ENCLOSED IS AN APPLICATION FOR CLAWSON SCHOOLS GSRP PROGRAM (OUR FREE 4-YEAR-OLD GREAT START READINESS PROGRAM) FOR SCHOOL YEAR 2024-2025

TO APPLY FOR THE GSRP PROGRAM:

1. **COMPLETE GSRP APPLICATION FORM**
2. **SEND IN PROOF OF INCOME—PAGE 3. (PROOF OF INCOME IS REQUIRED FOR ALL FAMILIES APPLYING TO THE GSRP PROGRAM—EVEN IF THEY DO NOT QUALIFY BASED ON INCOME).**
3. **COMPLETE CHILD ELIGIBILTY FORM AND CHECK ELIGIBILTY FACTORS, WHICH APPLY TO YOUR FAMILY – SEND IN DOCUMENTS**
4. **COMPLETE INTAKE FORM**
5. **EMAIL OR BRING IN A COPY OF YOUR CHILD'S BIRTH VERIFICATION**
6. **COMPLETE IMMUNIZATION FORM**
7. **COMPLETE EMERGENCY CARD – EVERY LINE MUST BE FILLED IN**
8. **COMPLETE STUDENT DATA FORM**
9. **SHOW PROOF OF RESIDENCY, MAY SEND IN ONE OF THE FOLLOWING:**
    - **DRIVER'S LICENSE**
    - **PAY STUB WITH YOUR CURRENT ADDRESS**
    - **UTILITY BILL**
    - **OTHER RECENT GOVERNMENT ISSUED DOCUMENTS LISTING THE ADDRESS AND NAME OF PARENT/GUARDIAN OF CHILD**
10. **COMPLETE RESOURCE REQUEST AND SHARING FORM**
11. **COMPLETE SCREENING CONSENT FORM**
12. **COMPLETE HOME LANGUAGE SURVEY**

ALL OF THE ABOVE ITEMS MUST BE SENT IN BEFORE A CHILD IS CONSIDERED FOR THE CLAWSON GSRP PROGRAM!

THE FIRST DAY OF THE 2024-2025 SCHOOL YEAR WILL BE MONDAY, SEPTEMBER 9th 2024

This material was developed under a grant awarded by the Michigan Department of Education

Dear Parents/Guardians:
Enclosed is an application packet for our FREE GSRP 4-year-old school readiness program.

The GSRP program meets Monday through Thursday for 34 weeks beginning Monday, September 9th. The all-day sessions will meet from 8:30 am – 3:30 pm.

If interested in our GSRP program, please complete the following information. **We will begin enrolling students on Monday, January 8th** Please call Claire Prost at 248-655-4402 or Heather Kotz at 248-655-4414 if you have any questions.

GSRP ADMISSION POLICY:
Children enrolled in our GSRP free program must:

- Be 4 years of age by 9-1-2024
- Qualify for program based on low income and/or eligibility factors.
- If you are over income, we can start enrolling students March 1st, if there are still openings available and will pay tuition based on a sliding fee scale.
- Unless your child is age **AND** income eligible, children who live out of district and do not already have siblings that attend the Clawson School District will be enrolled starting August 1st, 2024, if there are still openings available.
- Children who turn 4 years of age between Sept. 1, 2024 – Dec. 1, 2024 may also apply, but will not be enrolled until Sept. 1, 2024 if there are still openings available.

Eligibility Factors are:

- Diagnosed disability or identified developmental delays
- Parent/guardian with low educational attainment or did not graduate
- Severe or challenging behavior
- Abuse or neglect of child or parent
- Primary home language other than English
- Environmental Risk factors are parental loss, sibling issues, teenage parent, homeless and high-risk neighborhood exposure to toxic substances.

RANKING OF GSRP APPLICATIONS:
Applications are reviewed and ranked by the following income categories:

- 0-50% poverty
- 51-100% poverty
- 101-150% poverty
- 151-200% poverty
- 201-250% poverty
- 251-300% poverty

Within income categories, applicants are ranked by additional eligibility factors.

This material was developed under a grant awarded by the Michigan Department of Education

All of the following MUST be completed before your child will be considered for the Clawson GSRP program:

1. GSRP Applications Form
2. Proof of Income – W2,1040 page of your tax return or 3 (2 if you don't have 3) consecutive pay stubs.
3. Child Eligibility Form – Check eligibility factors which apply and send in supporting data.
4. Intake Form
5. Email or bring in a copy of your child's birth verification
6. Immunization Record Form
7. Emergency Card
8. Student Data Form
9. Proof of residence
10. Resource request and sharing form
11. Screening Consent form
12. Home Language Survey

IMMUNIZATIONS

When registering your child, the State of Michigan requires that you show proof of immunizations. Immunization form is due at time of registration. Immunization waivers are no longer available through the school district. To complete the waiver, contact your child's pediatrician or Oakland County Health Department. Health forms are only valid for 1 year.

The attached health form is due the first day of school, Monday, Sept.9th, 2024. This form must be completed and signed by your child's doctor.

There will be a PARENT MEETING in the beginning of September, but exact time, location and date have not yet been set.

Clawson Schools also has programs and assessments available for children birth to age 5 whose parents may have concerns about developmental delays in the areas of speech and language, gross or fine motor, cognitive, and/or social-emotional development. Call Julie Carl at 248-655-4416.

If you have any questions or concerns, please call Claire Prost at 248- 655-4402.

