ALGONAC COMMUNITY SCHOOLS

Give Michigan's Kids a Great Start

Readiness Program

Michigan's Nationally Recognized Pre-K Program

2015-2016 Application

Please complete the attached forms and return to G.S.R.P. at Pointe Tremble Elementary

FOR MORE INFORMATION CONTACT:

Amber Palicke
(810) 794-3022, ext. 1617
amber.palicke@acsk12.us

Vicki O'Toole
(810) 794-3022, ext. 1652
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Applications must include proof of income and birth certificate.

2015-2016 St. Clair County Early Head Start, Head Start and Great Start Readiness Programs Application

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

0–5 Head Start

Child MUST be: Under 3 or an expecting mother for the Early Head Start Program; 3 or 4 for the Head Start Preschool Program; 4 years old by Sept. 1, 2015 for the Great Start Readiness Program.

Return by mail, fax or email: Great Start Readiness Program/Pte. Tremble Elementary, 9541 Phelps Road, Algonac, MI 48001

Amber Palicke, amber.palicke@acsk12.us
(810)794-3022, ext. 1617 • Fax: (810)794-0040

Vicki O'Toole, votoole@algonac.k12.mi.us
(810)794-3022, ext. 1652 • (810)794-0040

APPLICANT

First Name | Middle Name | Last Name | Birthdate | Gender ☐ Male ☐ Female

Address | City | State | Zip

Race (not considered for eligibility):
☐ Asian ☐ American Indian/Alaska Native
☐ Black ☐ Hawaiian/Pacific Islander
☐ White ☐ Multi-Racial
☐ Other:_____

Hispanic
☐ Yes ☐ No

Is the child's primary language* English?
☐ Yes ☐ No
**Primary language means the dominant language used by a person for communication*
If no, what is the primary language? _____

MOTHER/GUARDIAN NAME

First Name | Middle Name | Last Name | Birthdate | Phone Number

Address (if different than child) | City | State | Zip

Email Address

Highest Grade Completed
☐ College
☐ High School
☐ GED
☐ Did not graduate

Current college student
☐ Full Time ☐ Part Time

Employment Status
☐ Full Time
☐ Part Time
☐ Seasonal
☐ Unemployed

Marital Status
☐ Single
☐ Married
☐ Separated
☐ Divorced
☐ Widowed

Child's Relationship
☐ Natural/Adopted
☐ Stepchild
☐ Grandchild
☐ Foster Child
☐ Other

Custody
☐ Yes
☐ No

Check all that apply:
☐ Lives with family
☐ Provides financial support
☐ Child support order
☐ Visitation
☐ Pregnant
Due Date:_____

FATHER/GUARDIAN NAME

First Name | Middle Name | Last Name | Birthdate | Phone Number

Address (if different than child) | City | State | Zip

Email Address

Highest Grade Completed
☐ College
☐ High School
☐ GED
☐ Did not graduate

Current college student
☐ Full Time ☐ Part Time

Employment Status
☐ Full Time
☐ Part Time
☐ Seasonal
☐ Unemployed

Marital Status
☐ Single
☐ Married
☐ Separated
☐ Divorced
☐ Widowed

Child's Relationship
☐ Natural/Adopted
☐ Stepchild
☐ Grandchild
☐ Foster Child
☐ Other

Custody
☐ Yes
☐ No

Check all that apply:
☐ Lives with family
☐ Provides financial support
☐ Child support order
☐ Visitation

ADDITIONAL INFORMATION

School district in which child lives
☐ Anchor Bay ☐ Marysville
☐ Algonac ☐ Memphis
☐ Capac ☐ Port Huron
☐ East China ☐ Yale

Elementary school closest to home:
_____

Emergency contact number

How did you hear about HS/GSRP?

Transportation needed?
☐ Yes
☐ No

If yes, bused from:
☐ Home
☐ Childcare
(Not provided in all areas

Program preference (check all that apply):
☐ Full Day (4-year-olds only)
☐ Part Day
☐ Home Based (Head Start only)

Classroom location preference

Annual family income* (last 12 months): $ _____ Number of children:_____ and adults:_____ in family

***Proof of current income is required before final eligibility determination and must be turned in with this application. Proof of income includes: 2014 Federal Tax Form, 2014 W-2's, Child Support Reports, Current DHS Cash Statement, Current SSI Statement, previous 12 months of pay stubs, or college scholarships/grants.**

These materials were developed under a grant awarded by the Michigan Department of Education and the U.S. Department of Health and Human Services.

