



GSRP PRESCHOOL CHECKLIST

Great Start Readiness Program (GSRP) is a school readiness program designed to prepare children for kindergarten and to pave the way for success in school. GSRP is funded through the State of Michigan grant and is free to qualifying families. To attend a child must live in Macomb County. Children must be 4 years old by September 1st. If your child has a birthdate between September 2nd and December 1st you may still apply. However, you will be put on a waitlist and will be considered after September 1st. Families must meet income guidelines. Parent participation and home visits are also required. **Before we are allowed to enroll a student into Fraser Public Schools the State of Michigan requires the following documents:**

Schedule an appointment to turn in registration paperwork (Friday appointments only). The link to schedule an appointment can be found on our website: <http://dooley.fraser.k12.mi.us>

- Fraser Public Schools Student Data Form
- CHILD INFORMATION RECORD
- Proof of Residency (2 items are required) NO JUNK MAIL
- Parent/Guardian ID (Driver's License, State ID, or Passport)
- Proof of Custody (when applicable)
- Original Birth Certificate
 - Order online at www.vitalcheck.com
 - Go to courthouse of the county where the child was born.
 - Contact State of Michigan Vital Records by phone at (517) 335-8656
- Current Immunization Records (students are not allowed to start at school without proof of immunizations)
- Current Physical (with physician's signature)
- Concussion Form
- Pesticide Form
- Program Measurement Form
- Parent Agreement
- Proof of Income

Fraser Public Schools Student Data Form

Please complete and return this enrollment form.

Student Information				
Student's Full Legal Name <div style="display: flex; justify-content: space-between;"> Last Name First Name Middle Name </div>			Gender <input checked="" type="checkbox"/> M <input type="checkbox"/> F	Grade
Home Street Address (with apt/suite)		Home City & Zip		Primary Phone
Mailing Address		Mailing City & Zip		Secondary Phone
Resident School District		Race (Please choose one from list below, regardless of Ethnicity) <div style="display: flex; flex-wrap: wrap;"> <div style="width: 50%;">1. <input type="checkbox"/> Alaskan Native/American Indian</div> <div style="width: 50%;">2. <input type="checkbox"/> Asian American</div> <div style="width: 50%;">3. <input type="checkbox"/> Black or African American</div> <div style="width: 50%;">4. <input type="checkbox"/> Native Hawaiian/Other Pacific Islander</div> <div style="width: 50%;">5. <input type="checkbox"/> White</div> <div style="width: 50%;">6. <input type="checkbox"/> Hispanic or Latino</div> <div style="width: 100%;">7. <input type="checkbox"/> Multi-Racial – If Multi-Racial, please list two:</div> </div>		
Ethnicity (Please choose one) Hispanic/Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/>				
Student's Date of Birth		Student Order of Birth (if multiple) Please circle: <input type="checkbox"/> 01 <input type="checkbox"/> 02 <input type="checkbox"/> 03 <input type="checkbox"/> 04 <input type="checkbox"/> 05 <input type="checkbox"/> 06 <input type="checkbox"/> 07 <input type="checkbox"/> 08		Birth City/State (if born in US)
Fill in Section Below for Students not Born in US				
U.S. Citizen Yes No	Date Entered US (month & year)	First Attended School in US (month & year)	Country of Birth	
Fill in Sections Below for All Students				
Primary Language			Language Spoken in Home	
Former School				
Attended School in this District Before? <input type="checkbox"/> Yes <input type="checkbox"/> No			If Yes, School Attended	
Former District			Former School	
Former School Address	Former School City, State & Zip		Suspended/Expelled from Former School? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Services Received at Former School				
<input type="checkbox"/> IEP 504	<input type="checkbox"/> Title I	<input type="checkbox"/> ELL	<input type="checkbox"/> Social Work	<input type="checkbox"/> Other Services
Please Describe Other Services <i>Please provide copies related to any of the above checked boxes</i>				
Forms Submitted				
<input type="checkbox"/> Birth Certificate	<input type="checkbox"/> Proof of Residency	<input type="checkbox"/> Immunization	<input type="checkbox"/> Hearing & Vision	<input type="checkbox"/> Concussion Awareness