Sincerely,

Claire Prost
Clawson Preschool Coordinator

This material was developed under a grant awarded by the Michigan Department of Education

MiEarly Childhood Connect

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

OaklandSchools

Oakland County Early Childhood GSRP Paper Application

(Information gathered needs to be uploaded into MiECC once child is enrolled)

Intake School/Agency*	
Primary Phone Number*	
Family Name*	
Address*	
Apartment/Unit #	
City*	
State*	
Zip Code*	
Date Received*:	
Referral Source* ☐ Agency ☐ Parent ☐ Guardian ☐ Other	
Initial Contact Method	☐ Email ☐ Phone ☐ Walk In ☐ Other: _____
How did you learn about us?	
Authorization to Share (please read this statement in full)*: Part of Oakland Schools is to support your family, which means we may refer you to another program or organization. Do you give permission to Oakland Schools to share the information you've given me today with affiliate/community organizations in order to best support your family? Information may also include the results of the Ages and Stages Questionnaire. This will remain in effect until the youngest child in the family turns five or your family requests, either verbally or in writing, that information sharing be stopped.	
Parent/Guardian Signature*	

For which year are you hoping to have your child enrolled or be considered for services?	☐ 2023-2024 ☐ 2024-2025
Desired Program Schedule	☐ Part Day ☐ School Day - 4 days per week ☐ School Day - 5 days per week
Child's Legal First Name* (should match birth verification document)	
Middle Name	
Child's Legal Last Name* (should match birth verification document)	
Suffix	
Date of Birth (month, date, year)* (should match birth verification document)	
Gender*	
Is Hispanic or Latino	☐ Yes ☐ No
Race/Ethnicity * Select the one that you most identify with.	☐ American Indian/Alaskan Native ☐ Asian ☐ Black/African American ☐ Native Hawaiian/Other Pacific Islander ☐ White
Do you need transportation? (transportation is not available in all areas)	☐ Yes ☐ No

Determining Eligibility Factors

The questions contained in this document are sensitive for families. Now that enrollment prioritization is based on income level, and eligibility factors determine prioritization within the income levels, it is not as necessary to gather this information at the start of the school year. This information:

- Can be gathered throughout the year and reported in April on the Child Information and Staff Report (CISR) that is submitted to Oakland Schools and then to MDE.
- Is more easily gathered once a collaborative relationship with the family has been established.
- Can be gathered informally through confidential chats at drop-off or pick-up or at more formal conversations like the home visit and conferences.

The following questions are designed to find more information while being aware of how sensitive these areas are for families. This document can be used to take notes on information gathered from families and kept in the child file as evidence that the program seeks eligibility factor information with the goal of providing support to the child and family.

Eligibility Factor Sample Questions

Check the IEP / IFSP box in MiECC if any of the following are marked Yes:

- Does your child have an individual education plan (IEP)? _____ Yes ____ No
- Did you child have an IFSP with a transition referral at age 3? _____ Yes ____ No
- Does your child have a chronic illness (example: asthma)? ____ Yes ___ No
    - If yes, please explain: _____
- Do you, a doctor, or other professional have any concerns regarding your child's development?

  ____ Yes ___ No
    - If yes, please explain: _____

Check the Severe or Challenging Behavior Box in MiECC if any of the following are marked Yes:

- Has your child's behavior prevented participation in another group setting? ____ Yes ___ No
- Is your child in counseling or therapy? ____ Yes ___ No
- Has your child been expelled from preschool / child care center / other setting? ___ Yes __ No

Check the Primary Home Language Other than English Box in MiECC if any of the following are marked Yes:

- Are there any languages other than English spoken in the home? ____ Yes ___ No
    - If yes, what language? _____
- What is your child's primary language? _____

Check the Parent or Guardian with Low Educational Attainment Box in MiECC if any of the following are Less than High School or Evidence of Parent Literacy Need:

- What is the highest level of education for the parents of the child?
  - Parent 1 (check all that apply):
    - Less than High School ____
    - High school ____
    - GED ____
    - College ____
  - Parent 2 (check all that apply
    - Less than High School ____
    - High school ____
    - GED ____
    - College ____

- Are there any literacy resources, either for the child or parent, the family would be interested in?
  _____

- Who reads to the child in the home? _____

Check the Abuse / Neglect of Child or Parent Box in MiECC if any of the following are Yes:

- Have you or your child ever felt unsafe in your home? ____ Yes ___ No
  - If yes, please explain: _____

- Has anyone in your home been a victim of physical, sexual, or emotional abuse or neglect?
  ____ Yes ___ No

- Is there a history of substance abuse in the home (alcohol, drugs, prescription drugs)?
  ____ Yes ___ No

- Does anyone in the home have a violent or destructive temper? ____ Yes ___ No

Check the Environmental Risk Box in MiECC if any of the following are Yes:

- Has any of the following occurred for the child?
  - Divorce _____
  - Parental:
    - Death _____
    - Military leave _____
    - Incarceration _____
    - Chronic illness _____

        - Living elsewhere due to school or work _____
    - Grandparents raising child _____
    - Foster child _____
    - Frequent changes in custody _____
    - Single parent _____
    - Teen parent at the time the first child was born _____
    - Sibling with:
        - Chronic illness _____
        - Challenging behavior _____
        - Disability _____
        - Death _____

- Do you consider yourself homeless? ____ Yes ___ No
- Did your family unexpectedly relocate in the last 6 months? ____ Yes ___ No
- How many times have you moved in the past 2 years? _____
- Are you residing with anyone other than your immediate family members? ____ Yes ___ No
- Residing in a neighborhood with:
    - High poverty ____ Yes ___ No
    - High crime ____ Yes ___ No
    - Limited access to critical community services ____ Yes ___ No
    - High death rates ____ Yes ___ No
    - Violence ____ Yes ___ No
- Daily exposure to:
    - Lead ____ Yes ___ No
    - Rodents ____ Yes ___ No
    - Insect infestations ____ Yes ___ No
    - Violence ____ Yes ___ No
    - Injury ____ Yes ___ No
    - Drug use ____ Yes ___ No
    - Crowded housing ____ Yes ___ No
    - Lack of utilities ____ Yes ___ No
    - No space for children's play ____ Yes ___ No
- Prenatal or postnatal exposure to toxic substances known to cause learning or developmental delays

