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

# Registration for All Tuition Based Programs

**Step 1** Schedule an appointment to turn in registration paperwork. The link to schedule an appointment can be found on our website. http://dooley.fraser.k12.mi.us

You may pick up the forms at the Dooley Center or you may complete them online, print them, and bring them with you.

**Required Student Enrollment Documents**

- Fraser Public Schools Student Data Form
- Original Birth Certificate
  If you do not have your child's birth certificate please use one of the Resources below to obtain an original certificate
  - ❖ Order online at www.vitalcheck.com
  - ❖ Go to courthouse of the county where the child was born
  - ❖ Call the State of Michigan Vital Records by phone at (517) 335-8656
- Current Physical (signed by physician)
- Current Immunization Records (students are not allowed to start school without proof of immunizations)
- Varicella (Chickenpox) Statement
- Concussion Form
- Little Learners Program Policies
- Pesticide Form
- Child Information sheet

## ALL FORMS ARE NEEDED FOR A CHILD TO ATTEND

**Step 2** Register online with our Bookkeeping department with the link that will be provided to you after Completing Step 1.

- ❖ Should you have any problems with registering online, please call
  - The Bookkeeper (586) 439-7038
  - Email Julianne.Snarski@fraserk12.org

## ALL REGISTRATIONS WILL BE PENDING UNTIL BOTH STEPS 1 & 2 ARE COMPLETE

**Step 3** Review our Little Learners Handbook

# Fraser Public Schools
# Student Data Form

***Please complete and return this enrollment form.***

## Student Information

| **Student's Full Legal Name**<br>Last Name First Name Middle Name | **Gender**<br>☐ M ☐ 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)**<br>1.☐Alaskan Native/American Indian 2.☐Asian American<br>3.☐Black or African American 4.☐Native Hawaiian/Other Pacific Islander<br>5.☐White 6.☐Hispanic or Latino<br>7.☐Multi-Racial – If Multi-Racial, please list two: | |
| **Ethnicity (Please choose one)**<br>Hispanic/Latino ☐ Not Hispanic or Latino ☐ | | |
| **Student's Date of Birth** | **Student Order of Birth (if multiple)**<br>Please circle:<br>☐01 ☐02 ☐03 ☐04 ☐05 ☐06 ☐07 ☐08 | **Birth City/State (if born in US)** |

## Fill in Section Below for Students not Born in US

| U.S. Citizen<br>☐ 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?**<br>☐Yes ☐No | **If Yes, School Attended** |
|---|---|
| **Former District** | **Former School** |

| **Former School Address** | **Former School City, State & Zip** | **Suspended/Expelled from Former School?**<br>☐Yes ☐No |
|---|---|---|

## Services Received at Former School

| ☐**IEP** ☐ 504 | ☐ **Title I** | ☐ **ELL** | ☐ **Social Work** | ☐ **Other Services** |
|---|---|---|---|---|

**Please Describe Other Services** ***Please provide copies related to any of the above checked boxes***

## Forms Submitted

| ☐**Birth Certificate** | ☐ **Proof of Residency** | ☐ **Immunization** | ☐ **Hearing & Vision** | ☐ **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)** |
| | |

| ☐ Asthma | ☐ Diabetes | ☐ Vision Problem | ☐ Hearing Problem | ☐ Peanut Allergy | ☐ Cystic Fibrosis<br>☐ Other |
|---|---|---|---|---|---|

| Physician Name | Physician Phone |
|---|---|
| | |

## 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?** ☐ Yes ☐ No |
| **Employer** | **Work Phone (with extension)** | **Receives Letter Mailings?** ☐ Yes ☐ 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?** ☐ Yes ☐ No |
| **Employer** | **Work Phone (with extension)** | **Receives Letter Mailings?** ☐ Yes ☐ 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?** ☐ Yes ☐ No |
| **Employer** | **Work Phone (with extension)** | **Receives Letter Mailings?** ☐ Yes ☐ 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?** ☐ Yes ☐ No |
| **Employer** | **Work Phone (with extension)** | **Receives Letter Mailings?** ☐ Yes ☐ 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 6-17may be used.

## 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.

*County Health Department includes the City of Detroit

May 3, 2021

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**

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

| **Reason for Medication** | | |
|---|---|---|
| **Concussion History** | | |
| Parent/Guardian Signature | Date | Was the health history reviewed by a health professional?<br>☐ Yes ☐ 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 |
|---|---|---|---|---|---|---|
| ☐ | ☐ | Vision<br>Date _____ | Visual Acuity | ☐ | ☐ | ☐ |
| | | | Muscle Imbalance | ☐ | ☐ | ☐ |
| | | | Other | ☐ | ☐ | ☐ |
| ☐ | ☐ | Hearing<br>Date _____ | ☐ Audiometer (R= Right, L=Left) | R/L | R/L | ☐ |
| | | | ☐ OAE (R= Right, L=Left) | R/L | R/L | ☐ |
| | | | ☐ Other (R= Right, L=Left) | R/L | R/L | ☐ |
| ☐ | ☐ | Urinalysis | Sugar | ☐ | ☐ | ☐ |
| | | | Albumin | ☐ | ☐ | ☐ |
| | | | Microscopic | ☐ | ☐ | ☐ |
| ☐ | ☐ | Blood Lead Level<br>Date _____ | Level _____ ug/dl | ☐ | ☐ | ☐ |