Health-Fill Out the Medical Forms Packet for any Boxes Checked

Preferred Hospital				Names & Schedule for Medications	
Emergency Medical Alerts, Allergies or Problems				Physical Limitations (Explain)	
<input type="checkbox"/> Asthma	<input type="checkbox"/> Diabetes	<input type="checkbox"/> Vision Problem	<input type="checkbox"/> Hearing Problem	<input type="checkbox"/> Peanut Allergy	Cystic Fibrosis Other

Physician Name	Physician Phone
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Contact 1 (Parent/Guardian)

First & Last Name	Relationship to Student	Contact Emergency Priority
Street Address, City, State & Zip	Home Phone	Cell Phone
Cell Phone 2/Pager	Email Address	Resides with Student? <input type="checkbox"/> Yes <input type="checkbox"/> No
Employer	Work Phone (with extension)	Receives Letter Mailings? <input type="checkbox"/> Yes <input type="checkbox"/> No

Contact 2

First & Last Name	Relationship to Student	Contact Emergency Priority
Street Address, City, State & Zip	Home Phone	Cell Phone
Cell Phone 2/Pager	Email Address	Resides with Student? <input type="checkbox"/> Yes <input type="checkbox"/> No
Employer	Work Phone (with extension)	Receives Letter Mailings? <input type="checkbox"/> Yes <input type="checkbox"/> No

Contact 3

First & Last Name	Relationship to Student	Contact Emergency Priority
Street Address, City, State & Zip	Home Phone	Cell Phone
Cell Phone 2/Pager	Email Address	Resides with Student? <input type="checkbox"/> Yes <input type="checkbox"/> No
Employer	Work Phone (with extension)	Receives Letter Mailings? <input type="checkbox"/> Yes <input type="checkbox"/> No

Contact 4

First & Last Name	Relationship to Student	Contact Emergency Priority
Street Address, City, State & Zip	Home Phone	Cell Phone
Cell Phone 2/Pager	Email Address	Resides with Student? <input type="checkbox"/> Yes <input type="checkbox"/> No
Employer	Work Phone (with extension)	Receives Letter Mailings? <input type="checkbox"/> Yes <input type="checkbox"/> No

Siblings

Name	Date of Birth	School Attended
Name	Date of Birth	School Attended
Name	Date of Birth	School Attended
Name	Date of Birth	School Attended

INTERNET ACCEPTABLE USE POLICY PRESS / VIDEO RELEASE

Fraser Public Schools has my permission to use photographs and/or videos of my child to show school activities to the public. I understand that the personally identifiable information may be used at the discretion of the media, involving no financial compensation to Fraser Public Schools, the student, or family of the student.

Press/Video Release ☐ Yes ☐ No

I understand that I have the right to deny consent to the release of photographs, information and/or Internet accessibility specified above by notifying the principal of my child's school.

Parent/Guardian Signature

Date

If permission is denied, please write "DENIED" on the signature line.

INTERNET USE

All students are able to use the Internet in accordance with Fraser Public Schools Internet acceptable use policy, available at each school. If you do not want your child to use the Internet, please contact his/her school principal.

MEDICAL ASSISTANCE

In the event that my child is injured or may need medical assistance and I cannot be reached, school personnel of this district are hereby authorized to take whatever action that is necessary to provide medical emergency care for my child. I agree to assume all expenses.

I certify that the information on this form is true and correct to the best of my knowledge.

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. 7-18) Previous edition 6-17 may be used.

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 Citation.	

BCAL-3731 (Rev. 7-18) Previous edition 6-17 may be used.