- Fetal Alcohol Syndrome ____ Yes ___ No
- Born addicted ____ Yes ___ No
- Environmentally-induced respiratory problems ____ Yes ___ No
- Other: _____ ____ Yes ___ No

Other Parent/Guardians in the household (dependent on the household income)

First Name*	
Last Name*	
Relationship to child*	

First Name*	
Last Name*	
Relationship to child*	

Siblings/other children in the household

First Name*	
Last Name*	
Date of Birth (month, date, year)*	
Gender*	

First Name*	
Last Name*	
Date of Birth (month, date, year)*	
Gender*	

First Name*	
Last Name*	
Date of Birth (month, date, year)*	
Gender*	

First Name*	
Last Name*	
Date of Birth (month, date, year)*	
Gender*	

First Name*	
Last Name*	
Date of Birth (month, date, year)*	
Gender*	

First Name*	
Last Name*	
Date of Birth (month, date, year)*	
Gender*	

First Name*	
Last Name*	
Date of Birth (month, date, year)*	
Gender*	

First Name*	
Last Name*	
Date of Birth (month, date, year)*	
Gender*	

Notes:

*indicates a required field in MiECC

Child's Name: _____

GSRP CHILD ELIGIBILITY FORM

PLEASE CHECK ALL FACTORS THAT APPLY:
Families that qualify based on extremely low income only need 1 risk factor to qualify for GSRP program.

_____**Low family income:**
Family of 2: up to $78,880
Family of 3: up to $99,440
Family of 4: up to $120,000
Family of 5: up to $140,560
Family of 6: up to $161,120
Family of 7: up to $181,680
Family of 8: up to $202,240

_____**Diagnosed disability or identified developmental delay**
(Child is eligible for special education services or child's developmental level is less than that of expected for his/her chronological age or chronic health issues cause development or learning problems).

_____**Severe or challenging behavior**
(Child has been expelled from preschool or child care center).

_____**Primary home language other than English**

_____**Parent/Guardian with low educational attainment**
(Parent/Guardian did not graduate from high school)

_____ **Abuse or neglect of child or parent**

_____ **Environmental Risks (Only count as 1 risk factor)**

- **Parental loss due to death, divorce, incarceration, military service, or absence**
- **Sibling issues—chronic illness, behavior, disability or death.**
- **Teen parent (Not yet age 20 when first child was born)**
- **Family is homeless or without stable housing**
- **Residence in a high-risk neighborhood**
- **Prenatal or postnatal exposure to toxic substances known to cause learning or developmental delays.**

I authorize that the eligibility factors that I have checked are true and will provide documentation as requested to verify these factors.

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

_____ _____ _____
GSRP Staff Signature **Date**

This material was developed under a grant awarded by the Michigan Department of Education

Great Start School Readiness Program (GSRP) Intake Form

Child's Name _____ **Date of Birth** _____

Parent(s)/Guardian(s) Name(s) _____

Address _____

Telephone (home) _____ **Cell** _____

How did you hear about the GSRP Program? _____

Has your child been in another preschool program? If yes, where? _____

Are you in need of assistance for the following? Please check all that apply:

_____ **Housing**	_____ **Education or Training**	_____ **Medical/Health**
_____ **Food**	_____ **Employment**	_____ **Parent Education**
_____ **Clothing**	_____ **Child Care**	

I certify that all of the information is true and accurate. I understand that this information is strictly confidential and any falsification may be grounds for my child becoming ineligible or being removed from the GSRP program.

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

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IMMUNIZATION RECORD

_____ _____

CHILD'S NAME **BIRTH DATE**

PLEASE WRITE THE DATES YOUR CHILD HAS HAD THE FOLLOWING SHOTS:

DPT:
1.
2.
3.
4.
5.

POLIO:
1.
2.
3.
4.

HAEMOPHILUS INFLUENZAE TYPE B (HIB):
1.
2.
3.
4.

MMR:
1.
2.

PNEUMOCOCCAL CONJUGATE (PCV):
1.
2.
3.
4.

HEPATITIS B:
1.
2.
3.

VARICELLA (chicken pox vaccine)
1.

or if your child has had chickenpox, please list date and year:

_____.

PARENTS VACCINES REQUIRED FOR CHILD CARE AND PRESCHOOL IN MICHIGAN

MDHHS Michigan Department of Health & Human Services

Whenever infants and children are brought into group settings, there is a chance for diseases to spread. Children must follow state vaccine laws in order to attend child care and preschool. These laws are the minimum standard for preventing disease outbreaks in group settings. The best way to protect your child from other serious diseases is to follow the recommended vaccination schedule at www.cdc.gov/vaccines. Talk to your health care provider to make sure your child is fully protected.

	2-3 months	4-5 months	6-15 months	16-18 months	19 months–4 years	5 years
Diphtheria, Tetanus, Pertussis (DTaP)	1 dose DTaP	2 doses DTaP	3 doses DTaP		4 doses DTaP	
Pneumococcal Conjugate (PCV13)	1 dose	2 doses	3 doses or Age-appropriate complete series	4 doses or Age-appropriate complete series		None
H. influenzae type b (Hib)	1 dose	2 doses		1 dose at or after 15 months or Age-appropriate complete series		None
Polio	1 dose	2 doses			3 doses	
Measles, Mumps, Rubella (MMR)*	None			1 dose at or after 12 months		
Hepatitis B*	1 dose	2 doses			3 doses	
Varicella (Chickenpox)*	None			1 dose at or after 12 months or Current lab immunity or History of varicella disease		

These rules apply to children who are the above ages upon entry into child care or preschool. During disease outbreaks, incompletely vaccinated children may be excluded from child care and preschool. Parents and guardians choosing to decline vaccines must obtain a certified non-medical waiver from a local health department. Read more about waivers at www.michigan.gov/immunize.

