Physician is due September 1.

School Physical (green)

Completed Enrollment Form (yellow)

Completed Child Information Card (white)

Copy of Immunization Card

Copy of Birth Certificate

Registration/Materials Fee - $35

Implementation of a daycare.

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

Cross Lutheran Preschool

Each month please make checks payable to:

Tuition payments are due during the first week of

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

4-days Weekly
$160 per month

3-days Weekly
$132 per month

2-days Weekly
$100 per month

Tuition rates according to the following schedule:

Tuition for the school year is divided into 9 monthly
(pays not apply toward tuition)
Registration/Materials $35

Tuition Schedule for 2019-2020

200 Rupper Street, Pigeon, MI 48755  (989)435-3390

Cross Lutheran Preschool

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

Look forward to serving your family.
### 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.

<table>
<thead>
<tr>
<th>For Provider Use Only:</th>
<th>Date of Admission</th>
<th>Date of Discharge</th>
</tr>
</thead>
</table>

### Name of Child (Last, First, Middle Initial)  
Child's Date of Birth  
Address (Number and Street, Building/Apartment Number)  
City  
State  
Zip Code  

<table>
<thead>
<tr>
<th>Parent/Legal Guardian's Name</th>
<th>Home Phone ( )</th>
<th>Parent/Legal Guardian's Name (Optional)</th>
<th>Home Phone ( )</th>
</tr>
</thead>
<tbody>
<tr>
<td>Home Address (if not child's address)</td>
<td>Cell Phone ( )</td>
<td>Home Address (if not child's address)</td>
<td>Cell Phone ( )</td>
</tr>
</tbody>
</table>
| 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.)

---

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.  

Parent/Legal Guardian Initials:  

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

---
CROSS LUTHERAN PRESCHOOL

CHILD ENROLLMENT FORM

We encourage parents to use this form as a method of communicating about your childrearing 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:

<table>
<thead>
<tr>
<th>NAME</th>
<th>AGE</th>
<th>SEX</th>
<th>NAME</th>
<th>AGE</th>
<th>SEX</th>
</tr>
</thead>
<tbody>
<tr>
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<td></td>
</tr>
</tbody>
</table>

Other members of the household:

<table>
<thead>
<tr>
<th>NAME</th>
<th>RELATIONSHIP</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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 ___________________________
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: ___________________________
Parent/Guardian: ___________________________  Last: ___________________________  First: ___________________________  Middle: ___________________________
Date of Birth: __________/________/________
Address: ___________________________  Number & Street: ___________________________  City: ___________________________  MI: ___________________________  Zip Code: ___________________________
Telephone: ___________________________  Home: ___________________________
Telephone: ___________________________  Work: ___________________________

**SECTION I – HEALTH HISTORY**

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

Yes ☐ ☐ No ☐ ☐ Does your child take any medication(s) regularly? 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**

