Merrill Community Child Development Center
2020-2021 Enrollment Checklists

List of documents to be handed in/completed before the first day of school:

Name of Child: _____

PRESCHOOL:

1. _____ MCCDC Enrollment Form
2. _____ Registration Fee
3. _____ Child Information Record (CIR)
4. _____ Release of Information Form
5. _____ Photo Release
6. _____ Walking Fieldtrips & Special Events Permission
7. _____ Handbook Acknowledgement Form
8. _____ Ages & Stages Questionnaire (ASQ) Developmental Screener
9. _____ Health Appraisal (Green health form) *Signed by doctor
10. _____ Immunization Shot Record
11. _____ Birth Certificate

GSRP:

12. _____ GSRP Interest Form (complete on Michiganpreschool.org)
13. _____ Risk Factor Verification Form
14. _____ Income Verification Form (tax return, W-2, or 3 pay stubs)
15. _____ Proof of Residency or Program Waiver (if out of district)
16. _____ Parent Notice of Program Measurement Form

Bussing Needs: _____

Before/After School: _____

Merrill Community Child Development Center

ENROLLMENT FORM- GREAT START READINESS PROGRAM (GSRP)

_____
Last First Middle

Student is to be called _____

Address_____ _____
(PO Box, Street) Home Telephone

City _____ Zip _____ County_____

Age _____ Birth Date _____ Place of Birth _____
(City) (State)

E-mail Address_____

Ethnicity_____

Father's Name _____ Cell # _____

Mother's Name_____ Cell # _____

Is either parent a stepparent? If yes, indicate which _____

With whom is the child living? _____

Number of persons in the home _____ In the family _____

Begin with the oldest child and list all of your children below whether they are of school age or not.

Name_____ Age_____ Date Of Birth_____

Child's health insurer name and policy number _____

_____

Are you eligible for Medicaid? _____
Do you receive financial aid? _____ Monthly amount? _____
Do you receive food stamps?_____ Monthly Amount?_____
Family Income: Yearly _____ Monthly _____ Weekly_____
(Choose best applicable)

Please list any agencies that your family currently utilizes such as 4-C, Family Independence Agency, Mental Health Department, Public Health Department, Westlund Child Guidance, etc.

AGENCY	AREA OF SERVICE
_____	_____
_____	_____

Please check all that apply:

For Mother	**For Father:**
Employed full time _____	Employed full time _____
Employed part time _____	Employed part time _____
Not employed _____	Not employed _____
Employed seasonal _____	Employed seasonal _____
Last year of high school completed ___	Last year of high school completed_____
GED _____	GED _____
Number of years of college _____	Number of years of college _____

MCCDC WILL NEED COPIES BEFORE CHILD IS ENROLLED:

_____**BIRTH CERTIFICATE**
_____**PROOF OF IMMUNIZATION**
_____**A MEDICAL PHYSICAL HEALTH FORM** (SIGNED BY DOCTOR)
_____**PROOF OF RESIDENCY**
_____**PROOF OF INCOME**

Parents are required to attend a recruitment session with MCCDC staff before enrollment is complete. Parents will be notified by phone of dates available to choose from. Above paperwork needs to be turned in before the first day of school or can be brought to recruitment session.

CERTIFICATION: I hereby certify that this information is true. If any part is false, my participation in this agency's programs may be terminated and I may be subject to legal action. I also understand that the information in this application will be held in strict confidence within the agency and is accessible to me during normal business hours.

Parent/Guardian Signature _____Date _____

Please return this form by June 8th to guarantee your child's spot for the 2020-2021 School year

Merrill Community Child Development Center
755 W. Alice Street
Merrill, MI 48637

Merrill Community Child Development Center

Release of Information Form
GSRP Preschool
2020-2021

In the best interest of my child, I hereby give permission for Merrill Preschool to share developmental and related information with any program or agency that provides services for my child.

I grant permission for Merrill Preschool to release my child's developmental assessments, classroom observation and work sampling to teachers in public or private school and/or agencies providing services for my child.

Child's Name: _____

Parent/Guardian Name: _____

Address: _____

Telephone: _____

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.)					

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

BCAL-3731 (Rev. 6-17) Previous editions 4-16, 6-15 and 7-12 may be used until September 30, 2018.

PERMISSION TO PHOTOGRAPH

I, _____ give permission to for the **Merrill Community**

(Parent or Guardian's Name)

Child Development Center Program to photograph my child _____

For the following purposes.