*If the child has not received these vaccines, documented immunity is required. All doses of vaccines must be valid (correct spacing and ages) for child care and preschool entry purposes.

Updated March 1, 2017

When Do Children and Teens Need Vaccinations?

Age	HepB Hepatitis B	RSV-mAb	DTaP/Tdap Diphtheria, tetanus, pertussis (whooping cough)	Hib *Haemophilus influenzae* type b	IPV Polio	PCV Pneumo-coccal conjugate	RV Rotavirus	MMR Measles, mumps, rubella	Vari-cella Chickenpox	HepA Hepatitis A	COVID-19	Dengue	HPV Human papillomavirus	Men-ACWY Meningococcal	MenB Meningococcal	Influenza Flu
at Birth	✔	✔[2] (0–7 mos)														
2 months	✔		✔	✔	✔	✔	✔									
4 months	✔[1]		✔	✔	✔	✔	✔									
6 months	✔ (6–18 mos)		✔	✔[1]	✔ (6–18 mos)	✔	✔[1]				✔[4] COVID-19 vaccine is recommended for everyone age 6 months and older					✔ (6 mos and older)
8 months																
12 months		✔[2] (8–19 mos)	✔[3] (15–18 mos)	✔ (12–15 mos)		✔ (12–15 mos)		✔ (12–15 mos)	✔ (12–15 mos)	✔✔ (2 doses given 6 months apart routinely at age 12–23 months) HepA vaccine (2 doses) is also recommended for children and teens not previously vaccinated						
15 months																
18 months																
19–23 months																
4–6 years			✔		✔			✔	✔							
7–10 years												✔✔✔[5] Dengue vaccine is recommended for certain children	✔✔[6,7]			
11–12 years			✔ (Tdap)											✔		Influenza vaccine is recommended every year for everyone age 6 months and older
13–15 years																
16–18 years														✔	✔✔[8,9,10]	

One dose each fall or winter. Some children younger than age 9 years need 2 doses; ask your child's healthcare provider if your child needs more than 1 dose.

NOTES

1 Your child may not need this dose depending on the brand of vaccine that your healthcare provider uses.

2 Infants whose mother did not receive an RSV vaccination during pregnancy and who are younger than 8 months 0 days should receive RSV preventive antibody (RSV-mAb) before or during the RSV season (typically October through March). Certain high-risk children (8 through19 months) will need RSV-mAb before theiir second RSV season.

3 This dose of DTaP may be given as early as age 12 months if it has been 6 months since the previous dose.

4 Children age 5 years or older generally need only one dose. The number of doses for children age 6 months through 4 years is determined by the vaccine brand.

5 Children ages 9 through 16 years who live in Puerto Rico, American Samoa, U.S. Virgin Islands, Federated States of Micronesia, Republic of Marshall Islands, and the Republic of Palau, and have lab-confirmed previous dengue infection are recommended to receive a 3-dose series of dengue vaccine.

6 HPV vaccine is routine at age 11 or 12 years but may be started at age 9.

7 Children with certain medical conditions will need a third dose.

8 This vaccine may be given to healthy teens. It is also recommended for adolescents with certain health conditions.

9 Your teen may need an additional dose depending on your healthcare provider's recommendation.

10 When MenACWY and MenB vaccines are both needed, a MenABCWY combination vaccine may be used.

Immunize.org

FOR PROFESSIONALS www.immunize.org / **FOR THE PUBLIC** www.vaccineinformation.org

www.immunize.org/catg.d/p4050.pdf
Item #P4050 (12/18/2023)
Scan for PDF

CHILD INFORMATION RECORD

State of Michigan - Department of Licensing and Regulatory Affairs - Child Care Licensing Bureau

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	Primary Phone ( )	Parent/Legal Guardian's Name (Optional)		Primary Phone ( )
Home Address (if not child's address)	2nd Phone (if applicable) ( )	Home Address (if not child's address)		2nd Phone (if applicable) ( )
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/or Special Instructions? Yes ☐ No ☐ If yes, explain: (Attach additional sheets, if necessary.)				

CCL-3731 (Rev. 3/17/2022) Previous editions 7-18 & 4-21 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 Clawson Preschool, 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.

CCL-3731 (Rev. 3/17/2022) Previous editions 7-18 & 4-21 may be used

CLAWSON PUBLIC SCHOOLS
STUDENT DATA FORM (please print)

Student# _____ Year of Grad._____
Entry Date _____ Schools of Choice _____
Resident District _____

School to attend: _____ Entering Grade:_____

Student's **Legal** Name: _____ Gender: ❑Male ❑ Female
(*As shown on birth certificate*) Last First Middle Name

Birth date: _____ Birth Place: _____ Country of Birth: _____
Month / Day / Year City or Township

Address: _____
Number Street Apt. # City Zip Code

Primary Phone Number _____

Ethnicity/Race Information (*collected for statistical purposes only*)

Part A. Is this student Hispanic/Latino? (Choose only one)

- ❑ No, not Hispanic/Latino
- ❑ Yes, Hispanic/Latino (A person of Cuban, Mexican, Puerto Rican, Cuban, South or Central American, or other Spanish culture or origin regardless of race)

The above question is about ethnicity, not race. No matter what you selected above, **please continue to answer the following** by marking one or more boxes to indicate what you consider your student's race to be.

Part B. What is the student's race? (Check all that apply)

❑ American Indian/Alaska Native ❑ Asian ❑ Black/African American ❑ Native Hawaiian/Other Pacific Islander ❑ White

MEDICAL CONDITIONS/PROBLEMS: check all that apply

If checked a medical plan must be on file in your child's school office

❑ ADD/ADHD	❑ Headaches	❑ Seizure disorder #
❑ Asthma #	❑ Heart Condition	❑ Other Allergy:_____
❑ Bee Sting Allergy #	❑ Nose bleeds	❑ Other Medical Conditions: _____
❑ Diabetes#	❑ Peanut Allergy #	

❑*Takes medication regularly? Please indicate medication and how often taken _____

*If taken during school hours, please contact school and obtain an Authorization for Medication form to be completed by the student's physician and parent or guardian.

