



Readiness Program

Michigan's Nationally Recognized Pre-K Program

2017-2018 Application

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

FOR MORE INFORMATION CONTACT:

(810) 794-8876

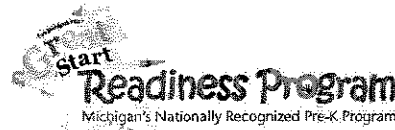
Amber Palicke
amber.palicke@acsk12.us

Vicki O'Toole
votoole@algonac.k12.mi.us

Applications must include proof of income and birth certificate.

These materials were developed under a grant awarded by the Michigan Department of Education

**2017-2018 St. Clair County
Early Head Start, Head Start and
Great Start Readiness Programs Application**



**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, 2017 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 Vicki O'Toole, votoole@algonac.k12.mi.us
(810) 794-8876 • Fax: (810) 794-0040 (810) 794-8876 • Fax: (810) 794-0040

APPLICANT				
First Name	Middle Name	Last Name	Birthdate	Gender <input type="checkbox"/> Male <input type="checkbox"/> Female
Address		City	State	Zip

Race (not considered for eligibility)	Hispanic
Check all that apply: <input type="checkbox"/> Asian <input type="checkbox"/> American Indian/Alaska Native <input type="checkbox"/> Black <input type="checkbox"/> Hawaiian/Pacific Islander <input type="checkbox"/> White	<input type="checkbox"/> Yes <input type="checkbox"/> No

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	Employment Status	Marital Status	Child's Relationship	Custody	Check all that apply:
<input type="checkbox"/> College <input type="checkbox"/> High School <input type="checkbox"/> GED <input type="checkbox"/> Did not graduate	<input type="checkbox"/> Full Time <input type="checkbox"/> Part Time <input type="checkbox"/> Seasonal <input type="checkbox"/> Unemployed	<input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Separated <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed	<input type="checkbox"/> Natural/Adopted <input type="checkbox"/> Stepchild <input type="checkbox"/> Grandchild <input type="checkbox"/> Foster Child <input type="checkbox"/> Other	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Lives with family <input type="checkbox"/> Provides financial support <input type="checkbox"/> Child support order <input type="checkbox"/> Visitation <input type="checkbox"/> Pregnant Due Date: _____
Current college student <input type="checkbox"/> Full Time <input type="checkbox"/> Part Time					

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	Employment Status	Marital Status	Child's Relationship	Custody	Check all that apply:
<input type="checkbox"/> College <input type="checkbox"/> High School <input type="checkbox"/> GED <input type="checkbox"/> Did not graduate	<input type="checkbox"/> Full Time <input type="checkbox"/> Part Time <input type="checkbox"/> Seasonal <input type="checkbox"/> Unemployed	<input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Separated <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed	<input type="checkbox"/> Natural/Adopted <input type="checkbox"/> Stepchild <input type="checkbox"/> Grandchild <input type="checkbox"/> Foster Child <input type="checkbox"/> Other	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Lives with family <input type="checkbox"/> Provides financial support <input type="checkbox"/> Child support order <input type="checkbox"/> Visitation
Current college student <input type="checkbox"/> Full Time <input type="checkbox"/> Part Time					

ADDITIONAL INFORMATION			
School district in which child lives <input type="checkbox"/> Anchor Bay <input type="checkbox"/> Marysville <input type="checkbox"/> Algonac <input type="checkbox"/> Memphis <input type="checkbox"/> Capac <input type="checkbox"/> Port Huron <input type="checkbox"/> East China <input type="checkbox"/> Yale	Emergency contact number	Transportation needed? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, bused from: <input type="checkbox"/> Home <input type="checkbox"/> Childcare (Not provided in all areas)	Program preference (check all that apply): <input type="checkbox"/> Full Day (4-year-olds only) <input type="checkbox"/> Part Day <input type="checkbox"/> Home Based (Head Start only)
Elementary school closest to home:	How did you hear about Head Start / GSRP?		Classroom location preference

Annual income (past 12 months) \$ _____	Number of family members (A family includes all persons related by blood, marriage, or adoption living in the same household)			
	# of children 0-2	# of children 3-4	# of children 5 and over	# of adults
				Total in family:

Proof of current income is required before final eligibility determination and must be turned in with this application. Proof of income includes: 2016 Federal Tax Form, 2016 W-2's, Child Support Reports, Current DHS Cash Statement, Current SSI Statement, previous 12 months of pay stubs, or college scholarships/grants.

