Dear Parent,

Thank you for considering Trinity Lutheran Church Early Childhood Center for your child's Preschool Education! We love serving families and look forward to having you become part of our Trinity family. You have indicated that you would like to enroll in the Great Start Readiness Program (GSRP). You may begin the enrollment process now, but we cannot finalize enrollment until the State School Bill has been signed and allocations have been announced. This means you will be placed on a waiting list until mid-to-end of August. We will contact you at that time to finish the enrollment process.

GSRP is a state-funded, FREE PreK program for ALL four-year-olds. As a nationally recognized program, Macomb County GSRP provides developmentally appropriate learning in a safe, nurturing, and positive environment, balancing high-quality instruction with play-based learning rich in language and literacy.

Your child must be 4 years old by September 1 of the school year you are enrolling in. Sometimes, GSRP allows us to enroll children who are 4 by December 1, but only if space is available after September 1. We will need a copy of your child's birth certificate. We will also need a copy of your child's immunization record. If you are not current on immunizations or want to request a waiver, you will need to contact the Macomb County Health Department (see attached notice from the Health Department).

We have attached forms and additional information that you will need:

- Registration Form
- Health Appraisal Form
- Placement Contract
- Enrollment Form
- Screening Consent Form
- Parent Notice of Program Measurement

To begin the enrollment process:

- Fill out the Registration Packet
- Call the center to set up an enrollment meeting with Jessica Platte at 586-463-8803
- Please bring the completed registration packet to your meeting with Jessica Platte, along with the completed health appraisal form (signed by a doctor), immunization record or waiver, driver's license, and proof of birth (birth certificate).

To finalize enrollment (in August):

- Wait for a contact from TLC to say that you are on the roster for the GSRP classroom.
- You will receive a letter in the first week of August with information about the school year, along with a list of forms that may still need to be submitted to finalize enrollment.
- Attend the open house during the last week of August (dates provided in August letter)

We look forward to serving your family. If you have any questions, please get in touch with us at 586-463-8803 or tlcecc@trinityct.org.

Sincerely,
Jacqueline Chaney
Early Childhood Director

Trinity Lutheran Church Early Childhood Center

Child Information Record

Great Start Readiness Program

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.

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.

BCAL-3731 (Rev. 7-12) Previous editions 9-09,3-08, 10-07, & 1-06 may be used until 12/31/13.

GSRP Childcare Child Placement Contract (for children who will need childcare before or after GSRP)

For _____ (name of child), I have received and read the Parent Information Booklet and agree to comply with all rules and responsibilities stated in them. I understand that compliance with these rules and responsibilities is a condition of my child's enrollment and part of this contract.

Care will normally begin from _____ to _____ on the following days of the week: _____.
Children may stay for Jesus Time from 3:05 to 3:20 PM, Monday through Friday, at no charge.

The current charge for caring for the above child is $5.90 per hour. A $10 fee will be assessed per child for each 5 minutes your child is in attendance past 6 PM, with a minimum fee of $10. The current charge for returning a check is $35.00. I understand that these charges and rates are subject to change, as they may be updated by the bank. If two checks are returned from the same family, we will no longer accept checks.

Payment to the Provider will be made in the following manner: **by check, money order, cash, or online credit card payment. We bill on Monday for the previous week, and payment is due by Wednesday.** Payment is considered late if not received on this day, and a $20 late fee will be assessed. If payment is not received by the end of the week, you will be reminded that childcare privileges have been suspended until payment is made.

I understand that I must provide the center with immunization records or an approved waiver of immunizations upon enrollment and as immunizations are updated. I must also provide a completed health form upon enrollment and annually thereafter. I assume responsibility for my child's state of health while at TLC Early Childhood Center. I also understand that I will be notified immediately if anything unforeseen occurs.

No modifications can be made to this contract except in writing.

I understand this is a legally binding contract, which I have read. By **signing this agreement, the parent, legal guardian, or responsible adult and the childcare facility agree to abide by all its provisions.** The parties hereto have executed this contract as of the specified date.