HEALTH APPRAISAL

Michigan Department of Health and Human Services

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, dentist, dental therapist, and dental hygienist.

(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)	Today's Date (mm/dd/yy)
Parent/Guardian (Last, First, Middle)	Home/Cell Phone Number
Address (Number, Street, City, Zip Code)	Work Phone Number

SECTION I – HEALTH HISTORY

Yes	No	Resolved	#	Is your child having any of the problems listed below?	Birth History
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	1	Allergies or Reactions (for example, food, medication or other)	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	2	Anaphylaxis	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	3	Does your child take any medication(s) regularly?	If yes, list medications
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	4	Hay Fever, Asthma, or Wheezing	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	5	Eczema or Frequent Skin Rashes	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	6	Convulsions/Seizures	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	7	Heart Trouble	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	8	Diabetes	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	9	Frequent Colds, Sore Throats, Earaches (4 or more per year)	Are there any current or past diagnosis(es) <input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	10	Trouble with Passing Urine or Bowel Movements	If yes, please describe
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	11	Shortness of Breath	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	12	Speech Problems	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	13	Menstrual Problems	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	14	Dental Problems Date of Last Exam _____ OR Date of Last Assessment _____	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		Other (please describe) _____	

Reason for Medication		
Concussion History		
Parent/Guardian Signature	Date	Was the health history reviewed by a health professional? <input type="checkbox"/> Yes <input type="checkbox"/> No Examiner's Initials _____

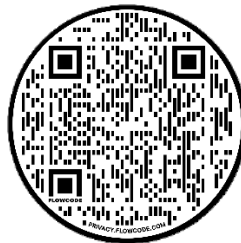
SECTION II – PHYSICAL EXAMINATION, INSPECTION, TESTS AND MEASUREMENTS

Required for Child Care and Head Start / Early Head Start

Test and Measurements						
Yes	No	Was child tested for	Tests and results	Normal	Referred	Under care
<input type="checkbox"/>	<input type="checkbox"/>	Vision Date _____	Visual Acuity			
			Muscle Imbalance			
			Other			
<input type="checkbox"/>	<input type="checkbox"/>	Hearing Date _____	<input type="checkbox"/> Audiometer (R= Right, L=Left)	R/L	R/L	
			<input type="checkbox"/> OAE (R= Right, L=Left)	R/L	R/L	
			<input type="checkbox"/> Other (R= Right, L=Left)	R/L	R/L	
<input type="checkbox"/>	<input type="checkbox"/>	Urinalysis	Sugar			
			Albumin			
			Microscopic			
<input type="checkbox"/>	<input type="checkbox"/>	Blood Lead Level Date _____	Level _____ ug/dl			
<input type="checkbox"/>	<input type="checkbox"/>	Height & Weight Other _____	Height			
	Weight					
	Other _____					
<input type="checkbox"/>	<input type="checkbox"/>	Hemoglobin/Hematocrit	⇒			
<input type="checkbox"/>	<input type="checkbox"/>	Blood Pressure	Reading _____			

Note: All children in Medicaid need to be tested at 1 and 2 years of age, or once between 3 and 6 years of age if not previously tested. All children, regardless of Medicaid status, should be tested at those same ages if they live in an area where lead risk is high.

Complete pediatric tuberculosis risk assessment available at:
https://www.michigan.gov/documents/mdhhs/4_MI_Pediatric_TB_Risk_Assessment_661537_7.pdf **OR**
 feel free to use the attached QR code instead of the full link text.



