Cross Lutheran Preschool

200 Ruppert Street, Pigeon, MI 48755, (989)453-3330
crosslutheranschool.org

Tuition Schedule for 2016-2017

Registration/Materials $35
(does **not** apply toward tuition)

Tuition for the school year is divided into 9 monthly payments, according to the following schedule:

2-days weekly	$80 per month
3-days weekly	$110 per month
4-days weekly	$135 per month

Members of Cross Lutheran Church receive
a $10 discount monthly on tuition.

Tuition payments are due during the first week of each month. Please make checks payable to:
Cross Lutheran Preschool

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Welcome to Cross Lutheran Preschool. We are happy to be part of this special time in your child's life, and look forward to serving your family.

In order to ensure a complete registration for your child, please provide the following:

_____ Registration/Materials fee - $35

_____ Copy of birth certificate.

_____ Copy of immunization record.

_____ Completed Child Information Card (white)

_____ Completed Enrollment Form (yellow)

_____ School Physical (purple)
Physicals are due September 1.

Thank you,
Beth Elston, Director

CROSS LUTHERAN PRESCHOOL

CHILD ENROLLMENT FORM

We encourage parents to use this form as a method of communicating about your child-rearing practices and your child's background. Being aware of this information will help our staff do a better job of meeting your child's needs and minimize potential conflicts and confusion.

Child's name: ______________________ Nickname: ______________

Birthdate: __________ Age: ______ Sex: ______ Phone: ____________

Address: ____
street city zip

Other children in the family:

NAME	AGE	SEX	NAME	AGE	SEX

Other members of the household:

NAME	RELATIONSHIP

Pets at home (name and type of animal): ______________________

____

____

Has your child had any previous group experiences? Please describe: __________

____

____

Why do you wish your child to attend the school? ______________

____

____

Has there been any change in the family since the child's birth, such as divorce, death, illness, relocation of family, etc?

____

____

____

____

Does your child have any specific physical needs that we should be aware of (nap, toileting, allergies, medical conditions, etc.)?

____

____

____

____

Does your child have any specific emotional needs that we should be aware of (fears, special blanket, etc.)?

____

____

____

____

What are your child's favorite activities?

____

____

____

____

Any additional information: ____

____

____

______________________________________ ____________________
Signature Date

Parent: section I

Michigan Department of Community Health
HEALTH APPRAISAL

Physician - sections II, IV and signature

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: ____/____/______

Address: ______________ Number & Street ______________ City MI ______ ZIP Code   Today's Date: ____/____/______

Parent/ Guardian: ______________ Last ______________ First ______ Middle   Telephone: (____) ______ Home

Address: ______________ Number & Street ______________ City MI ______ ZIP Code   Telephone: (____) ______ Work

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 Programs: Date of Last Exam: ____/____/____
☐	☐	☐	Other (please describe): ______________

Birth History: ______________

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

If yes, please describe

☐ ☐ Does your child take any medication(s) regularly?

If yes, list medications:

Reason for medication: ______________

______________ 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 Date: ____/____/____	Visual Acuity Muscle Imbalance Other:			
☐	☐	HEARING Date: ____/____/____	Audiometer Other:			
☐	☐	URINALYSIS Date: ____/____/____	Sugar Albumin Microscopic			
☐	☐	BLOOD LEAD LEVEL Date: ____/____/____	Level: ______ µg/dL	➔		

No	Yes	Was child tested for:	Test Results:	Normal	Referred	Under Care
☐	☐	HEIGHT & WEIGHT	Height: ______ Weight: ______			
☐	☐	Other:	Other: ______			
☐	☐	HEMOGLOBIN / HEMATOCRIT	➔			
☐	☐	BLOOD PRESSURE	Reading: ______			
☐	☐	TUBERCULIN Date: ____/____/____	Type: ______ Negative: ☐			

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: ____/____/____

The Michigan Department of Community Health is an equal opportunity employer, services, and programs provider.

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	DATE ADMINISTERED MM/DD/YYYY	
Hepatitis B (Hep B)	1	3
	2	
DTa / DTP / DT Td / Tdap (circle type)	1	5
	2	6
	3	7
	4	8
Haemophilus Influenza type b (HIB)	1	3
	2	4
Polio – IPV / OPV (circle type)	1	3
	2	4
Pneumococcal Conjugate (PCV7)	1	3
	2	4
Rotavirus (Rota)	1	3
	2	
Measles, Mumps, Reubella (MMR)	1	2
Varicella (Chickenpox)	1	2

History of Chickenpox Disease? ☐ Yes ☐ No If yes, date:

VACCINES	DATE ADMINISTERED MM/DD/YYYY	
Hepatitis A (Hep A)	1	2
Influenza TIV/LAIV	1	3
	2	4
Meningococcal MCV4 / MPSV4	1	2
Human Papillomavirus (HPV)	1	3
	2	4
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 child's school or local health department.

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 ______________________ 's teeth. As a result of this examination, my recommendation for treatment is: ______________

child's name

______________________ ___/___/___

Dentist's Signature Date

PHYSICIAN'S SIGNATURE

______________________ ___/___/___ ______________________ ______________

Examiner's Signature Date Examiner's Name (print or type) Degree or License

______________________ ______________________ MI ________ (___)________

Number & Street City 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 schedule of well-child care 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 Departments of Human Services, Education, Community Health; Michigan American Association of Pediatrics; Early Childhood Investment Corporation; Child Care Licensing, Head Start, Michigan State Medical Society; Michigan Association of Osteopathic Physicians and Surgeons

The Michigan Department of Community Health is an equal opportunity employer, services, and programs provider.

CHILD INFORMATION RECORD

State of Michigan Department of Human Services - Bureau of Children and Adult 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

Father/Legal Guardian's Name		Home Phone ( )	Mother/Legal Guardian's Name		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 (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 Special Instructions (Attach additional sheets, if necessary.)	

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.	( )

I give permission to ________________________________, licensed by the Department of Human Services
(Provider's Name)

to secure emergency medical and/or emergency surgical treatment for the above named minor child while in care.

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

Department of Human Services (DHS) will not discriminate against any individual or group because of race, religion, age, national origin, color, height, weight, marital status, sex, sexual orientation, gender identity or expression, political beliefs or disability. If you need help with reading, writing, hearing, etc., under the Americans with Disabilities Act, you are invited to make your needs known to a DHS office in your area.

AUTHORITY: 1973 PA 116
COMPLETION: Required
PENALTY: Rule Violation Citation.