Staff use only	Risk number	**Risk Factors:** Answer all of the following questions by placing an X in the Yes or No box	**Yes**	**No**
	CEHS	• Is this child in Foster Care or a Ward of the Court?		
		• Is this family homeless, living in shelter?		
		• Is this family currently receiving Cash Assistance from DHS?		
		• Does this family currently receive Supplemental Security Income?		
Low or no earned income / income not adequate for meeting basic needs *Proof of current income is required before final eligibility determination and must be turned in with this application*			If you mark yes for any of the above, call for income submission requirements	
	1	• Annual family income below 100% of Federal Poverty Guidelines		
		• Annual family income equal to or less than 250% of Federal Poverty Guidelines		
Diagnosed disability or identified developmental delay				
	2	• Does your child have a referral or diagnosis from a physical or mental health system or provider, or other early childhood program?		
		• Does your child have an Early On transition referral at age three?		
		• Does your child have a Special Education referral; with developmental concerns, noted but not eligible for services?		
		• 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				
	3	• Has your child been expelled from preschool or a child care center?		
		• Does your child demonstrate intense anger or aggression, hit, pinch, bite or throw things when he/she is angry?		
		• Has your family participated in Family Counseling or any other program to help deal with your child's behavior?		
Primary home language other than English				
	4	• Is your child entering school not able to speak English and must learn the language?		
		• Do you speak another language in your home other than English? Specify:		
Parent/Guardian with low educational attainment				
	5	• Did either parent not graduate from high school or attend special/remedial classes in school?		
		• Does either parent have trouble reading to your child?		
Physical/sexual abuse/neglect of child or parent/substance abuse/addiction				
	6	• Is or has your child been abused physically or sexually?		
		• Is or has there been domestic or spousal abuse of a parent or sibling?		
		• Has your child been removed from home for neglect or has a parent been charged with neglect?		
		• Has there been abuse of alcohol, prescription, or non-prescription drugs by family members who live in the home?		
Environmental risk				
	7	• Has the enrolling child lost a parent or sibling by death?		
		• Does this child have a parent in jail / prison with whom they have a current relationship with?		
		• Is this child living with a relative or person other than the biological parent(s)?		
		• Has the enrolling child lost a parent to divorce?		
		• Does the enrolling child have a parent who is currently away due to active military service?		
		• Is this a single parent family?		
		• Does the child or family member(s) in the home suffer from mental illness? (i.e., Bipolar Mania, Schizophrenia, Clinical Depression, Personality Disorder, etc.) *Specific documentation from physical or mental health system or provider will be required*		
		• Does the child or family member(s) in the home suffer from chronic illness or life threatening disease? (i.e., cancer, dialysis, heart failure, seizure, sickle cell anemia, etc.) *Specific diagnosis documentation from physical health system provider will be required*		
		• Were you a teenage parent?		
		• Has the enrolling child ever been diagnosed as failure to thrive?		
		• Was the enrolling child exposed to toxic substances known to cause learning or developmental delays; such as Fetal Alcohol Syndrome, drugs, or exposure 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 times 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 St. Clair County Early Head Start, Head Start and/or the Great Start Readiness Program.

Parent/Guardian signature _____ Date _____

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.

BCAL-3731 (Rev. 7-12) Previous editions 9-09,3-08, 10-07, & 1-06 may be used until 12/31/13.

Enrollment date: _____

Entering grade_____

School & Teacher:_____

___MCIR ___ Birth Certificate

___Proof of Residency

Algonac Community Schools

Student/Family Registration Information Form

Grades K-5

Student's name: _____ Birthdate: _____
(LAST) (FIRST)

Street Address: _____ City: _____ Zip: _____ Sex: ___

Priority Phone #: _____ Alternate Phone #:_____ Alternate Phone #:_____

Parent/Guardian name(s): _____

EMERGENCY INFORMATION: In case of an emergency and parent(s) cannot be reached, please notify the people below in priority order:

1. Name: _____ Phone: _____ Relationship:_____

2. Name: _____ Phone: _____ Relationship:_____

3. Name: _____ Phone: _____ Relationship:_____

4. Name: _____ Phone: _____ Relationship:_____

Please complete pertinent medical information on this child:

