Cross Lutheran Preschool

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

Tuition Schedule for 2018-2019

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	$90 per month
3-days weekly	$120 per month
4-days weekly	$145 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:
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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.

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Class Schedule Choices

3-year-olds:

Two or three days weekly, choice of Tuesday, Wednesday or Thursday.

4-year-olds:

Two, three, or four days weekly, choice of Monday, Tuesday, Wednesday, Thursday. Mondays are reserved for 4-year-olds only.

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Class Schedule Choices

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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.)			

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 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

BCAL-3731 (Rev. 6-17) Previous editions 4-16, 6-15 and 7-12 may be used until September 30, 2018.

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

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?
☐	☐	☐	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?

Reason for medication:

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 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: ____/____/____

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.

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