MADISON DISTRICT PUBLIC SCHOOLS

Serving Families One Student at a Time

26524 John R Road · Madison Heights, MI 48071 · (248) 399-7800 · Fax (248) 399-2229

Enrollment Check List

__ Child's Birth Certificate

__ Child's Shot Record

__ Child's Health Insurance Card

__ Parent/Guardian I.D. Card

__ Proof of Residency (i.e. I.D. Card, Utility Bill, Lease Agreement, etc…)

__ Proof of Income (i.e. Tax Return, Check Pay Stub, Proof of State Aid)

__ Child's Physical

__ Child's TB Test

__ CACFP Participant Enrollment Form

__ Application for Free and Reduced Price School Meals

Application for Great Start Readiness Program

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FOR OFFICE USE ONLY
STUDENT ID#: _____

Great Start Readiness Program

DATE: _____

CHILD APPLICATION FORM

PARENT COMPLETES THIS PAGE

SCHOOL/CENTER: _____

CHILD'S NAME: _____ BIRTHDATE: _____ SEX: F ( ) M ( )

CHILD'S ADDRESS: _____ ZIP: _____ HOME TELEPHONE: _____

BIRTH CERTIFICATE#: _____ BIRTHPLACE: _____

BIRTH WEIGHT: _____ LBS. _____ OZS. PREMATURE BIRTH: YES ( ) NO ( )

Special Needs/Disabling Condition: _____ Diagnosed: YES ( ) NO ( )
If Special Needs has been diagnosed by an Agency/Physician, complete Release of Information Form.

Parent/Guardian Name: _____ Relationship to Child: _____

Mother's Age at 1st Pregnancy: _____ Marital Status: Single _____ Married _____ Separated _____

Total # in Family: _____ Ethnic Group: _____

Ethnic Codes: 1 = Native American 2a = Asian or 2b = Pacific Islander 3 = Black, Not Hispanic
4a = Hispanic White or 4b = Hispanic Black 5 = White, Not Hispanic

What is your child's Native Language? _____

Is the primary language in your child's home a language other than English? YES ( ) NO ( )
If yes, what is the language? _____ Immigration date, if not born in the U.S. _____

Are You Employed? YES ( ) NO ( )
If yes, Part-Time ( ) Full-Time ( ) Seasonal ( )

Are You in School or Training? YES ( ) NO ( )
If yes, Part-Time ( ) Full-Time ( )

Is Your Spouse Employed? YES ( ) NO ( ) NA ( )
If yes, Part-Time ( ) Full-Time ( ) Seasonal ( )

Is Your Spouse in School or Training? YES ( ) NO ( )
If yes, Part-Time ( ) Full-Time ( )

Are You Enrolled in Work First? YES ( ) NO ( ) NA ( )

Source(s) of Income: 1st _____ 2nd _____
W, BM, M, 2XM (Weekley, Bi-Weekley, Monthly, Twice Per Month)
W, BM, M, 2XM (Weekley, Bi-Weekley, Monthly, Twice Per Month)

Do you receive: WIC ( ) Focus: HOPE ( ) NA ( ) Is Child: Anemic ( ) Lead Poisoned ( ) NA ( )

Do you receive: Food Stamps ( ) Medicaid ( ) SSI ( ) Child Care Assistance ( ) NA ( )

Do you need full year: YES ( ) NO ( ) and/or full day child-care? YES ( ) NO ( )

PARENT COMPLETES THIS SECTION

IF NOT PARENT, PROOF OF GUARDIANSHIP CASE#: (m) _____

	Mother	Father	Foster Parent(s) / Stepparent(s) Or Guardian(s) / Relationship	Number of Other Dependent Children In Your Household	
Name:				**Name(s)**	**Age**
Birthdate:					
Birthplace: (*City, State or Nation)*					
Home Language:					
Date Naturalized:					
Educational Status:					
Occupation:					
Home Address: *(if different)*					
Home Phone: *(if different)*					
Cell Phone or Pager Number:					
Business Address: *(Street Address, City, Zip Code)*					
Business Phone:					
Employer:					
Work / School Schedule: *(days & times)*					

Type of MEDICAID Insurance: _____ Case#: _____ Child's Recipient ID#: _____

OTHER Medical Insurance: (Type): _____ Claim Number: _____

The above information is true and correct to the best of my knowledge. I understand that if any of this information changes, or is found to be incorrect, I am obligated to immediately notify this program. I understand that the above information and all information contained in the child's foster will remain **CONFIDENTIAL**. I hereby make application for my child and myself to be enrolled in a Detroit Public School Preschool Program based on all the information in the Child's Registration Form.