Parent, Legal Guardian, or Responsible Adult	**TLC Early Childhood Center**
_____	_____
(Signature)	(Signature)
_____	_____
(Printed Name)	(Printed Name)
_____	ECC Director
(Relationship to Children)	(Title)
DATE_____	DATE_____

HEALTH APPRAISAL

Michigan Department of Health and Human Services

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, dentist, dental therapist, and dental hygienist.
(**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)	Today's Date (mm/dd/yy)
Parent/Guardian (Last, First, Middle)	Home/Cell Phone Number
Address (Number, Street, City, Zip Code)	Work Phone 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	Anaphylaxis
☐	☐		3	Does your child take any medication(s) regularly?
☐	☐	☐	4	Hay Fever, Asthma, or Wheezing
☐	☐	☐	5	Eczema or Frequent Skin Rashes
☐	☐	☐	6	Convulsions/Seizures
☐	☐	☐	7	Heart Trouble
☐	☐	☐	8	Diabetes
☐	☐	☐	9	Frequent Colds, Sore Throats, Earaches (4 or more per year)
☐	☐	☐	10	Trouble with Passing Urine or Bowel Movements
☐	☐	☐	11	Shortness of Breath
☐	☐	☐	12	Speech Problems
☐	☐	☐	13	Menstrual Problems
☐	☐	☐	14	Dental Problems Date of Last Exam _____ **OR** Date of Last Assessment _____
☐	☐	☐		Other (please describe) _____

Birth History

If yes, list medications

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

If yes, please describe

Reason for Medication		
Concussion History		
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

Test and Measurements

Yes	No	Was child tested for	Tests and results	Normal	Referred	Under care
☐	☐	Vision Date _____	Visual Acuity			
			Muscle Imbalance			
			Other			
☐	☐	Hearing Date _____	☐ Audiometer (R= Right, L=Left)	R/L	R/L	
			☐ OAE (R= Right, L=Left)	R/L	R/L	
			☐ Other (R= Right, L=Left)	R/L	R/L	
☐	☐	Urinalysis	Sugar			
			Albumin			
			Microscopic			
☐	☐	Blood Lead Level Date _____	Level _____ ug/dl			

Note: All children in Medicaid need to be tested at 1 and 2 years of age, or once between 3 and 6 years of age if not previously tested. All children, regardless of Medicaid status, should be tested at those same ages if they live in an area where lead risk is high.

☐	☐	Height & Weight	Height			
			Weight			
		Other _____	Other _____			
☐	☐	Hemoglobin/Hematocrit	⇨			
☐	☐	Blood Pressure	Reading _____			

Complete pediatric tuberculosis risk assessment available at:
https://www.michigan.gov/documents/mdhhs/4._MI_Pediatric_TB_Risk_Assessment_661537_7.pdf **OR** feel free to use the attached QR code instead of the full link text.

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 based on this information.*

Vaccines (Circle Type)	Date Administered mm/dd/yy		Vaccines (Circle Type)	Date Administered mm/dd/yy	
Hepatitis B (HepB)	1	3	Hepatitis A (HepA)	1	3
	2	4		2	
DTaP/DTP/DT/Td	1	4	Influenza (IIV/LAIV)	1	3
	2	5		2	4
	3	6	Meningococcal MenACWY (MCV4)	1	3
				2	
Tdap	1		Meningococcal B (Bexsero, Trumenba)	1	3
				2	
Haemophilus Influenzae type b (HIB)	1	3	Human Papillomavirus (9vHPV, 4vHPV, 2vHPV)	1	3
				2	
	2	4	Additonal Vaccines Specify Date & Type	Type of Vaccine(s)	Date of Vaccine(s)
Polio (IPV/OPV)	1	4		1	
	2	5		2	
	3			3	
Pneumococcal Conjugate (PCV7/PCV13)	1	3	Indicate and attach physician diagnosis or laboratory evidence of immunity as applicable.		
	2	4			
Rotavirus (RV1/RV5)	1	3	***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.		
	2				
Measles, Mumps, Rubella (MMR/MMRV)	1	3			
	2				
Varicella (Chickenpox), (Var, MMRV)	1	2			
History of Chickenpox Disease? ☐ Yes ☐ No If yes, date _____			Parent/Guardian refused recommended immunizations at visit: ☐		

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)

Yes	No	
☐	☐	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 EXAM OR ASSESSMENT RECOMMENDATIONS (OPTIONAL)

Child's Name	Has received ☐ Dental Exam	☐ Dental Assessment
Findings and Recommendation (Check all that apply) ☐ No Urgent Needs ☐ Routine Care Needed ☐ Treated Decay ☐ Restorative/Urgent Needs for Dental Care ☐ Untreated Decay ☐ Further Referral for Specialist		
Signature		Date
Check One ☐ Dentist ☐ Dental Therapist ☐ Dental Hygienist		

PHYSICIAN'S SIGNATURE

Examiner's Signature	Date	Examiner's Name (Print)		Degree or License
Number & Street	City	MI	Zip Code	Telephone Number

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 preventative and primary health care, including medical, dental, and mental health. The schedule must incorporate the well-childcare 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.

Childcare and Biblical Instruction

Dear GSRP Applicant,

Trinity Lutheran Early Childhood Center is happy to offer childcare after the GSRP classroom hours.