Still Photographs: To display in center's scrapbook or Bulletin boards; shown to current and perspective clients	**Yes**	**No**
Display on information boards for community events	**Yes**	**No**
Display photos for internet advertising: website, Facebook, Regional Resource Center Referrals	**Yes**	**No**
Videos: Videos used for community events and center functions	**Yes**	**No**

I understand that it is my responsibility to update this form in the event that I no longer wish to Authorize one or more of the above uses. I agree that this form will remain in effect during the term of my child's enrollment.

Note: Understand that due to privacy policies, parents/guardians are allowed to post/upload pictures of ONLY their child(ren) Please do not post/upload pictures of other children that attend **Merrill Community Child Development Center.**

Parent/Guardian Signature: Date:

Merrill Community Child Development Center

Walking Field Trips & Special Events

During the 2020-2021 school year my child _____ has permission to attend the walking fieldtrip/s and special events for MCCDC preschool. I understand that my child will be walking around the school area/village with the class and teachers on those days.

_____ _____

parent/guardian signature date

HEALTH APPRAISAL

Dear Parent or Guardian: The following information is requested so that the school can work with the parent to meet the physical, intellectual and emotional needs of the child. Fill out the information requested in Section I. Section III may be certified by the transcription of information from the certificate of immunization. The remaining sections are to be completed by a doctor, nurse and dentist. **(BE SURE TO BRING YOUR CHILD'S IMMUNIZATION RECORDS TO THE EXAMINATION.)**

PERSONAL

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

SECTION I - HEALTH HISTORY

Yes	No	Resolved	# Is your child having any of the problems listed below?
☐	☐	☐	1 Allergies or Reactions (for example, food, medication or other)
☐	☐	☐	2 Hay Fever, Asthma, or Wheezing
☐	☐	☐	3 Eczema or Frequent Skin Rashes
☐	☐	☐	4 Convulsions/Seizures
☐	☐	☐	5 Heart Trouble
☐	☐	☐	6 Diabetes
☐	☐	☐	7 Frequent Colds, Sore Throats, Earaches (4 or more per year)
☐	☐	☐	8 Trouble with Passing Urine or Bowel Movements
☐	☐	☐	9 Shortness of Breath
☐	☐	☐	10 Speech Problems
☐	☐	☐	11 Menstrual Problems
☐	☐	☐	12 Dental Problems: Date of Last Exam / /
☐	☐	☐	Other (please describe): _____
☐	☐		Does your child take any medication(s) regularly?
Reason for Medication			

Birth History:

Are there any current or past diagnosis(es) ☐ Yes ☐ No

If yes, please describe:

If yes, list medications:

_____ / / _____
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

Tests and Measurements

No	Yes	Was child tested for:	Test results:	Normal	Referred	Under Care
☐	☐	VISION	Visual Acuity			
			Muscle Imbalance			
		Date: / /	Other:			
☐	☐	HEARING	Audiometer			
			Other:			
		Date: / /				
☐	☐	URINALYSIS	Sugar			
			Albumin			
		Date: / /	Microscopic			
☐	☐	BLOOD LEAD LEVEL	Level _____ ug/dl ⇨			
		Date: / /				

No	Yes	Was child tested for:	Test results:	Normal	Referred	Under Care
☐	☐	HEIGHT & WEIGHT	Height			
			Weight			
		Other: _____	Other			
☐	☐	HEMOGLOBIN / HEMATOCRIT	⇨			
☐	☐	BLOOD PRESSURE	Reading: _____			
☐	☐	TUBERCULIN	Type: _____			
		Date: / /	Neg.: ☐ Pos.: ☐ _____ mm			

NOTE: Blood lead level required for all children enrolled in Medicaid must be tested at one and two years of age, or once between three and six years of age if not previously tested. All children under age six living in high-risk areas should be tested at the same intervals as listed above.