_____ _____ _____ _____

Signature of Parent / Guardian **Date** **Signature of Staff Verifying and Auditing Form** **Date**

STAFF COMPLETES THIS SECTION

Child Risk Factor	
1. Extremely Low 2. Low family income 3. Diagnosed disability or identified development delay 4. Severe or challenging behavior 5. Primary home language other than English 6. Parent/guardian with low educational attainment 7. Abuse/neglect of child or parent 8. Environmental Risk	Risk Factors Accrued: _____ Is child Head Start income eligible: Yes _____ No _____
Date enrolled:	

INCOME VERIFICATION Parent / Guardian Name	Wages / Salary W, BW, M, 2XM	Amount of TANF (2XM)	Amount of Monthly SSI / Social Security	Foster Care/Other	Date & Type of Verification/Proof	Annual Total
T O T A L						

* Date enrolled is the first actual day of attendance.

CHILD INFORMATION RECORD

State of Michigan Department of Human Services - Bureau of Children and Adult 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

Father/Legal Guardian's Name	Home Phone ( )	Mother/Legal Guardian's Name	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 (optional)		
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. 7-12) Previous editions 9-09, 3-08, 10-07, & 1-06 may be used until 12/31/13. **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.	( )

I give permission to _____ , licensed by the Department of Human Services
(Provider's Name)

to secure emergency medical and/or emergency surgical treatment for the above named minor child while in care.

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

Department of Human Services (DHS) will not discriminate against any individual or group because of race, religion, age, national origin, color, height, weight, marital status, sex, sexual orientation, gender identity or expression, political beliefs or disability. If you need help with reading, writing, hearing, etc., under the Americans with Disabilities Act, you are invited to make your needs known to a DHS office in your area.

AUTHORITY: 1973 PA 116
COMPLETION: Required
PENALTY: Rule Violation Citation.

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MADISON DISTRICT PUBLIC SCHOOLS
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Dear Parents/Guardian,

Your child will receive a breakfast or snack each day in the Great Start Program. The district participates in the United States Department of Agriculture Child and Adult Care Food Program. Meal and snacks served must meet the Department requirements. Food substitutions may be made only when supported by a physician's statement indicating an allergy or other medical reason for the substitution. Please ask your physician to complete and sign this form if child requires a substitution and must avoid certain foods. Return the form to Valerie Martin before school begins in September. If you have any questions please call Valerie Martin at (248) 399-7800, ext 3404.

1. **Medical/special dietary restrictions** (check or describe)

   _____ Food Allergy (explain) _____

   _____ Lactose Intolerance

   _____ Iron Intolerance _____ Obesity

   _____ Other (describe) _____

2. **Foods to be omitted**

   _____ Iron Fortified Infant Cereal _____ Wheat Products

   _____ Milk _____ Other (list) _____

3. **Foods to be substituted**

   _____ Low Iron Infant Formula _____ Vita-mite

   _____ Rice Products _____ Other (list) _____

4. **Description of handicapping condition that may restrict child's diet:**

   _____

   _____

_____ _____

Physician's Signature Date

MADISON DISTRICT PUBLIC SCHOOLS
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CHILD PLACEMENT CONTRACT

Note: This contract is required of all licensed child care centers as provided by **R 400.5105b** of the Michigan Administrative Code.

As of _____, the _____ Prekindergarten
(Date) (School)

Program agrees to provide childcare services for _____.
(Child's Name)

Part 1: Contract Provisions Provided by Childcare Facility

The _____ Prekindergarten Program as a licensed childcare facility will provide the following provisions of the Michigan Administrative Code as required by **R 400.5105b:**

R 400.5102 Licensee.
Rule 102
(2) A license shall have the following administrative responsibilities regarding staff:
(c) Develop and implement a written screening policy for all staff and volunteers, including parents, who have contact with children.