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 based on this information.*

Vaccines (Circle Type)	Date Administered mm/dd/yy		Vaccines (Circle Type)	Date Administered mm/dd/yy				
Hepatitis B (HepB)	1	3	Hepatitis A (HepA)	1	3			
	2	4		2				
DTaP/DTP/DT/Td	1	4	Influenza (IIV/LAIV)	1	3			
	2	5		2	4			
	3	6	Meningococcal MenACWY (MCV4)	1	3			
				2				
Tdap	1		Meningococcal B (Bexsero, Trumenba)	1	3			
				2				
<i>Haemophilus Influenzae</i> type b (HIB)	1	3	Human Papillomavirus (9vHPV, 4vHPV, 2vHPV)	1	3			
	2	4		2				
Polio (IPV/OPV)	1	4	Additional Vaccines Specify Date & Type	Type of Vaccine(s)	Date of Vaccine(s)			
	2	5		1				
	3			2				
			3					
Pneumococcal Conjugate (PCV7/PCV13)	1	3	Indicate and attach physician diagnosis or laboratory evidence of immunity as applicable.					
	2	4						
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.					
	2							
Measles, Mumps, Rubella (MMR/MMRV)	1	3						
	2							
Varicella (Chickenpox), (Var, MMRV)	1	2						
History of Chickenpox Disease? <input type="checkbox"/> Yes <input type="checkbox"/> No						Parent/Guardian refused recommended immunizations at visit: <input type="checkbox"/>		
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)

Yes	No
<input type="checkbox"/>	<input type="checkbox"/>
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: _____	

<input type="checkbox"/>	<input type="checkbox"/>	Should the child's activity be restricted because of any physical defect or illness? If yes, check and explain degree of restriction(s):
		<div style="display: flex; justify-content: space-between;"> <div> <input type="checkbox"/> Classroom <input type="checkbox"/> Swimming Pool </div> <div> <input type="checkbox"/> Playground <input type="checkbox"/> Competitive Sports </div> <div> <input type="checkbox"/> Gymnasium <input type="checkbox"/> Other </div> </div>
Other Recommendations		

SECTION V – DENTAL EXAM OR ASSESSMENT RECOMMENDATIONS (OPTIONAL)

Child's Name	Has received <input type="checkbox"/> Dental Exam <input type="checkbox"/> Dental Assessment	
Findings and Recommendation (Check all that apply)		
<input type="checkbox"/> No Urgent Needs	<input type="checkbox"/> Routine Care Needed	<input type="checkbox"/> Treated Decay
<input type="checkbox"/> Restorative/Urgent Needs for Dental Care	<input type="checkbox"/> Untreated Decay	<input type="checkbox"/> Further Referral for Specialist
Signature		Date
Check One <input type="checkbox"/> Dentist <input type="checkbox"/> Dental Therapist <input type="checkbox"/> Dental Hygienist		

PHYSICIAN'S SIGNATURE

Examiner's Signature	Date	Examiner's Name (Print)	Degree or License
Number & Street	City	<div style="display: flex; align-items: center;"> <div style="border: 1px solid black; width: 30px; height: 30px; margin-right: 5px;"></div> <div style="margin-left: 5px;">MI</div> </div>	Zip Code
		Telephone Number	

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 preventative and primary health care, including medical, dental, and mental health. The schedule must incorporate the well-childcare 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.

The Michigan Department of Health and Human Services will not exclude from participation in, deny benefits of, or discriminate against any individual or group because of race, sex, religion, age, national origin, color, height, weight, marital status, partisan considerations, or a disability or genetic information that is unrelated to the person's eligibility.

Educational Material for Parents and Students (Content Meets MDCH Requirements)

Sources: Michigan Department of Community Health, CDC and the National Operating Committee on Standards for Athletic Equipment (NOCSAE)

UNDERSTANDING CONCUSSION

Some Common Symptoms

Headache
Pressure in the Head
Nausea/Vomiting
Dizziness

Balance Problems
Double Vision
Blurry Vision
Sensitive to Light

Sensitive to Noise
Sluggishness
Haziness
Fogginess
Grogginess

Poor Concentration
Memory Problems
Confusion
“Feeling Down”

Not “Feeling Right”
Feeling Irritable
Slow Reaction Time
Sleep Problems

WHAT IS A CONCUSSION?