**Tests and Measurements**

<table>
<thead>
<tr>
<th>No</th>
<th>Yes</th>
<th>Was child tested for:</th>
<th>Test results:</th>
<th>Normal</th>
<th>Referred</th>
<th>Under Care</th>
<th>No</th>
<th>Yes</th>
<th>Was child tested for:</th>
<th>Test Results:</th>
<th>Normal</th>
<th>Referred</th>
<th>Under Care</th>
</tr>
</thead>
<tbody>
<tr>
<td>☐</td>
<td>☐</td>
<td>VISION</td>
<td></td>
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<td>☐</td>
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<tr>
<td>☐</td>
<td>☐</td>
<td>Date: __________/<strong><strong><strong><strong>/</strong></strong></strong></strong></td>
<td>Visual Acuity</td>
<td>☐ ☐ ☐</td>
<td>HEIGHT &amp; WEIGHT</td>
<td>Height:</td>
<td>☐ ☐ ☐</td>
<td>Other:</td>
<td>☐ ☐ ☐</td>
<td>Weight:</td>
<td>☐ ☐ ☐</td>
<td>Other:</td>
<td>☐ ☐ ☐</td>
</tr>
<tr>
<td>☐</td>
<td>☐</td>
<td>Other:</td>
<td>Muscle Imbalance</td>
<td>☐ ☐ ☐</td>
<td>☐ ☐ ☐</td>
<td>HEMOGLOBIN / HEMATOCRIT</td>
<td>☐ ☐ ☐</td>
<td>☐ ☐ ☐</td>
<td>☐ ☐ ☐</td>
<td>☐ ☐ ☐</td>
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<td>☐ ☐ ☐</td>
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<tr>
<td>☐</td>
<td>☐</td>
<td>HEARING</td>
<td>Other:</td>
<td>☐ ☐ ☐</td>
<td>BLOOD PRESSURE</td>
<td>Reading:</td>
<td>☐ ☐ ☐</td>
<td>☐ ☐ ☐</td>
<td>☐ ☐ ☐</td>
<td>☐ ☐ ☐</td>
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<tr>
<td>☐</td>
<td>☐</td>
<td>Date: __________/<strong><strong><strong><strong>/</strong></strong></strong></strong></td>
<td>Audimeter</td>
<td>☐ ☐ ☐</td>
<td>TUBERCULIN</td>
<td>Type:</td>
<td>☐ ☐ ☐</td>
<td>Date: __________/<strong><strong><strong><strong>/</strong></strong></strong></strong></td>
<td>☐ ☐ ☐</td>
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<td>☐ ☐ ☐</td>
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<tr>
<td>☐</td>
<td>☐</td>
<td>URINALYSIS</td>
<td>Other:</td>
<td>☐ ☐ ☐</td>
<td>Microscopic</td>
<td>Negative:</td>
<td>☐ ☐ ☐</td>
<td>☐ ☐ ☐</td>
<td>☐ ☐ ☐</td>
<td>☐ ☐ ☐</td>
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<td>☐</td>
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<td>Date: __________/<strong><strong><strong><strong>/</strong></strong></strong></strong></td>
<td>Sugar</td>
<td>☐ ☐ ☐</td>
<td>☐ ☐ ☐</td>
<td>☐ ☐ ☐</td>
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<td>☐</td>
<td>☐</td>
<td>Date: __________/<strong><strong><strong><strong>/</strong></strong></strong></strong></td>
<td>Albumin</td>
<td>☐ ☐ ☐</td>
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<tr>
<td>☐</td>
<td>☐</td>
<td>Date: __________/<strong><strong><strong><strong>/</strong></strong></strong></strong></td>
<td>Microscopic</td>
<td>☐ ☐ ☐</td>
<td>☐ ☐ ☐</td>
<td>☐ ☐ ☐</td>
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<tr>
<td>☐</td>
<td>☐</td>
<td>Date: __________/<strong><strong><strong><strong>/</strong></strong></strong></strong></td>
<td>Level: __________ µg/dL</td>
<td>☐ ☐ ☐</td>
<td>☐ ☐ ☐</td>
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</tbody>
</table>

**Examinations and/or Inspections**

**Essential Findings Deviating from Normal:**

Exam Date: __________/________/________

DCH-3305 (10/09) 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.

<table>
<thead>
<tr>
<th>VACCINES</th>
<th>DATE ADMINISTERED</th>
<th>MM/DD/YYYY</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hepatitis B (Hep B)</td>
<td>1</td>
<td>3</td>
</tr>
<tr>
<td>DTa / DTP / DT</td>
<td>1</td>
<td>5</td>
</tr>
<tr>
<td>Td / Tdap (dose type)</td>
<td>2</td>
<td>6</td>
</tr>
<tr>
<td>Haemophilus Influenza type b (HIB)</td>
<td>4</td>
<td>3</td>
</tr>
<tr>
<td>Polio - IPV / OPV (dose type)</td>
<td>2</td>
<td>4</td>
</tr>
<tr>
<td>Pneumococcal Conjugate (PCV7)</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>Rotavirus (Rota)</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>Measles, Mumps, Rubella (MMR)</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>Varicella (Chickenpox)</td>
<td>1</td>
<td>2</td>
</tr>
</tbody>
</table>

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

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)

☐ ☐ 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: ___________________________