**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.

| | | | | | | |
|---|---|---|---|---|---|---|
| ☐ | ☐ | Height & Weight | Height | ☐ | ☐ | ☐ |
| | | | Weight | ☐ | ☐ | ☐ |
| | | Other _____ | Other _____ | ☐ | ☐ | ☐ |
| ☐ | ☐ | Hemoglobin/Hematocrit | ⇨ | ☐ | ☐ | ☐ |
| ☐ | ☐ | Blood Pressure | Reading _____ | ☐ | ☐ | ☐ |

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 | |
| *Haemophilus Influenzae* type b (HIB) | 1 | 3 | Human Papillomavirus (9vHPV, 4vHPV, 2vHPV) | 1 | 3 |
| | | | | 2 | |
| | 2 | 4 | Additional Vaccines Specify Date & Type | Type of Vaccine(s) | Date of Vaccine(s) |
| Polio (IPV/OPV) | 1 | 4 | | 1 | |
| | 2 | 5 | | 2 | |
| | 3 | | | 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? ☐ Yes ☐ No<br>If yes, date _____ | | | Parent/Guardian refused recommended immunizations at visit: ☐ | | |
| 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 | |
|---|---|---|
| ☐ | ☐ | 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 EXAM OR ASSESSMENT RECOMMENDATIONS (OPTIONAL)**

| Child's Name | Has received ☐ Dental Exam ☐ Dental Assessment |
|---|---|

Findings and Recommendation (Check all that apply)

☐ No Urgent Needs ☐ Routine Care Needed ☐ Treated Decay
☐ Restorative/Urgent Needs for Dental Care ☐ Untreated Decay ☐ Further Referral for Specialist

| Signature | Date |
|---|---|

Check One

☐ Dentist ☐ Dental Therapist ☐ Dental Hygienist

**PHYSICIAN'S SIGNATURE**

| Examiner's Signature | Date | Examiner's Name (Print) | | Degree or License |
|---|---|---|---|---|
| Number & Street | City | MI | 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.

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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.

**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** | **Balance Problems** | **Sensitive to Noise** | **Poor Concentration** | **Not "Feeling Right"** |
| **Pressure in the Head** | **Double Vision** | **Sluggishness** | **Memory Problems** | **Feeling Irritable** |
| **Nausea/Vomiting** | **Blurry Vision** | **Haziness** | **Confusion** | **Slow Reaction Time** |
| **Dizziness** | **Sensitive to Light** | **Fogginess** | **"Feeling Down"** | **Sleep Problems** |
| | | **Grogginess** | | |

## 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 heath 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.

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

# Little Learners Program Policies

**Please initial that you have read each of the following statements. This form can also be found in the Parent Handbook.**

_____ I understand that the tuition for Traditional Preschool is due on the 10th of each month.

_____ I understand that that a schedule must be provided for Early Childhood Care

_____ **I understand that failure to make payments in a timely manner may result in my child being dropped from the program**

_____ I understand that if I am late picking up my child I may be charged a $15.00 late fee for every 15 minutes I am late. This fee will be added to my invoice.

_____ I understand that I will make preschool and childcare staff aware of any changes with phone numbers, addresses, e-mail address and information pertaining to my child.

_____ I understand I must provide local emergency contact information.

_____ I understand the illness policy, which includes a child being fever/diarrhea/vomit free for 24 hours without medication before returning to school.

_____ I understand that additional illness policies may be in place based on the current requirements from MCHD, MDHHS and Michigan Child Care Licensing.

_____ I will make sure staff is aware of any allergies, medications and special needs that my child may have and will have my child's immunization record on file at the school.

_____ I understand the parents provide transportation to and from all field trips and there are no refunds for preschool tuition if I can't attend.

_____ 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, the FPS website or FPS TV channel.

_____ 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 child care and preschool staff have been cleared through a comprehensive background check.

_____ I understand that all Tuition Preschool and Early Childhood Care classrooms are peanut and tree nut free. I will not send to school items that contain peanut or tree nut products.

_____ I have read the Parent Handbook found on Dooley's website under information: http://dooley.fraser.k12.mi.us and I agree to the policies described within it. A copy of this handbook can also be viewed in the Dooley Center office.

Child's Name _____

Parent/Guardian's Signature _____ Date _____/_____/_____

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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 ____/_____/_____

# CHILD INFORMATION SHEET

Child's full name: _____

Nickname: _____ Birth date: _____/_____/_____

Allergies: _____ If so, please list: _____

_____

Mother's Name: _____ Occupation: _____

Father's Name: _____ Occupation: _____

Home address: _____

Home phone number: (_____) _____-_____

With whom does your child live? _____

Name and age of siblings: _____

What languages are spoken in the home? _____

Does your child have any special needs? _____ If so, please explain: _____

_____

List your child's skills and interests (such as books, music he/she enjoys using):

_____

Describe events such as death, divorce, illness and hospital trips:

_____

Are there particular areas in which your child needs help?

_____

Any other concerns or things that you feel we should know about?

_____

Is there any other information you would like to share with the teacher?

_____

_____

You may describe your family's traditions and cultural heritage on the back.