R 400.5106 Program.
Rule 106
(1) A developmentally appropriate program shall be implemented that includes all of the following ideas:
(a) Physical Development
(b) Social Development
(c) Emotional Development
(d) Intellectual Development
(2) The following types of activities shall be provided daily:
(a) Quiet and active
(b) Individual, small groups and large groups
(c) Large and small muscle
(d) Child initiated and staff initiated
(e) Developmentally appropriate language and literacy experiences throughout the day accumulating for not less than 30 minutes
(f) Early math and science experiences

(3) Daily activities shall be planned so that each child may do the following:

(a) Have opportunities to feel successful and feel good about himself or herself and develop independence
(b) Use materials and take part in activities which encourage creativity
(c) Learn new ideas and skills
(d) Participate in imaginative play

(6) The program shall provide daily outdoor play unless prevented by inclement weather.
(7) The program shall provide a naptime and quiet time
(11) The program shall permit parents to visit for the purpose of observing their children during the day.

Part 2: Additional Contract Provisions

I will work with my child's teacher and other staff to ensure that my child's Health Appraisal, Immunizations and other health requirements are kept updated throughout the school year.

If my child is sick or has a contagious disease, I will take my child to the doctor and/or keep my child home until he/she is able to return to school, or I will bring a doctor's statement verifying that my child is able to return to school.

I understand that the staff may contact me if there are any health problems or if any additional health information is needed.

I will also keep my phone number(s), and address current.

I have read, understand and received a copy of the Attendance Policy.

I have read, understand and received a copy of the Late Pick Up Policy.

Upon signing this agreement, the parent, legal guardian or responsible adult and the child care staff agree to abide by all the provisions contained in this contract.

Staff Signature: _____

Staff Position / Title: _____

Parent / Legal Guardian Signature: _____

Relationship to Child: _____

MADISON DISTRICT PUBLIC SCHOOLS
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Volunteers to our schools are vital to our success in providing the highest quality educational services to your children. Without volunteers, many of the school, classroom, and extracurricular activities could not take place. We thank all of those individuals who offer to help in school activities and events.

For the safety of our students a volunteer form must be filled out each year.

Please complete the information below. A background check through the Michigan State Police will be performed. Once the report is received by the district, your name will be made available to your school to begin volunteering if you choose to do so. We do ask volunteers to report to the school office to sign in and pick up a volunteer badge. Please return the badge to office when you sign out.

If you have any questions, please call Sharon Kline in the Madison Board Office at (248) 399-7800. Thank you for helping us keep your children safe at school.

Please print *(one form per family)*

1. Volunteer Name: _____ Date of Birth: _____

   Volunteer Signature: _____

2. Volunteer Name: _____ Date of Birth: _____

   Volunteer Signature: _____

   Child's Full Name: _____

   School: _____

   Preschool: _____

Your signature indicates your consent to a Michigan State Police background check.

Please indicate if you have had any training in the following:

CPR _____ First Aid _____ Universal Precautions _____

Office use only

District signature approving volunteer _____ Date: _____

MADISON DISTRICT PUBLIC SCHOOLS
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HEALTH OBSERVATION OF CHILD DEVELOPMENT FORM

Child's Name: _____ Birthdate: _____

School: _____ Date: _____

Directions: Check any of the following conditions that you as teacher have observed that may warrant referral, additional screening or treatment. This form needs to be completed during the enrollment process. Send original to the instructional specialist and keep the copy in the child's folder.

Assessor: _____

VISION

_____ shows symptoms of eye fatigue or stress as indicated:
{ } blinking; { } squinting; { } itching; { } tearing
_____ shows symptoms of eye infection as indicated by:
{ } redness; { } discharge; { } holds materials far from eyes
{ } closes one eye or squints; { } stranismus (lazy eye)

HEARING

_____ has difficulty hearing over background noise
_____ turns head to one side frequently
_____ misunderstands instructions
_____ often asks for instructions to be repeated

SPEECH

_____ is difficult to understand
_____ voice quality is: { } too loud; { } too weak;
uses _____ number of words in a sentence

SELF-RELIANCE

_____ lacks confidence
_____ is careless
_____ needs encouragement in order to perform
_____ lacks independent toileting skills

EMOTIONAL FUNCTION

_____ cries or angers easily
_____ is easily frustrated
_____ requires much praise
_____ needs encouragement and attention
_____ has difficulty cooperating
_____ acts without thinking
_____ avoids difficult tasks
_____ has short attention span
_____ shows symptoms of nervousness indicated by:
{ } hits; { } kicks or pushes others; { } yells at others or
uses name calling