LAST SCHOOL ATTENDED:

School Name _____ Grade _____
Address _____ Date Entered _____ Date Left _____
City _____ State & Zip_____ Phone Number_____

SERVICES YOUR CHILD RECEIVED AT PRIOR SCHOOL:

Does your child have a 504 plan? Yes _____ No _____ (*Please provide a copy of the 504 plan*)
Does your child have an IEP (Individual Education Plan) Yes _____ No_____ (*Please provide a copy of the IEP and MET*)

Eligibility (if known) _____

Information about Parents / Guardians:

	Female Parent/Guardian in Household		*Male Parent/Guardian in Household*		*PARENT Living Elsewhere*
Name:					
Relationship to child:					
Cell Phone:					
Work Phone:					
Email:					
On Full-time Active Military Duty?	☐ Yes ☐ No		☐ Yes ☐ No		☐ Yes ☐ No

Parent Living Elsewhere Address: _____

(Should this person receive mailings?) ☐Yes ☐ No

Are custody papers on file with Clawson Public Schools ☐Yes ☐ No

Clawson Public Schools **cannot enforce** custody restrictions without a court order on file.

Emergency Contact Information:

When parent/guardian is unavailable, please list four adults to whom the child can be released from school due to illness and/or provide transportation. Adults may be asked to present identification. **List in order of preference.** PLEASE PRINT LEGIBLY

NAME _____ RELATIONSHIP TO CHILD _____ PHONE: (____) _____

NAME _____ RELATIONSHIP TO CHILD _____ PHONE: (____) _____

NAME _____ RELATIONSHIP TO CHILD _____ PHONE: (____) _____

NAME _____ RELATIONSHIP TO CHILD _____ PHONE: (____) _____

Other children that reside in the home:

Child's Name	Birth Date	Relationship	Grade

Please note any problems or concerns, which would assist the school in working with your child:

_____

I affirm that as the parent/legal guardian, all information provided above is true and accurate, and that my child and I reside at the listed address. I understand any false information provided by me, may subject me to legal penalties for perjury.

_____ _____

Parent/Legal Guardian signature Date

CLAWSON PUBLIC SCHOOLS
HOME LANGUAGE SURVEY

The Clawson Public Schools district is collecting information regarding the language background of each of its students. This information will be used by the district to determine the number of children who should be provided bilingual instruction according to Sections 380.1152-380.1157 of the School Code of 1995, Michigan's Bilingual Education Law.

Today's Date _____ School _____

Name of student _____
First Middle Last

Student birth date: _____ Grade _____ Country of birth _____

1. Is your child's native tongue a language other than English? ☐ Yes ☐ No
   (The child's native tongue/language is the language most often spoken by the student.)
   If yes, what is that language? _____
2. Is the **primary** language used in your child's home or environment a language other than English?
   (The primary language is the dominant language used at home regardless of the language spoken by the student.)
   ☐ Yes ☐ No
   If yes, what is that language? _____
3. Did your child attend school in another country? ☐ Yes ☐ No
   If yes: How many years? _____ Which country? _____
4. Has your child been enrolled in a school in the United States? ☐ Yes ☐ No
   If yes, when did your child first enroll in that school? Month _____ Year _____
5. What language (or languages) does your child read? _____
6. What language (or languages) does your child write? _____
7. Has your child ever been in a bilingual or English as a Second Language program? _____
8. If so, what was the last grade in which he/she was enrolled in that program? _____

I understand that my child, _____, will receive English language proficiency testing if he/she speaks a language other than English. I will be notified if my child qualifies for English as a Second Language program services. I understand that **at that time** I have the right to refuse English as a Second Language program services for my child. However, I can request services at a later date.

_____ _____
Parent or Guardian signature Date

2-14-18

Screening Consent Form

The Ages and Stages Questionnaire-3 (ASQ-3) is a screening tool that asks questions about your child's overall and social emotional development, looking at how children are doing in the important areas of communication, physical ability, problem solving, and personal-social skills.

These screens can help identify your child's strengths as well as any areas where your child may need support. The screening should take about 10-20 minutes to answer questions about your child.

Your individual information is protected to ensure confidentiality. Information is entered on a web-based database that is secure and password protected. Identifying information from the screen will be seen only by the developmental screening specialist, who scores your screening and provides the results to you and the teacher.

General information about the ages and results of children's screening scores are computed at the Oakland Intermediate School District in order to better understand the strengths and challenges of the children living in Oakland County.

I have read the above description and give Great Start Oakland and Clawson Schools consent to screen my child(ren).

- ❑ Yes, I do wish to participate
- ❑ No, I do NOT wish to participate

Parent/Guardian Signature	Date
Child's name	Child's name (if applicable)

This material was developed under a grant awarded by the Michigan Department of Education

Child's Name _____

Resource Request and Sharing Form

We understand that having a young child can create a lot of questions for a family. From the time a family is expectiong a child to the time the child enters Pre-Kindergarten there are a lot of changes in the growth and development of the child and the family. With much change, there can be unanswered questions. Please use as much or as little of the following space to share any questions you have about the growth and development of your child or changes your family has experienced. We will use the information to share resources we are aware of that align with your questions.

If you are aware of any resources that are beneficial for other families in our program, please let us know about them in the following space.

This material was developed under a grant awarded by the Michigan Department of Education

Getting to Know More about Your Child

Tell us more about your child to help us support the transition into school. Enrollment is not determined based on responses to these questions.