Examinations and/or Inspections

Essential Findings Deviating from Normal:

Exam Date: / /

SECTION III - IMMUNIZATIONS

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

VACCINES (Circle Type)	DATE ADMINISTERED MM/DD/YYYY	
Hepatitis B (HepB)	1	3
	2	
DTaP/DTP/DT/Td	1	4
	2	5
	3	6
Tdap	1	
Haemophilus Influenzae type b (HIB)	1	3
	2	4
Polio (IPV/OPV)	1	3
	2	4
Pneumococcal Conjugate (PCV7/PCV13)	1	3
	2	4
Rotavirus (RV1/RV5)	1	3
	2	
Measles,Mumps, Rubella (MMR)	1	2
Varicella (Chickenpox)	1	2
History of Chickenpox Disease? ☐ Yes ☐ No If yes, date:		

VACCINES (Circle Type)	DATE ADMINISTERED MM/DD/YYYY	
Hepatitis A (HepA)	1	2
Influenza (IIV/LAIV)	1	3
	2	4
Meningococcal (MCV4 / MPSV4)	1	2
Human Papillomavirus (HPV9/HPV4/HPV2)	1	3
	2	
	Type of Vaccine(s)	Date of Vaccine(s)
OTHER Vaccines Specify Date & Type	1	
	2	
	3	

Indicate and attach physician diagnosis or laboratory evidence of immunity as applicable

*NOTE: According to Public Act 368 of 1978, any child enrolling in a Michigan school for the first time must be adequately immunized, vision tested and hearing tested. Exemptions to these requirements are granted for medical, religious and other objections, provided that the waiver forms are properly prepared, signed and delivered to school administrators. Forms for these exemptions are available at your provider office for medical waiver forms and through your local health department for nonmedical waiver forms.

Parent/Guardian refused immunizations: ☐

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

_____ _____ ___/___/___

Health Professional's Signature Title Date

SECTION IV - RECOMMENDATIONS

(Required for Child Care and Head Start/Early Head Start)

No	Yes	
☐	☐	Is there any defect of vision, hearing or other condition for which the school could help by seating or other actions? If yes, please explain:
☐	☐	Should the child's activity be restricted because of any physical defect or illness? If yes, check and explain degree of restriction(s): ☐ Classroom ☐ Playground ☐ Gymnasium ☐ Swimming Pool ☐ Competitive Sports ☐ Other

Other Recommendations

SECTION V - DENTAL EXAMINATION AND RECOMMENDATIONS (OPTIONAL)

I have examined _____ 's teeth. As a result of this examination, my recommendation for treatment is: _____

child's name

_____ ___/___/___

Dentist's Signature Date

PHYSICIAN'S SIGNATURE

_____ ___/___/___ _____ _____

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

_____ _____ MI _____ (_____)_____

Number & Street City ZIP Code Telephone

Information required for:

Early On - Hearing and Vision Status; Diagnosis; Health Status

Child Care Licensing - Physical Exam, Restrictions, Immunizations

Head Start/Early Head Start - Determination that child is up-to-date on a schedule of age-appropriate preventive and primary health care, including medical, dental, and mental health. The schedule must incorporate the well-child care visit required by EPSDT and the latest immunizations schedule recommended by the Centers for Disease Control and Prevention, State, tribal, and local authorities. An EPSDT well-child exam includes height, weight, and blood tests for anemia at regular intervals based on age.

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Developed in Cooperation with the Department of Health and Human Services, Education, Michigan American Association of Pediatrics, Early Childhood Investment Corporation, Child Care Licensing, Head Start, Michigan State Medical Society, Michigan Association of Osteopathic Physicians and Surgeons.

Merrill Community Child Development Center
Parent Handbook Acknowledgement 2020-2021
GSRP Preschool

Name of Child: _____

I, _____, received and have read the Merrill Community Child Development
(parent signature)

Center Parent Handbook and am aware of the policies and procedures. (Initial on the line)

- I will follow MCCDC policies and procedures to the best of my ability _____
- I will complete all required enrollment documents by **September 1, 2020** _____
- I will have my child attend all GSRP days and times to the best of my ability _____
- I will supply needed items of clothing for my child _____
- I will have my child present for 2 home visits (Fall/Spring) _____
- I will attend 2 parent-teacher conferences during the year (Fall/Spring) _____
- I will supervise my child on 2 preschool field trips (Fall/Spring) _____
- I will attend 2 parent involvement/educational sessions this school year _____

MCCDC 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. Licensing inspection and special investigation reports from the past 2 years are available on the Bureau of Children and Adult Licensing website at www.michigan.gov/michildcare.

- I am aware the Licensing Handbook is available for review and is located next to the family resource board in the preschool classrooms. _____

Sign below and initial on the smaller lines after each bullet acknowledging agreement to the above statements.

_____ _____
(Signature) (Date)