Current medication or treatment: _____

Allergies: _____

Previous operations: _____ Hospital confinement: _____

Dentist name: _____ Phone Number: _____

Doctor name: _____ Phone Number: _____

Preferred local hospital: _____

Whenever my child is involved in a school activity and I am unavailable or otherwise unable to provide authorization, I do hereby grant to the school principal or his/her designee the authority to act for me and to provide any required consents and authorization for the delivery of emergency medical care, diagnoses and treatment, including surgical interventions, if necessary on behalf of my minor child listed above and to do all other necessary things as I might or could do to provide for the child's health and safety, if I were present.
This authorization is valid for the current school year or until such time as I withdraw the authorization.

_____ _____
Signature of parent/guardian Date

Student Informatio 

(Continue on back)

Student Name: _____ Birthplace: _____

1. Is your child Hispanic/Latino? ___YES ___NO

2. Which racial group(s) does your child belong?

___American Indian or Alaska Native

___Asian

___Black or African American

___Native Hawaiian or Other Pacific Islander

___White

3. Is your child's native tongue a language other than English?
___YES ___NO What is that language? _____

4. Is the primary language used in your child's home or environment a language other than English?
___YES ___NO What is that language? _____

5. Is this child subject to any court order regarding custody? ___YES ___NO

6. Does your child receive Special Education Services? ___YES ___NO ___Speech/Language ___Special Education ___504

Family Information

Child lives with: ___Mother & Father ___Mother & Stepfather ___Mother only ___Father & Stepmother ___Father only

___Other: _____

	Mother	*Father*	*Stepmother*	*Stepfather*
Name				
Birthplace				
Last school grade completed				
Employer				
Work Phone #				

Siblings	*Sex*	*Birthdate*	*Age*	*School*	*Grade*

Parental Permissions

I give Algonac Community Schools permission to use my child's likeness and/or voice by way of: (check all that apply)

___Any school publication (yearbook, Reporter, school paper, building web page)
___digital imaging, video conferencing or videotaping (for educational use)

I give my child permission to: (check all that apply)

___attend any "in-district" field trips.
___use the Internet for research.
___ride his/her bike to school.
___walk to/from school.

_____ _____
Signature of Parent/Guardian 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	Received	# Is your child having any of the problems listed below?
☐	☐	☐	1 Allergies or Reactions (for example, food, medication or other)
☐	☐	☐	2 Hay Fever, Asthma, or Wheezing
☐	☐	☐	3 Eczema or Frequent Skin Rashes
☐	☐	☐	4 Convulsions/Seizures
☐	☐	☐	5 Heart Trouble
☐	☐	☐	6 Diabetes
☐	☐	☐	7 Frequent Colds, Sore Throats, Earaches (4 or more per year)
☐	☐	☐	8 Trouble with Passing Urine or Bowel Movements
☐	☐	☐	9 Shortness of Breath
☐	☐	☐	10 Speech Problems
☐	☐	☐	11 Menstrual Problems
☐	☐	☐	12 Dental Problems: Date of Last Exam / /
☐	☐	☐	Other (please describe): _____
☐	☐		Does your child take any medication(s) regularly?

Reason for Medication

_____ / /
Parent/Guardian Signature Date

Birth History:

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

If yes, please describe:

If yes, list medications:

Was the health history reviewed by a health professional?
☐ Yes ☐ No ***Examiner's Initials:*** _____

SECTION II - PHYSICAL EXAMINATION, INSPECTION, TESTS AND MEASUREMENTS

Required for Child Care and Head Start / Early Head Start

Tests and Measurements

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

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

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

Examinations and/or Inspections

Essential Findings Deviating from Normal:

Exam Date: / /

SECTION III - IMMUNIZATIONS

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

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

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

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

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 _____ (child's name)'s teeth. As a result of this examination, my recommendation for treatment is: _____

Dentist's Signature | Date

PHYSICIAN'S SIGNATURE

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

Number & Street | City | MI | 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 Departments of Human Services, Education, Community Health, 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.

Student Name _____ Parent Name(s) _____

INSURANCE INFORMATION

Health Insurance Policy name and number

_____

_____

_____ My child _____ is not covered by insurance. If my child does get insurance I will notify the school with insurance information.

Name address and phone number of Child's physician or health clinic

_____

_____

_____