Please circle the interest areas in our classroom that you think your child will enjoy the most:

Block Area	House Area	Art Area
Toy Area	Reading and Writing Area	Sand and Water Area
Woodworking Area	Movement & Music Area	Computer Area
	Outdoor Area	

Experiences with Language(s)

What language(s) does your family speak? _____

How much experience (exposure) has your child had with the(se) languages? _____

Is your child growing up with two languages? _____ If so, what are the languages? _____

Can you tell me about your child's use of English (if at all)? _____

Experiences:

What are some of the ways your child plays at home? _____

Does your child play with children from other households? _____If yes, how?_____

Has your child ever used: scissors? _____ Glue? _____ Crayons? _____ Paint? _____ Pencil? _____

What other school-type experience has your child had? _____

Approximately how many hours does your child spend daily watching TV? _____

Approximately how many hours does your child spend daily playing video games? _____

Approximately how many hours does your child spend daily on the computer or a tablet? _____

Eating Habits:

At what time does your child eat breakfast? _____ Lunch? _____ Dinner? _____

Between meal snacks? _____ Does your child feed himself/herself? _____

Food Favorites: _____

Food Dislikes: _____

Food Allergies: _____

What foods does your child eat at home? _____

Great Start Readiness Program

This material was developed under a grant awarded by the Michigan Department of Education.

Optional

CLAWSON PRESCHOOL
PARENTAL RELEASE FORM

Dear Parent/Guardian:

Occasionally, for educational purposes, pictures or videotaped recordings will be made in classrooms and/or of students in other schools programs. Some of the pictures or recordings may be used in presentations or used on local cable or broadcast stations or in local newspapers. Your child's name may be mentioned with either a picture or in the videotaped recordings.

PLEASE CIRCLE DO OR DO NOT IN THE FOLLOWING STATEMENTS:

I DO/DO NOT give permission for _____
(Student's Name)
to be included in any videotaped recordings.

I DO/DO NOT give permission for _____
(Student's Name)
to be photographed for the news media or special programs and/or presentations.

I DO/DO NOT give permission for _____
(Student's Name)
photographs and/or videotaped recordings to be put on school related websites.

I understand my child's name may be used in conjunction with any pictures(s) used.

_____ _____
Parent/Guardian Signature Date

CHILD PLACEMENT CONTRACT

Note: This contract is required of all licensed child care centers by R400.5105b of the Michigan Administrative Code. The Michigan Department of Consumer and Industry Services is required to inspect the child care center and enforce the contract based on the terms provided in this contract.

Clawson Public Schools agrees to provide child care services for the following named child:

_____ _____

(Printed Name of Child) (Date of Birth)

[illegible]

The Clawson Public Schools, as a licensed child care facility, will provide the following provisions of the Michigan Administrative Code as required by R 400.5105b:

R400.5102 Licensee.

Rule 102. (2) A licensee shall have the following administrative responsibilities regarding staff:

(b) Develop and implement a written screening policy for all staff and volunteers including parents who have contact with children.

R400.5106 Program.

Rule 106. (1) A center shall provide a program of daily activities and relationships that offers opportunities for the developmental growth of each child in all of the following areas:

(a) Physical development, including large and small muscle.
(b) Social development, including communication skills
(c) Emotional development, including positive self-concept.
(d) Intellectual development

(2) A center shall permit parents to visit the program for the purpose of observing their children at all times.

(3) A center operating with children in attendance for 5 or more hours per day shall provide for daily outdoor play, unless prevented by inclement weather conditions.

(4) A center shall provide child under school age in attendance for 5 or more continuous hours a day with an opportunity to rest.

(5) A center shall provide children less than 3 years of age with an opportunity to rest regardless of the number of hours in care.

(6) A center shall permit children under 12 months of age to eat and sleep on demand.

[R 400.5205 and R 400.5209 apply only to children from birth to 2 ½ years of age as required in Part 2 of these rules.]

R 400.5205 Formula; milk;foods

Rule 205. (1) The requirements of R 400.5110 apply to infant formula and feeding in addition to the requirements of subrules (2) to (11) and (13) of this rule.

(2) When a center provides formula for the child who is on the infant formula, commercially prepared, pre-bottled, ready-to-feed formula shall be provided. A center shall keep a list of formulas it offers and the number of calories per ounce that each formula provides.

(3) A formula shall be iron-fortified for a child who is less than 6 months of age, unless otherwise recommended by the parent or a licensed physician for the individual child. Iron-fortified cereal if not already provided the recommended by the parent or licensed physician for the individual child.

(4) Formula left in a bottle at the end of a feeding shall be discarded with the bottle.

(5) Special formula required for an individual child by the center in commercially prepared, pre-bottled, ready-to-feed units, unless provided by the parent as specified in subrule (12) of this rule.

