

Cross Lutheran Preschool

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

Tuition Schedule for 2019-2020

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	\$100 per month
3-days weekly	\$132 per month
4-days weekly	\$160 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

Please note that preschool rates, the number of days offered, and other policies are subject to change pending the implementation of a daycare.

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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 card
- _____ Completed Child Information Card (white)
- _____ Completed Enrollment Form (yellow)
- _____ School Physical (green)

Physicals are due September 1.

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. 6-17) Previous editions 4-16, 6-15 and 7-12 may be used until September 30, 2018.

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.)

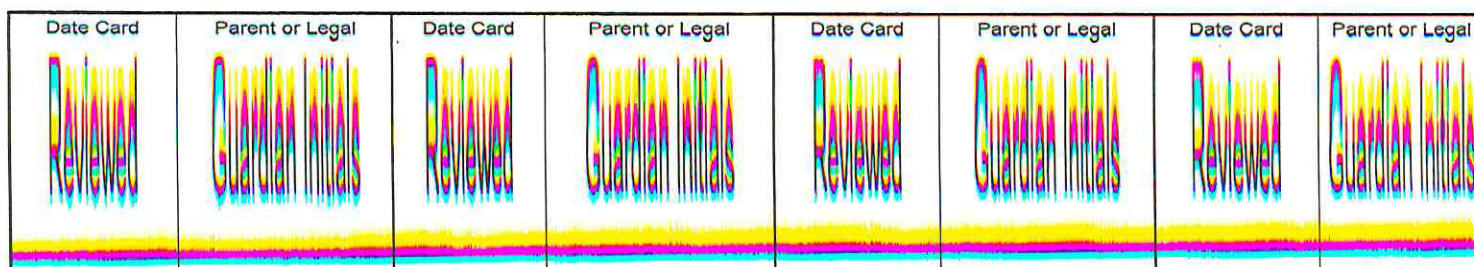
1.	()	2.	()
3.	()	4.	()

Parent/Legal Guardian Initials:

_____ I give permission to Cross Lutheran Preschool, licensed by the Department of Licensing and Regulatory Affairs to secure emergency medical 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 _____



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

Michigan Department of Community Health
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: ____/____/____

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?	Birth History:
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	1	Allergies or Reactions (for example, food, medication or other)	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	2	Hay Fever, Asthma, or Wheezing:	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	3	Eczema or Frequent Skin Rashes	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	4	Convulsions/Seizures	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	5	Heart Trouble	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	6	Diabetes	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	7	Frequent Colds, Sore Throats, Earaches (4 or more per year)	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	8	Trouble with Passing Urine or Bowel Movements	Are there any current or past diagnosis(es): <input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	9	Shortness of Breath	If yes, please describe
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	10	Speech Problems	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	11	Menstrual Problems	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	12	Dental Programs: Date of Last Exam: ____/____/____	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Other (please describe): _____		
<input type="checkbox"/>	<input type="checkbox"/>		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? <input type="checkbox"/> Yes <input type="checkbox"/> No Examiner's Initials: _____

SECTION II - PHYSICAL EXAMINATION, INSPECTION, TESTS AND MEASUREMENTS

Required for Child Care and Head Start / Early Head Start

Tests and Measurements

No	Yes	Was child tested for:	Test results:	Normal	Referred	Under Care	No	Yes	Was child tested for:	Test Results:	Normal	Referred	Under Care
<input type="checkbox"/>	<input type="checkbox"/>	VISION Date: ____/____/____	Visual Acuity Muscle Imbalance Other: _____				<input type="checkbox"/>	<input type="checkbox"/>	HEIGHT & WEIGHT Other: _____	Height: _____ Weight: _____ Other: _____			
<input type="checkbox"/>	<input type="checkbox"/>	HEARING Date: ____/____/____	Audiometer Other: _____				<input type="checkbox"/>	<input type="checkbox"/>	HEMOGLOBIN / HEMATOCRIT BLOOD PRESSURE	Reading: _____			
<input type="checkbox"/>	<input type="checkbox"/>	URINALYSIS Date: ____/____/____	Sugar Albumin Microscopic				<input type="checkbox"/>	<input type="checkbox"/>	TUBERCULIN Date: ____/____/____	Type: _____ Negative: <input type="checkbox"/>			
<input type="checkbox"/>	<input type="checkbox"/>	BLOOD LEAD LEVEL Date: ____/____/____	Level: _____ µg/dL				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: ____/____/____

Copy Card

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		VACCINES	DATE ADMINISTERED MM/DD/YYYY	
Hepatitis B (Hep B)	1	3	Hepatitis A (Hep A)	1	2
	2			2	3
DTa / DTP / DT Td / Tdap (circle type)	1	5	Influenza TIV/LAIV	1	3
	2	6		2	4
	3	7	Meningococcal MCV4 / MPSV4	1	2
	4	8		2	3
Haemophilus Influenza type b (HIB)	1	3	Human Papillomavirus (HPV)	1	3
	2	4		2	4
Polio - IPV / OPV (circle type)	1	3	OTHER Vaccines: Specify Date & Type	Type of Vaccine(s)	Date of Vaccine(s)
	2	4		1	
Pneumococcal Conjugate (PCV7)	1	3		2	
	2	4	3		
Rotavirus (Rota)	1	3	Indicate and attach physician diagnosis or laboratory evidence of immunity as applicable.		
	2		*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.		
Measles, Mumps, Reubella (MMR)	1	2	Parent/Guardian refused immunizations: <input type="checkbox"/>		
Varicella (Chickenpox)	1	2	I certify that the immunization dates are true to the best of my knowledge:		
History of Chickenpox Disease? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, date: _____					
<p align="center">_____ Health Professional's Signature _____ Title _____ / / _____ Date</p>					

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 NA 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 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.

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