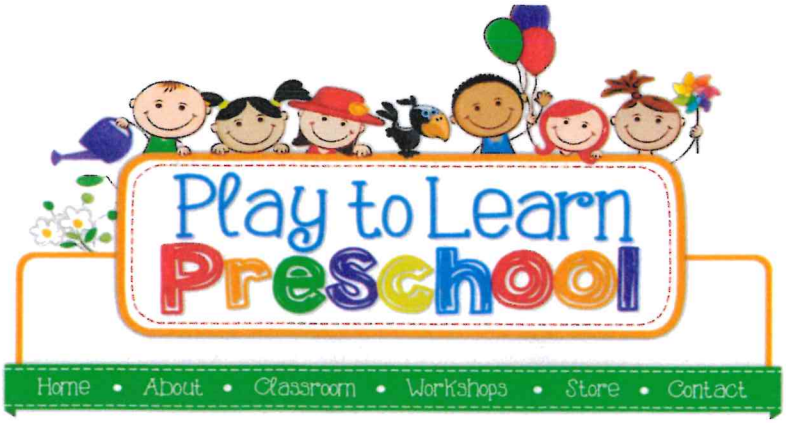

Pre-School is an important & loving bridge between home & school. Your child will have a positive experience in the coming year with us at Salem Lutheran. It should improve your child's ability to cope with unfamiliar situations, develop a sense of achievement & self worth, & sharpen social & academic skills. Additionally, he/she will make new friends & have many new & different learning experiences.

WE HAVE LOTS OF FUN HERE & WE ARE SO GLAD YOU WILL BE JOINING US!

Doors Open at 7:45 – Classes are from 9 am – 11:30 am

IN YOUR REGISTRATION PACKET YOU WILL FIND!

Child Information Record (Including Emergency Contact & Release of Child)
(Every box should have information)

Enrollment Form ... Return ASAP with: $100 Non-Refundable Registration Fee
This will secure your enrollment
$160 Monthly Tuition for Lambs Class (3 year olds)
$200 Monthly Tuition for Lions Class (4 year olds)

Volunteer Screening Form
Photo Release Form
Snack Policy

Health Appraisal This form must be filled out & signed by you & the doctor.
Call to make your appointment for the summer months.
That way the clearance will last the full school year.
We will also need their Shot Record.
The Health Appraisal does not have to be turned in until starting of school.

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 _____, 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

Application for Admission
Salem Lutheran preschool
275 Marvin Street
Coloma, Michigan 49038

Non-refundable registration fee enclosed Ck#_____Amount$_____Date_____

CHILD'S NAME_____ M or F
(Last) (First) (Middle)

CHILD'S ADDRESS_____
(Street) (City) (Zip Code)

HOME PHONE_____BIRTHDAY_____

ALLEGRIES_____

PLEASE STATE ANYTHING ABOUT YOUR CHILD THAT WOULD BE PARTICULARLY HELPFUL FOR THE TEACHER TO KNOW_____

_____

MOTHER'S NAME_____EMPLOYER_____
EMPLOYER PHONE_____
MOTHER'S ADDRESS_____WORK HOURS_____

FATHER'S NAME_____EMPLOYER_____
EMPLOYER PHONE_____
FATHER'S ADDRESS_____WORK HOURS_____

Brothers and sisters (names and ages)_____

Are you currently a member of a Christian Church? _____ Yes _____ No

If "yes," which church do you attend?_____

If "no," are you interested in becoming a member of Salem? _____ Yes _____ No

FAMILY PHYSICIAN_____PHONE_____

PLEASE FILL OUT THE INFORMATION ON THE OPPOSITE SIDE OF THIS SHEET

******INSTRUCTIONS FOR REACHING PARENTS/GUARDIANS IN AN EMERGENCY This is VITAL—Any changes MUST be given to us immediately.***

_____

_____

****For your convenience and ours PLEASE make sure that the above emergency information and the "Child Information"(white) form match, thank you.*

Parent Volunteer Statement-Licensing Requirement

Our preschool program encourages and welcomes parent participation in the classroom and activities. However, to meet our State of Michigan DHS preschool licensing requirements, we must ensure the safety and well-being of our students by carefully screening and monitoring the adults your child may come in contact with.

By signing this document, you are confirming that you have never been involved in a substantiated case of child abuse or neglect or been placed on the DHS Central Registry for child abuse or neglect, or have been convicted of a felony involving harm or threatening harm.

If the preschool does not have this signed statement on file, the State of Michigan, **DHS** preschool licensing regulations require you to **limit interactions with your child only** during any visits to the preschool classroom or activity.

I/we the parent(s) or guardian of _____

1.] Have not been convicted of child abuse or neglect ***and***
2.] Have not been convicted of a felony involving harm or threatened harm.

_____

Parent/Guardian Signature Date

_____

Parent/Guardian Signature Date

Preschool: _____

PHOTO RELEASE

We love Pre-School Memories. As part of our program, we take lots of photos of your child and the class.

The photos that are taken are used for a Memory Book of your Child, Bulletin Boards, Art Projects and Program Promoting Purposes. All photos will be given back to you at the end of the year.

On occasion, we will post pictures of children on social media or in the paper for advertising purposes. Please note that:

No name ... Home Address ... Telephone #
Or other identifiable information will appear with the image.

If you do not wish to grant consent at this time, you will be contacted for permission if a photo of your child is being considered for public use.

I give my permission for Salem Lutheran Pre-School to take pictures of my child, and on occasion, post or publish whatever photo meets the need of the program.

_____

Happy Memories

SNACK POLICY

Our Snack Policy states that as the parent, you will be notified which snacks are being served to children each day. Per the requirements, a snack consists of 2 items from a list provided by the state. Juice is not on their approved list, so we will serve water. All leftover snack items will be returned to you.

The best way to incorporate these requirements is for the Director to set the snack schedule and have parents agree to provide the snack items required for each day. You will be asked to provide an average of 4-6 snacks per year including a birthday snack either close to your child's birthday or a half birthday date. Birthday snacks are the only snacks we make up for missed classes due to snow days, etc.

In the case that a parent forgets a snack, we will provide an alternative snack for the class.

Upon signing this form, you agree to provide the approved snacks set for your day.

Parent signature: _____

Date: _____

HEALTH APPRAISAL

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

PERSONAL

CHILD'S NAME (Last, First, Middle)			DATE OF BIRTH (mm/dd/yy) / /
ADDRESS (Number & Street)	(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			

Birth History:

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

If yes, please describe:

If yes, list medications:

_____ / / _____

Parent/Guardian Signature Date

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.