A **concussion is a type of traumatic brain injury** that changes the way the brain normally works. A concussion is caused by a fall, bump, blow, or jolt to the head or body that causes the head and brain to move quickly back and forth. A concussion can be caused by a shaking, spinning or a sudden stopping and starting of the head. Even a “ding,” “getting your bell rung,” or what seems to be a mild bump or blow to the head can be serious. A concussion can happen even if you haven’t been knocked out.

You can’t see a concussion. Signs and symptoms of concussions can show up right after the injury or may not appear or be noticed until days or weeks after the injury. If the student reports any symptoms of a concussion, or if you notice symptoms yourself, seek medical attention right away. A student who may have had a concussion should not return to play on the day of the injury and until a health care professional says they are okay to return to play.

IF YOU SUSPECT A CONCUSSION:

- 1. SEEK MEDICAL ATTENTION RIGHT AWAY** – A health care professional will be able to decide how serious the concussion is and when it is safe for the student to return to regular activities, including sports. Don’t hide it, report it. Ignoring symptoms and trying to “tough it out” often makes it worse.
- 2. KEEP YOUR STUDENT OUT OF PLAY** – Concussions take time to heal. Don’t let the student return to play the day of injury and until a health care professional says it’s okay. A student who returns to play too soon, while the brain is still healing, risks a greater chance of having a second concussion. Young children and teens are more likely to get a concussion and take longer to recover than adults. Repeat or second concussions increase the time it takes to recover and can be very serious. They can cause permanent brain damage, affecting the student for a lifetime. They can be fatal. It is better to miss one game than the whole season.
- 3. TELL THE SCHOOL ABOUT ANY PREVIOUS CONCUSSION** – Schools should know if a student had a previous concussion. A student’s school may not know about a concussion received in another sport or activity unless you notify them.

SIGNS OBSERVED BY PARENTS:

- Appears dazed or stunned
- Is confused about assignment or position
- Forgets an instruction
- Can’t recall events prior to or after a hit or fall
- Is unsure of game, score, or opponent
- Moves clumsily
- Answers questions slowly
- Loses consciousness (even briefly)
- Shows mood, behavior, or personality changes

CONCUSSION DANGER SIGNS:

In rare cases, a dangerous blood clot may form on the brain in a person with a concussion and crowd the brain against the skull. A student should receive immediate medical attention if after a bump, blow, or jolt to the head or body s/he exhibits any of the following danger signs:

- One pupil larger than the other
- Is drowsy or cannot be awakened
- A headache that gets worse
- Weakness, numbness, or decreased coordination
- Repeated vomiting or nausea
- Slurred speech
- Convulsions or seizures
- Cannot recognize people/places
- Becomes increasingly confused, restless or agitated
- Has unusual behavior
- Loses consciousness (even a brief loss of consciousness should be taken seriously.)

HOW TO RESPOND TO A REPORT OF A CONCUSSION:

If a student reports one or more symptoms of a concussion after a bump, blow, or jolt to the head or body, s/he should be kept out of athletic play the day of the injury. The student should only return to play with permission from a health care professional experienced in evaluating for concussion. During recovery, rest is key. Exercising or activities that involve a lot of concentration (such as studying, working on the computer, or playing video games) may cause concussion symptoms to reappear or get worse. Students who return to school after a concussion may need to spend fewer hours at school, take rests breaks, be given extra help and time, spend less time reading, writing or on a computer. After a concussion, returning to sports and school is a gradual process that should be monitored by a health care professional.

Remember: Concussion affects people differently. While most students with a concussion recover quickly and fully, some will have symptoms that last for days, or even weeks. A more serious concussion can last for months or longer.

To learn more, go to www.cdc.gov/concussion.