(6) When formula is discontinued, all of the following provisions shall apply:
  (a) A center provide and use whole homogenized vitamin D-fortified cow's milk, unless otherwise directed by the parent or a licensed physician.
  (b) Milk shall be poured into clean cups or bottles and have sanitized nipples. Excess milk left in a bottle or cup shall be discarded.
  (c) Nipples shall be thoroughly cleaned and sanitized after each feeding and before being used again. This sterilization shall be by boiling the nipples for not less than 5 minutes.
(7) This rule does not preclude a mother form visiting the center in order to breast-feed her child or from sending to the center expressed milk for the child.
(8) A child too young to sit in a highchair or at a feeding table shall be held in a semi-sitting position or placed in an infant seat while being fed.
(9) A child who is unable to hold his or her bottle shall be held when the bottle is given.
(10) Solid foods shall be introduced to the individual child according the parent's or a licensed physician's instructions.
(11) Commercial baby food containers that are opened, and foods prepared in the center which are stored, shall be covered, dated, and labeled as to the contents and refrigerated. The contents shall be used or discarded within a 36 hour period. A child shall not be fed directly from baby food containers if the contents are to be fed to the child at more than 1 sitting or more than 1 child.
(12) When a parent chooses to provide formula or food in accordance with R 400.5110(1)(b), the center shall assure that the food, formula, bottles, nipples, and containers comply with all of the following provisions:
  (a) Formula shall be prepared at the child's home and placed in an assembled bottle unit before being brought to the center.
  (b) Formula, milk, and perishable foods needing refrigeration shall be refrigerated. Formula shall not be stored longer than 24 hours after opening. Foods shall be covered and labeled as to the contents, date of opening, and the specific child for whom its use is intended. Foods other than formula shall be used or discarded within a 36 hour period after opening.
  (c) Each bottle and nipple supplied by a parent shall be used for a single feeding only and then returned to the parent.
  (d) Formula and mild left in a bottle at the end of a feeding shall be discarded.
(13) An exception to subrules (2) and (3) of this rule may be made when a center which provides formula is located in an area where commercially prepared, pre-bottled , ready-to-feed formula is not available for center use and the center is in compliance with all of the following provisions:
  (a) All formula shall be commercially prepared ready-to-feed formula
  (b) All formula shall be poured directly from the opened can of formula into clean bottles with disposable liners.
  (c) All nipples shall comply with either of the following provisions:
    (I) Be disposable nipples, each of which shall be for a single use only be an individual child
    (II) and shall be discarded after use.
    (III) Be reusable nipples, each of which is cleaned after each single use with hot detergent water and rinsed thoroughly. Each reusable nipple shall then be sterilized by boiling fully for not less than 5 minutes in water before reuse.
  (d) Each liner shall be for a single use only by an individual child and shall be discarded after use along with any remaining formula.
  (e) All liner, nipples, formula and other equipment used in bottle preparation shall be prepared, handled, and stored in a sanitary and sterile manner as required to safeguard children.
  (f) Prepared bottles and opened cans of formula shall be refrigerated until used by the child.
  (g) All opened formula which has not been used within the manufacturer's stated use time after opening shall be discarded. All bottles filled with formula and all opened cans of formula shall be dated to show the date and time of the opening of the commercially prepared formula and the manufacturer's stated use time of the formula. An individual formula for an individual child shall be labeled identifying the individual child for whom its use is intended. Bottles liners and disposable nipples of the unused bottles shall be discarded with the formula. Reusable nipples shall be cleaned and sterilized as required in subdivision (c) of this subrule before being used by a child.

Rule 400.5209 Diapering; toilet training plan.
Rule 209. (1) Diapers shall be disposable or from a commercial diaper service. If a child's health condition necessitates that disposable diapers or diapers from a commercial service cannot be used, then an alternative arrangement may be made according to the parent's or a licensed physician's instructions.
(2) Diapering shall be done in the child's own crib or in a designated diapering area.
(3) A center shall maintain a diapering area, and all supplies and equipment shall be maintained in a safe and sanitary manner.
(4) The caregiver shall thoroughly wash his or her hands after each diapering, and after cleaning up bodily fluids, using soap and running water.
(5) A washcloth or towel, or both used in diapering shall not be used subsequently on another part of the body or for any other purpose until laundered.
(6) Toilet training shall be planned cooperatively between the child's primary caregiver and the parent so that the toilet routine established is consistent between the center and the child's home, and at a minimum, shall include washing hands after toilet use. The center shall empty and sanitize all training devices immediately after each use.
(7) The caregiver shall change diapers when soiled or wet.

Upon signing this agreement, the parent, legal guardian or responsible adult and the child care facility agrees to abide by all of the provisions contained in the contract.

In witness wherof, the parties hereto have executed this contract as of the specified date:

Parent, Legal Guardian or Responsible Adult	Clawson Public Schools
	Claire Prost
Signature	Signature
	Claire Prost
Printed Name	Printed Name
	Clawson Preschool Director
Relationship to Child	Title
Date	

HEALTH APPRAISAL

Dear Parent or Guardian: The following information is requested so that the school can work with the parent to meet the physical, intellectual and emotional needs of the child. Fill out the information requested in Section I. Section III may be certified by the transcription of information from the certificate of immunization. The remaining sections are to be completed by a doctor, nurse and dentist. **(BE SURE TO BRING YOUR CHILD'S IMMUNIZATION RECORDS TO THE EXAMINATION.)**

PERSONAL

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

SECTION I - HEALTH HISTORY

Yes	No	Resolved	# Is your child having any of the problems listed below?
☐	☐	☐	1 Allergies or Reactions (for example, food, medication or other)
☐	☐	☐	2 Hay Fever, Asthma, or Wheezing
☐	☐	☐	3 Eczema or Frequent Skin Rashes
☐	☐	☐	4 Convulsions/Seizures
☐	☐	☐	5 Heart Trouble
☐	☐	☐	6 Diabetes
☐	☐	☐	7 Frequent Colds, Sore Throats, Earaches (4 or more per year)
☐	☐	☐	8 Trouble with Passing Urine or Bowel Movements
☐	☐	☐	9 Shortness of Breath
☐	☐	☐	10 Speech Problems
☐	☐	☐	11 Menstrual Problems
☐	☐	☐	12 Dental Problems: Date of Last Exam / /
☐	☐	☐	Other (please describe): _____
☐	☐		Does your child take any medication(s) regularly?

