOOL DISTRICT
HOME LANGUAGE SURVEY

The Anchor Bay School District is collecting information regarding the language background of each new student.

This information will be used by the district to determine the number of children who should be provided bilingual instruction according to Sections 380.1152-380.1157 of the School Code of 1995, Michigan's Bilingual Education Law.

Please provide the following information:

Name of Student _____ Date of Birth _____

Name of School _____ Grade _____

1. Is your child's native language a language other than English?
   Yes. If yes, what is that language? _____
   No

2. If the "primary language" used in your child's home environment a language other than English?
   Yes. If yes, what is that language? _____
   No

3. Was the student born outside of the United States?
   (For Title III Immigrant Funding purposes)
   Yes
   No

4. When did your child start school in the United States?

Please return this form with enrollment/registration forms.

Anchor Bay Early Childhood Programs
FAMILY & SOCIAL HISTORY

Teacher's Name _____

Childs Name._____ Birth date_____
(Please print clearly)

In order to help the teachers to know a little bit about your child, please take a few minutes to complete this Family and Social History form and return it to your child's teacher at Meet & Greet.

Does your child have a nickname? _____

Parent's marital status (circle) married single divorced widowed re-married partner

Who does the child live with? Mom Dad Both Parents Grandparents Other_____

Primary language spoken in the home_____ Secondary Language_____

At what age did your child begin to talk in complete sentences? _____

At what age did your child begin to crawl? _____ Walk? _____

At what age was your child independently toilet trained? _____

What word(s) does your child use when they need to use the bathroom? _____

Does your child wear a pull-up? Day _____ Night _____

What type of toys does your child enjoy playing with?_____

Has your child ever been in another preschool, daycare or play group?_____ If yes, where? _____

Has your child ever been excluded from another preschool or daycare? _____If yes, reason: _____

Please list any brothers & sisters names and their ages:

Does your child have any pets?_____ If yes, what kind?

Are there any holidays that you do not want your child to participate in?

Does your child have any allergies? (Be Specific)
You will be asked to complete an Allergy Alert by the teacher.

Do you have any concerns about your child's speech, language, hearing, vision, or development?
Please briefly describe your concern.

Please describe your child's behavior and temperament.

What do you hope for your child to gain from preschool this year?

Please share with us anything else you want us to know about your child and anything you think might help him/her to be more comfortable in our school.

PARENT OBSERVATION CHECKLIST FOR CHILDREN 3-5 YEARS OLD

Child's Name _____ Date _____

Please observe your child at home and with friends. Place a check next to the items that apply to your child. Your observations will help to determine if your child has a communicating problem that may be affecting his/her relationships outside of school. Thank you for taking the time to provide this important information regarding your child.

- — Avoids speaking with family members.
- — Avoids speaking to other adults.
- — Avoids speaking to other children.
- — Uses more gestures than speech.
- — Has a speech problem that is distracting to others.
- — Is unable to retell a story or experience.
- — Is unable to answer questions appropriately.
- — Does not say all sounds.
- — Leaves out sounds in words.
- — Stutters.
- — Speaks too rapidly or slowly.
- — Has a voice problem. (Too high, too low, hoarse etc.)
- — Has speech patterns of a much younger child (Vocabulary and sentence structure)
- — Is hard for parents to understand.
- — Is hard for others to understand.
- — Does not follow spoken directions.
- — Requires repetition of spoken directions.
- — Is easily distracted.
- — Has difficulty paying attention to a story.
- — Has difficulty hearing.
- — Is aware of his/her speech problem.
- — Is teased about his/her speech by siblings or other children.
- — I believe my child has a problem communicating.
- — Is frustrated by his/her speech problem.
- — Has difficulty processing what is said to them
- — Has difficulty concentrating
- — Unable to follow simple 2 - 3 step directions
- — Is overly sensitive to sensory stimulus:
    - — Sounds
    - — Touch
    - — Smells
    - — Tastes
    - — Sight (bright or flickering fluorescent lights)

Comments: _____

— I currently have a speech evaluation scheduled for my child on _____

— I would like information about setting up an appointment

_____

Parent Signature Daytime phone number

MDHHS-3305, HEALTH APPRAISAL

Michigan Department of Health and Human Services (MDHHS)
(Revised 7-24)

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 1. Section 4 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).

