ALGONAC COMMUNITY SCHOOLS

Give Michigan's Kids a Great Start

Readiness Program

Michigan's Nationally Recognized Pre-K Program

2019-2020 Application

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

FOR MORE INFORMATION CONTACT:

Amber Palicke

G.S.R.P. Coordinator

amber.palicke@acsk12.us

(810) 794-9317 extension 1305

Applications must include proof of income and birth certificate.

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

2019-2020 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, 2019 for the Great Start Readiness Program.

Return by mail, fax or email:
Great Start Readiness Program/Algonquin Elementary
Attn: Amber Palicke
9185 Marsh Road, Algonac, MI 48001

Phone: (810) 794-9317, ext. 1305
Fax: (810) 794-0040
Email: amber.palicke@acsk12.u

APPLICANT

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

Address | City | State | Zip

Race (not considered for eligibility)
Check all that apply: ☐ Asian ☐ American Indian/Alaska Native ☐ Black ☐ Hawaiian/Pacific Islander ☐ White

Hispanic ☐ Yes ☐ 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:
☐ College ☐ High School ☐ GED ☐ Did not graduate Current college student ☐ Full Time ☐ Part Time	☐ Full Time ☐ Part Time ☐ Seasonal ☐ Unemployed	☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed	☐ Natural/Adopted ☐ Stepchild ☐ Grandchild ☐ Foster Child ☐ Other	☐ Yes ☐ No	☐ 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	Employment Status	Marital Status	Child's Relationship	Custody	Check all that apply:
☐ College ☐ High School ☐ GED ☐ Did not graduate Current college student ☐ Full Time ☐ Part Time	☐ Full Time ☐ Part Time ☐ Seasonal ☐ Unemployed	☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed	☐ Natural/Adopted ☐ Stepchild ☐ Grandchild ☐ Foster Child ☐ Other	☐ Yes ☐ No	☐ 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 Head Start /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 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: 2018 Federal Tax Form, 2018 W-2's, Child Support Reports, Current DHS Cash Statement, Current SSI Statement, previous 12 months of pay stubs, or college scholarships/grants.

St. Clair County RESA

These materials were developed under a grant awarded by the Michigan Department of Education and the U.S. Department of Health and Human Services (ACS REV 2/2019)

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 ***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'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 _____

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.)				

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

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 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

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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: Milliside 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

(Continue on back)

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

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?
h	□h	□h	1 Allergies or Reactions (for example, food, medication or other)
h	□h	□h	2 Hay Fever, Asthma, or Wheezing
h	□h	□h	3 Eczema or Frequent Skin Rashes
h	□h	□h	4. Convulsions/Seizures
h	□h	□h	5 Heart Trouble
h	□h	□h	6 Diabetes
h	□h	□h	7 Frequent Colds, Sore Throats, Earaches (4 or more per year)
h	□h	□h	8 Trouble with Passing Urine or Bowel Movements
h	□h	□h	9 Shortness of Breath
h	□h	□h	10 Speech Problems
h	□h	□h	11 Menstrual Problems
h	□h	□h	12 Dental Problems: Date of Last Exam / /
h	□h	□h	Other (please describe): _____

h □h 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) h Yes h No

If yes, please describe:

If yes, list medications:

Was the health history reviewed by a health professional?
h Yes h 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
h	□h	VISION Date: / /	Visual Acuity			
			Muscle Imbalance			
			Other:			
h	□h	HEARING Date: / /	Audiometer			
			Other:			
h	□h	URINALYSIS Date: / /	Sugar			
			Albumin			
			Microscopic			
h	□h	BLOOD LEAD LEVEL Date: / /	Level _____ ug/dl			

No	Yes	Was child tested for:	Test results:	Normal	Referred	Under Care
h	□h	HEIGHT & WEIGHT	Height			
			Weight			
h	□h	Other: _____	Other			
h	□h	HEMOGLOBIN / HEMATOCRIT				
h	□h	BLOOD PRESSURE	Reading: _____			
h	□h	TUBERCULIN Date: / /	Type: _____ Neg.: h Pos.: h _____ 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? h Yes h 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	
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 provider office for medical waiver forms and through your local health department for nonmedical waiver forms.

Parent/Guardian refused immunizations: h

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 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 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 _____ (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 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.