Childcare is available Monday thru Friday from 3:20 PM to 6:00 PM and will take place in the GSRP classroom. Please note that childcare may not be available during scheduled breaks, including spring break, parent-teacher conferences, holiday breaks or weather-related closures

Childcare is offered at an hourly rate of $5.90 per hour. Billing for the previous week is completed Mondays, and you will be notified of the charges. Payment is due Wednesday of the same week. Families may qualify for a childcare subsidy through the State of Michigan. If approved, we will bill the state and notify you of your co-pay amount for the previous week on Monday.

Trinity's mission is to make fully devoted followers of Jesus through Christ-centered care and education of children. While we are unable to share Biblical instruction during GSRP classroom hours, we are happy to provide care from 3:05 – 3:20 PM at no charge. During this time, we will provide Biblical teaching in the form of age appropriate Jesus Time activities which will include telling of the Bible accounts, songs, finger-plays, etc. We welcome all children to participate. Childcare charges will be assessed after 3:20 PM.

If you would like to take advantage of the childcare program, please fill out the attached contract and indicate the days and hours that your will use this program so that we can plan for staffing and activities. If you would like to participate in Jesus time, just tell your child's teacher. You will not be billed for that time.

Sincerely,

Jacqueline Chaney

Early Childhood Director

Great Start Readiness Program
Enrollment Form

Child's Legal Name:

Last _____ First _____ Middle Name_____

Birthdate ____/____/_____ Sex: Male___ Female ___ Home Language: _____

Parent/Guardian Name_____ Parent/Guardian Name _____

Phone Number _____ Phone Number _____

Address _____ City _____ Zip _____

Resident School District_____

Email Address_____

Email Address_____

Race:

____ American Indian or Alaska Native
____ Asian American
____ Black or African American
____ Native Hawaiian or other Pacific Islander
____ White
____ Hispanic or Latino

LIST ALL PERSONS WHO LIVE IN THE HOME
For any children 17 and under, please also include birthdate

Name	Birthdate	Relationship

Please self-report your gross annual household income:	

Please check all that apply:

	PRIORITIZATION FACTORS
	Homeless
	Foster Care
	IEP (General Education Setting)

I hereby affirm the information provided in this form is true to the best of my knowledge and belief

_____ _____

Parent/Guardian Signature Date

Screening Consent Form

The first 5 years of life set the stage for success in school and for a life time.

The Ages & Stages Questionnaire-3 (ASQ-3) and the Ages & Stages-Social Emotional (ASQ-SE) are screening tools that ask questions about your child's overall and social emotional development, looking at how children are doing in the important areas of communication, physical ability, social skills and problem-solving skills.

These screens can help identify your child's strengths, as well as, any areas where your child may need support. The screening should take about 10-20 minutes to answer questions about your child.

Your individual information is protected to ensure confidentiality. Information is entered on a web based database that is secure and password protected. Identifying information from the screen will be seen only by the developmental screening specialist, who scores your screening and provides the results to you.

General information about the ages and results of children's screening scores are compiled at the Macomb Intermediate School District in order to better understand the strengths and challenges of the children living in Macomb County.

I have read the above description and give Great Start Macomb and Trinity Lutheran Church Early Childhood Center consent to screen my child(ren).

☐ Yes, I do wish to participate

☐ No, I do NOT wish to participate

_____ _____

Parent/Guardian Signature Date

_____ _____

Child's name & birth date Child's name & birth date

_____ _____

Child's name & birth date Child's name & birth date

Great Start Readiness Program
Michigan's Nationally Recognized Pre-K Program

PreK for ALL
Bright start for kids.
Brighter future for Michigan.

MISD
Macomb Intermediate School District

Parent Notice of Program Measurement*

_____ is required to work with the Michigan Department of Lifelong Education, Advancement, and Potential (MiLEAP) to measure the effect of the state-wide Great Start Readiness Program (GSRP). Information is sometimes collected about GSRP staff, enrolled children, and their families. Program staff or a representative from MiLEAP might:

- Ask parents questions about their child and family.
- Observe children in the classroom.
- Measure what children know about letters, words, and numbers.
- Ask teachers how children are learning and growing.

Information from you and about your child will not be shared with others in any way that you or your child could be identified. It is protected by law.

Questions?

Contact: MiLEAP-GSRP@Michigan.gov or (517)241-7004
Or
MiLEAP, Office of Early Education,
105 W. Allegan Street, Lansing, MI 48933

*Provided to parents upon enrollment.

_____ _____
Parent Signature Date

_____ _____ _____
GSRP Staff Signature Position/Title Date