Staff use	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? (e.g., living in a shelter/hotel/car/campground or doubled-up with relatives or friends)		
		• 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			If you mark yes for any of the above, call for income submission requirements	
Proof of current income is required before final eligibility determination and must be turned in with this application				
	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's native tongue a language other than English?		
		• Is the primary language* used in your child's home or environment a language other than English? If yes, what is the language?: _____ *Primary language* means the dominant language used by a person for communication.		
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?		
		• 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?		
		• Is your child negatively affected by issues related to a sibling? (e.g., chronic illness, behavior issues, disability, death)		
		• 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 _____

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

SECTION I - HEALTH HISTORY

<p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> # Is your child having any of the problems listed below?</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> 1 Allergies or Reactions (for example, food, medication or other)</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> 2 Hay Fever, Asthma, or Wheezing</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> 3 Eczema or Frequent Skin Rashes</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> 4 Convulsions/Seizures</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> 5 Heart Trouble</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> 6 Diabetes</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> 7 Frequent Colds, Sore Throats, Earaches (4 or more per year)</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> 8 Trouble with Passing Urine or Bowel Movements</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> 9 Shortness of Breath</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> 10 Speech Problems</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> 11 Menstrual Problems</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> 12 Dental Problems: Date of Last Exam / /</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Other (please describe): _____</p> <p><input type="checkbox"/> <input type="checkbox"/> Does your child take any medication(s) regularly?</p> <p>Reason for Medication _____</p> <p>Parent/Guardian Signature _____ Date / /</p>	<p>Birth History:</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>Are there any current or past diagnosis(es) <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>If yes, please describe:</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>If yes, list medications:</p> <p>_____</p> <p>_____</p> <p>Was the health history reviewed by a health professional?</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No Examiner's Initials: _____</p>
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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	No	Yes	Was child tested for:	Test results:	Normal	Referred	Under Care
<input type="checkbox"/>	<input type="checkbox"/>	VISION	Visual Acuity	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	HEIGHT & WEIGHT	Height	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
		Date: / /	Muscle Imbalance	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Weight	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
			Other:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Other:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	HEARING	Audiometer	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	HEMOGLOBIN / HEMATOCRIT		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
		Date: / /	Other:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	BLOOD PRESSURE	Reading: _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	URINALYSIS	Sugar	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	TUBERCULIN	Type: _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
		Date: / /	Albumin	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Date: / /	Neg.: <input type="checkbox"/> Pos.: <input type="checkbox"/> _____ mm	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
			Microscopic	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	BLOOD LEAD LEVEL	Level _____ ug/dl	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	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.				
		Date: / /		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

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		VACCINES (Circle Type)	DATE ADMINISTERED MM/DD/YYYY	
Hepatitis B (HepB)	1	3	Hepatitis A (HepA)	1	2
	2		Influenza (IV/LAV)	1	3
DTaP/DTP/DT/Td	1	4		2	4
	2	5	Meningococcal (MCV4 / MPSV4)	1	2
	3	6	Human Papillomavirus (HPV9/HPV4/HPV2)	1	3
Tdap	1			2	
Haemophilus Influenzae type b (HIB)	1	3	OTHER Vaccines Specify Date & Type	Type of Vaccine(s)	Date of Vaccine(s)
	2	4		1	
Polio (IPV/OPV)	1	3		2	
Pneumococcal Conjugate (PCV7/PCV13)	1	3	3		
	2	4	Indicate and attach physician diagnosis or laboratory evidence of immunity as applicable		
Rotavirus (RV1/RV5)	1	3	*NOTE: According to Public Act 368 of 1978, any child enrolling in a Michigan school for the first time must be adequately immunized, vision tested and hearing tested. Exemptions to these requirements are granted for medical, religious and other objections, provided that the waiver forms are properly prepared, signed and delivered to school administrators. Forms for these exemptions are available at your provider office for medical waiver forms and through your local health department for nonmedical waiver forms.		
Measles, Mumps, Rubella (MMR)	1	2	Parent/Guardian refused immunizations: h		
Varicella (Chickenpox)	1	2			
History of Chickenpox Disease? h Yes h No If yes, date:					
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)

h 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:

h Should the child's activity be restricted because of any physical defect or illness?
If yes, check and explain degree of restriction(s): h Classroom h Playground h Gymnasium h Swimming Pool h Competitive Sports h 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 _____

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.

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.

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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**Algonac Community Schools
Student/Family Emergency Information Form
Grades K-6**

FOR OFFICE USE ONLY:
School year: _____ Bus #: _____
Grade: _____ Teacher: _____
School: Millside Elementary

Student's name: _____ Birthdate: _____
(LAST) (FIRST) (M.I.)

Home Phone #: _____ Gender: M F Grade: _____ City of Birth: _____

Street Address: _____ City: _____ Zip: _____

I give Algonac Community Schools permission to use my child's likeness and/or voice in any school publication (yearbook, Reporter, school paper, building web page). Yes No

EMERGENCY INFORMATION: In case of an emergency 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: _____
If your child will need to take medication at school, please ask for a District Medication Form, which must be completed by your child's doctor.

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 Information

Student Name: _____

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

Parent Information

Name of parents/guardians with whom student resides-include last name if different from student:

FEMALE

Name: _____

Relationship to student: _____

Cell Phone: _____

Work Phone: _____

Email Address: _____

Court appointed guardian? Yes No

MALE

Name: _____

Relationship to student: _____

Cell Phone: _____

Work Phone: _____

Email Address: _____

Court appointed guardian? Yes No

Name of parent living elsewhere:

Name: _____ Relationship to student: _____

Address: _____ City _____ Zip Code: _____

Home Phone: _____ Cell Phone: _____ Work Phone: _____

Email Address: _____

Sibling Information

Sisters/brothers living at student's home address:

Name	Gender	Birthdate	School	Grade
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

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