Parents and Students Must Sign and Return the Educational Material Acknowledgement Form

CONCUSSION AWARENESS

EDUCATIONAL MATERIAL ACKNOWLEDGEMENT FORM

By my name and signature below, I acknowledge in accordance with Public Acts 342 and 343 of 2012 that I have received and reviewed the Concussion Fact Sheet for Parents and/or the Concussion Fact Sheet for Students provided by _____

Sponsoring Organization

Participant Name Printed

Parent or Guardian Name Printed

Participant Name Signature

Parent or Guardian Name Signature

Date

Date

Return this signed form to the sponsoring organization that must keep on file for the duration of participation or age 18.

Participants and parents please review and keep the educational materials available for future reference.

Dear Parent/Guardian:



**Key Points Related to Claiming a Nonmedical Immunization Waiver for Children
Attending Michigan Schools and Licensed Childcare Programs**

In early 2015, Michigan instituted an administrative rule change on nonmedical waivers for childhood immunizations. Parents/guardians seeking to obtain a nonmedical immunization waiver for their child/children who are enrolled in school or licensed childcare programs are required to attend an educational session, where they are provided with information about vaccine-preventable diseases and vaccinations.

Key Points

- The rule applies to parents/guardians seeking a nonmedical immunization waiver for their child/children enrolled in public or private:
 - Licensed childcare, preschool, and Head Start programs
 - Kindergarten, 7th grade, and any newly enrolled student into the school district
- This rule preserves your ability to obtain a nonmedical waiver.
- Nonmedical waivers (religious or philosophical/other objections) are available at your county health department and cannot be found at schools/childcare programs or physician offices.
- Parents/Guardians are required to follow these steps when seeking a nonmedical waiver:
 1. Contact your county health department for an appointment to speak with a health educator.
 2. During the visit, immunization-related questions and concerns of the parents/guardians can be brought up for discussion. The staff will present evidence-based information regarding the risks of vaccine-preventable diseases and the benefits/potential risks (risks consisting mostly moderate side effects) of vaccination.
 3. Schools/childcare programs will only accept the current, un-altered, official State of Michigan form (Any new waivers issued should have the revision date of January 10, 2021.)
 - A county health department will not issue a waiver without both signatures as it would be considered an incomplete and invalid waiver.
 - Forms cannot be altered in any way (this includes crossing information out).
 4. Take the current, certified waiver form to your child's school or childcare program.
- If your child has a medical reason (that is, a true medical contraindication or precaution) for not receiving a vaccine, a physician (MD/DO) must sign the State of Michigan Medical Contraindication Form.
- Based on the public health code, a child without an up-to-date immunization record, a certified nonmedical waiver form, **or** a physician (MD/DO)-signed medical waiver shall be excluded from school/childcare.

For more information, please visit www.michigan.gov/immunize > click on *Local Health Departments* > click on *Immunization Waiver Information*. This website will provide you with a link to all the county health departments, along with their addresses and phone numbers.



Health
Department

Statement of Varicella Disease CHICKENPOX

The Michigan Public Health Code Act 368 of 1978 Part 92 Immunization and Macomb County Immunization Regulations require all children admitted to any public, private, parochial, special education, alternative education, adult education, career/technical education, homeschool cooperative, virtual school or charter academy, childcare center, nursery school, preschool, camp, or any other organized care or educational facility operating in Macomb County to present a certificate indicating dates of all required immunizations.

Complete the portion below **only** if your child has had varicella (chickenpox) disease. **This form must be signed and witnessed at your child's school/childcare program.**

I certify my child: _____
Last Name First Name M.I.

Birth Date Grade Date of School Enrollment

Has had varicella disease _____
(When did varicella occur: Age or Date?)

Signature: _____ Date: _____
(Parent or Legal Guardian)

Witnessed by: _____ Date: _____
(School/Program Staff)

School District: _____

School/Childcare Program: _____

PLACE THIS FORM IN THE CHILD'S PERMANENT RECORD



Dooley Center
16170 Canberra
Roseville MI 48066
586-439-7600
Fax 586-439-7601
Melissa. Laseck - Director

Advisory To Parents / Guardians

Dear Parent or Guardian:

State of Michigan law requires that schools and day care centers that may apply pesticides on school or day care property must provide an annual advisory to parents or guardians of students attending the facility.