Reason for Medication

_____ / /
Parent/Guardian Signature Date

Birth History:

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

If yes, please describe:

If yes, list medications:

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

SECTION II - PHYSICAL EXAMINATION, INSPECTION, TESTS AND MEASUREMENTS

Required for Child Care and Head Start / Early Head Start

Tests and Measurements

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

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

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

Examinations and/or Inspections

Essential Findings Deviating from Normal:

Exam Date: / /

SECTION III - IMMUNIZATIONS

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

VACCINES (Circle Type)	DATE ADMINISTERED MM/DD/YYYY	
Hepatitis B (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? ☐ Yes ☐ 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: ☐

I certify that the immunization dates are true to the best of my knowledge

Health Professional's Signature _____ Title _____ Date ___/___/___

SECTION IV - RECOMMENDATIONS

(Required for Child Care and Head Start/Early Head Start)

No	Yes	
☐	☐	Is there any defect of vision, hearing or other condition for which the school could help by seating or other actions? If yes, please explain:
☐	☐	Should the child's activity be restricted because of any physical defect or illness? If yes, check and explain degree of restriction(s): ☐ Classroom ☐ Playground ☐ Gymnasium ☐ Swimming Pool ☐ Competitive Sports ☐ Other

Other Recommendations

SECTION V - DENTAL EXAMINATION AND RECOMMENDATIONS (OPTIONAL)

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

Dentist's Signature _____ Date ___/___/___

PHYSICIAN'S SIGNATURE

Examiner's Signature _____ Date ___/___/___ *Examiner's Name (Print or Type)* _____ Degree or License _____

Number & Street _____ City _____ MI ZIP Code _____ (___) Telephone _____

Information required for:

Early On - Hearing and Vision Status; Diagnosis; Health Status

Child Care Licensing - Physical Exam, Restrictions, Immunizations

Head Start/Early Head Start - Determination that child is up-to-date on a schedule of age-appropriate preventive and primary health care, including medical, dental, and mental health. The schedule must incorporate the well-child care visit required by EPSDT and the latest immunizations schedule recommended by the Centers for Disease Control and Prevention, State, tribal, and local authorities. An EPSDT well-child exam includes height, weight, and blood tests for anemia at regular intervals based on age.

****

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.

MEDICATION PERMISSION AND INSTRUCTIONS
CHILD CARE HOMES AND CENTERS
Department of Licensing and Regulatory Affairs
Bureau of Community and Health Systems
Child Care Licensing Division

If you are giving or applying any medication to a child in care, the following must be completed by the parent for **each** medication. An interruption in medication will require a new permission form.

TO BE COMPLETED BY PARENT

I give my permission for _____ (Caregiver, Facility) to give or apply the medication

_____ (Specify, prescribed medication/over the counter product), to my child _____ (Child's Name), as follows:

DIRECTIONS:

1. Date to Begin Giving Medication	2. Date to Stop Medication
3. Times Medication is to be Given	4. Amount (dosage) of Medication Each Time Given
5. Storage of Medication	
6. Other Directions, if Any	
Signature of Parent	Date

TO BE COMPLETED BY THE CAREGIVER GIVING THE MEDICATION:

DATE	TIME	AMOUNT GIVEN	CAREGIVER'S NAME	CAREGIVER'S SIGNATURE

It is recommended this form be reviewed with the parent every 3 months if the medication is ongoing.

LARA is an equal opportunity employer/program.

Child's name _____

Clawson Early Childhood Center
IN-DISTRICT FIELD TRIP
PERMISSION SLIP

Dear Parent/Guardian,

Throughout each school year special field trips are planned to support our curriculum. When field trips are outside of Clawson, your child's teacher will send home a specific permission slip for you to approve and sign.

Since some of our educational field trips are within the Clawson community (the Clawson Performing Arts Center, fire hall, police station, post office, park, etc.) we thought it would be helpful to have one permission slip at the beginning of each school year that you could sign for all field trips within the community of Clawson. You will be notified about trips to the post office, police station, etc., any trip that is more than a few blocks away from our building.

Please read and initial _____ 2024-2025 School Year

My child may participate in all field trips within the Clawson community sponsored by Clawson Early Childhood during the current school year.

While my child is on any field trip it is my understanding that the school district personnel in charge will take all normal precautions to ensure the safety of all students. I further understand that I have the responsibility to see that my child understands they must cooperate and obey the school district personnel in charge of any field trip to the fullest extent possible

PARENT NOTIFICATION OF THE LICENSING NOTEBOOK
Child Care Organizations Act, 1973 Public Act 116
Michigan Department of Licensing and Regulatory Affairs
Child Care Licensing Bureau

CENTER MUST CHECK ONE

☐ The center keeps a licensing notebook containing a summary sheet, all licensing inspections and special investigations, and related corrective action plans for the last 5 years. The licensing notebook is available to parents/guardians during regular business hours. Reports from at least the past three years are available at www.michigan.gov/michildcare.

☒ The center does not keep a licensing notebook, but internet is available onsite. Reports from at least the last three years are available at www.michigan.gov/michildcare.

I have read the above statement issued by Clawson Early Childhood Center
Name of Child Care Center

Child(ren)'s Name(s):	

Parent Name _____

Parent Signature _____ Date _____

LARA is an equal opportunity employer/program.

CLAWSON EARLY CHILDHOOD PARENT HANDBOOK ACKNOWLEDGMENT LETTER

Child(ren)'s Name(s) (Last, First)	Center Name Clawson Early Childhood Center

A written information packet has been provided (online) at the time of enrollment. The packet included all the following information:

- Criteria for admission and withdrawal
- Schedule of operation, denoting hours, days, and holidays during which the center is open and services are provided.
- Fee policy
- Discipline policy
- Food service policy
- Program philosophy
- Typical daily routine
- Parent notification plan for accidents, injuries, incidents, illnesses.
- Exclusion policy for child illnesses.
- Notice of the availability of the center's licensing notebook

- The center does not keep a licensing notebook, but the internet is available onsite. Reports from at least the last three years are available at www.michigan.gov/michildcare.

- Other _____

I certify that I received all of the above items.

_____ _____

Parent Signature Date

Note: A single BCAL-4340 form may be used for all children in the same family

LARA is an equal opportunity employer/program.
Auxiliary aids, services and other reasonable accommodations are available upon request to individuals with disabilities.