SECTION 1 – 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 2 – 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, describe

☐	☐	☐	11. Shortness of Breath	
☐	☐	☐	12. Speech Problems	
☐	☐	☐	13. Menstrual Problems	
☐	☐	☐	14. Dental Problems Date of Last Exam OR Date of Last Assessment	
☐	☐	☐	15. Other (describe)	

Reason for Medication

Concussion History

Parent/Guardian Signature Date

Was the health history reviewed by a health professional? Examiner's Initials

☐ Yes ☐ No

SECTION 3 - PHYSICAL EXAMINATION, INSPECTION, TESTS AND MEASUREMENTS

Required for Child Care and Head Start / Early Head Start

Test and Measurements

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

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 4 – IMMUNIZATIONS

Statements such as "UP-TO-DATE" or "COMPLETE" will not be accepted. Admission to school may be denied based on this information.*****

Vaccines (Select Type)	Date Administered (mm/dd/yy)		
Hepatitis B (HepB)	1.	2.	3.
	4.		
DTaP/DTP/DT/Td	1.	2.	3.
	4.	5.	6.
Tdap	1.		
Haemophilus Influenzae type b (HIB)	1.	2.	3.
	4.		
Polio (IPV/OPV)	1.	2.	3.
	4.	5.	
Pneumococcal Conjugate (PCV)	1.	2.	3.
	4.		
Rotavirus (RV1/RV5)	1.	2.	3.
Measles, Mumps, Rubella (MMR/MMRV)	1.	2.	3.
Varicella (Chickenpox), (Var, MMRV)	1.	2.	
Hepatitis A (HepA)	1.	2.	3.

Influenza	1.	2.	3.
(IIV/LAIV)	4.		
Meningococcal (MCV4, MenABCWY)	1.	2.	3.
Meningococcal B (Bexsero, Trumenba, MenABCWY)	1.	2.	3.
Human Papillomavirus (HPV)	1.	2.	3.

Additional 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.

History of Chickenpox Disease? If yes, date

☐ Yes ☐ No

☐ Parent/Guardian refused recommended immunizations at visit.

I certify that the immunization dates are true to the best of my knowledge

Health Professional Signature Title Date

SECTION 5 - RECOMMENDATIONS (Required for Child Care and Head Start/Early Head Start)

Is there any defect of vision, hearing, or other condition for which the school could help by seating or other actions?

☐ Yes ☐ No

If yes, explain

Should the child's activity be restricted because of any physical defect or illness?

☐ Yes ☐ No

Check all that apply

☐ Classroom ☐ Playground ☐ Gymnasium

☐ Swimming Pool ☐ Competitive Sports ☐ Other

If yes, explain degree of restriction(s)

Other Recommendations

SECTION 6 - DENTAL EXAM OR ASSESSMENT RECOMMENDATIONS

Child's Name

Type of Service
☐ Dental Exam ☐ Dental Assessment

Findings (Check all that apply)
☐ No findings ☐ Treated Decay ☐ Untreated Decay

Recommendations (Check one)
☐ Routine Care
☐ Referral for dental treatment
☐ Referral for urgent dental care

Provider Signature | Date

Check one
☐ Dentist ☐ Dental Therapist ☐ Dental Hygienist

SECTION 7 - PHYSICIAN'S SIGNATURE

Examiner's Name (Print) | Degree or License | Telephone Number

Examiner's Signature | Date

Address | City | State **MI** | Zip Code

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.

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.

Anchor Bay Early Childhood Programs
Notification of Licensing Regulations

All of our early childhood programs are licensed through the State of Michigan. One of our requirements is to make parents are of all our policies and procedures. You would have read these online when you registered your child.

- 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.
- The Parent Handbook is available for download on the Early Childhood Page of the Anchor Bay Schools website: www.anchorbay.misd.net

I have read the above statement issued by Anchor Bay Early Childhood Programs .

Child's Name: _____

Teacher's Name: _____

Parent Name: _____

Parent Signature_____ Date _____