Please be advised that the Fraser Public Schools district utilizes an Integrated Pest Management (IPM) approach to control pests. IPM is a pest management system that utilizes all suitable techniques in a total pest management system with the intent of preventing pests from reaching unacceptable levels or to reduce an existing population to an acceptable level. Pest management techniques emphasize sanitation, pest exclusion, and biological controls. One of the objectives of using an IPM approach is to reduce or eliminate the need for chemical applications of pesticides. However, certain situations may require the need for pesticides to be utilized.

Please be advised that parents or guardians of children attending Fraser Public Schools may review the district's Integrated Pest Management program and records of any pesticide application upon request.

If you have questions regarding the district's pest management procedures, please contact:

Fraser Operations & Maintenance
33499 Klein Road
Fraser, MI 48026
(586) 439-7114
enviromental@fraserk12.org

Child's Name _____

Parent's Signature _____ Date ____/____/____



Dooley Center
16170 Canberra
Roseville MI 48066
586-439-7600
Fax 586-439-7601
Melissa Laseck - Director

GSRP Parent Agreement

Child's Name _____

_____ I understand that my child will attend school on a regular basis as he/she is in good health.

_____ I understand that I must notify the school office and bus garage (If using transportation) if my Child will be absent.

_____ I understand that I must make sure that my child's immunizations are up to date in the school office to continue to attend preschool.

_____ I understand I will make my child's teacher aware of any changes with phone numbers, addresses, email address and information pertaining to my child.

_____ I understand that I must provide local emergency contact information.

_____ I understand I must make my child's teacher aware of any allergies, medications, and special needs that my child may have.

_____ I understand the toilet-trained policy and procedure.

_____ I understand that my child may be photographed or videotaped during their time in the program. These photos or tapes may be used in newsletters, FPS website or FPS TV channel.

_____ I understand that the GSRP class may take short walks around the school area without prior notice.

_____ I am being made aware of a Licensing Notebook. I understand that: (i) The licensing notebook is available for parents to review during regular business hours. (ii) The licensing notebook contains all the licensing inspection reports, special investigation reports and related corrective action plans for the last 5 years, (iii) Licensing inspection reports, special investigation reports and related corrective action plans for at least the last 3 years are available on the department's child care licensing website at www.michigan.gov/michildcare.

_____ I understand that all preschool employees of Dooley-Fraser Public Schools have had a comprehensive background check.

_____ I understand that all Dooley classrooms are peanut and tree nut restricted. I will not send to school items that contain peanut or tree nut products.

_____ I have received and read the GSRP Parent Handbook, and I agree to the policies described within the handbook. Another GSRP Parent Handbook will be given if requested.

Parent/Guardian's

Signature: _____ Date: ____/____/____



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Parent Notice of Program Measurement*

The Dooley Center is required to work with the Michigan Department of Education (MDE) to measure the effect of the state-wide Great Start Readiness Program (GSRP). Information is sometimes collected about GSRP staff, enrolled children, and their families. Program staff or a representative from MDE might:

- Ask parents questions about their child and family.
- Observe children in the classroom.
- Measure what children know about letters, words, numbers, etc....
- Ask teachers how children are learning and growing.

Information from you and about your child will not be shared with others in any way that you or your child could be identified. It is protected by law.

If you have any questions, please contact:

- The Dooley Center at (586) 439-7600
Or
- The MDE Office of Great Start Preschool and Out-of-School Time Learning at
 - Mde-gsrp@michigan.gov
 - (517) 241-7004
 - 608 W Allegan, PO Box 30008, Lansing, MI 48909

Child's Name _____

Parent's Name _____

Parent's Signature _____ Date ____/____/____