MOTOR SKILLS

_____ performs significantly below age in large muscle skills development (like walking up and down stairs; riding a bike)
_____ performs significantly below age in small muscle skills development (using crayons, scissors or forks/spoons)

PHYSICAL APPEARANCE

_____ appears to lack good physical health and stamina-tires easily

List any significant observations that suggest a need for medical care, such as rashes, obesity, fragility and clumsiness:

_____

_____

_____

_____

Referral made: { } Yes { } No

Reason for referral:

_____

_____

_____

Results: _____

Undercare: _____

MADISON DISTRICT PUBLIC SCHOOLS
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PARENT NEEDS ASSESSMENT

School: _____ Teacher: _____ Room#: _____ Date: _____

Parent/Guardian: _____ Telephone: _____ GSRP: _____ HS: _____

Suggested Topics: Number in the order of wants (1-first, 2-second, etc.)

Child Growth and Development
_____ Self-Esteem & Your Child's Success
_____ Helping Children Develop Good Language & Thinking Skills
_____ Activities to Do at Home/The Value of Play
_____ Effective Discipline/Encouragement

Health and Safety Information
_____ Asthma
_____ Dental Health (Adult & Pediatrics)
_____ Communicable Diseases & Immunizations
_____ Family Planning/Teenage Pregnancy/Birth Control
_____ STDs (Sexually Transmitted Diseases)
_____ Cancer/Self Breast/Testicular Exam
_____ Fire Safety/Home Safety
_____ Lead Poisoning/Poisons
_____ Car Seat Safety
_____ Indoor/Outdoor Safety/First Aid Tips

Nutrition Information
_____ Diet/Exercise/Weight Control/Child Obesity
_____ Healthy Snacks
_____ Menu Planning/Cutting Food Costs
_____ Basic Cooking & Related Skills

Disability Information
_____ Working with Disabled Children (mildly & severely)
_____ Rights & Responsibilities of the Handicapped
_____ Mainstreaming Handicapped Children
_____ Networking with Resources for Disabilities
_____ ADHD (Attention Disorders and Hyperactivity Deficit)

Coping Skills/Personal Enhancement
_____ Stress/Time Management
_____ Basic Parenting
_____ Male & Female Relationships Issues

Other Topics:

_____

_____

Family Services Community Resources
_____ Abuse (Child, Aged Parent, etc.)
_____ Substance Abuse (Drug/Alcohol)
_____ Welfare Rights & Public Assistance Programs
_____ Personal Safety/Crime in the City
_____ Domestic Violence
_____ Landlord/Tenant Rights
_____ Grandparent Support In Parenting
_____ Foster Parenting (Rights/Responsibilities)

Consumer Education
_____ Utilities (Energy Saving Ideas)
_____ Budgeting/Household Management, etc.
_____ Financial Literacy
_____ Environmental Justice & Advocacy

Career Development/Personal Enhancement
_____ GED, High School, Vocational Educational Information
_____ College/Technical Training Information
_____ Computer Literacy
_____ Effective Resume Writing

Parent's Rights and Responsibilities
_____ Role as Parents as Volunteers in the Classroom
_____ Program Decision Making Opportunities for Parents
_____ Leadership Training
_____ Transitioning Into the LSCO/PTA
_____ The Role of Fathers in Prekindergarten & Kindergarten

Please list any talents and/or areas of expertise that you are willing to share in the classroom/parent meeting:

_____

_____

_____

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PRE-KINDERGARTEN HEALTH APPRAISAL POLICY

In order to ensure the safety and well being of all its students, The Madison District Public Schools, in accordance with the Michigan Health Department; requires that all prekindergarten students have a **health appraisal** on file.

This form is due **within 30 days** of the first day of a child's attendance in the Great Start Readiness Program. The health appraisal is good for one year, but must not expire before the end of the school year. It **must** be signed and dated by the attending nurse or physician.

If the deadline is not observed, your child will be placed on the waiting list. When the health appraisal has been submitted, he/she will be moved to the top of the waiting list, until the next slot for enrollment is available.

I have read and understand the Health Appraisal Policy:

Name _____

Parent/Guardian of _____

Signature _____

School _____

Teacher _____