

# GSRP PreK Application

## 2026-2027

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### Qualifications for GSRP:

- Your child must be 4-years-old (but not yet 5-years-old) by September 1, 2026  
*We can accept children who turn 4 between September 2 and December 1, but they can only be enrolled after September 1, if there is space available*
- You must live in Berrien County  
*Families from neighboring counties may apply, but must complete a Cross County Prior Approval form*

### Prioritization Factors:

- Income
- Homelessness\*
- Foster Care Placement\*
- Individualized Education Program (IEP)

*Each applicant will be ranked by the family's federal poverty level (FPL), and programs will enroll children in the lowest FPL brackets first. Children who are experiencing homelessness, are in foster care, have an IEP, or were previously enrolled in Strong Beginnings are prioritized regardless of income.*

*\*Children whose household income is at or below 100% FPL, who are experiencing homelessness, or who are in foster care qualify to be served by Head Start, and must apply there first. Please contact Flowers Early Learning at [flowersearlylearning.org](http://flowersearlylearning.org) or 1-800-792-0366. If a family qualifies for Head Start but wishes to be served by GSRP, the GSRP site must first seek approval from Head Start.*

### Required Documentation:

- Proof of Age** - Such as a birth certificate, passport, immigration record, or baptismal certificate
- Proof of Residency** - Such as a driver's license, rent receipt, utility bill, or letter from shelter or host (if between homes)
- Child Information Record**
- IEP, if applicable
- Health Appraisal Form - *Completed by a medical provider, must be submitted within 30 days after the child's start date*

These materials were developed under a grant awarded by MiLEAP

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## GSRP Preschool Locations in Berrien County

*Please note - acceptance into a GSRP classroom does not guarantee that you will be accepted into that school's Kindergarten or Young 5's program, you will have to follow the process or school of choice process per school.*

<b>School Districts</b>		
<p><b>Benton Harbor Area Schools</b> Discovery Enrichment Center 465 S. McCord Street - Benton Harbor Phone - (269) 605-1601 Email - <a href="mailto:Sandra.tyler@bhas.org">Sandra.tyler@bhas.org</a> Website - <a href="http://dec.bhas.org/o/dec">dec.bhas.org/o/dec</a> <b>Full Day Program, Monday-Thursday</b> Transportation provided within District</p>	<p><b>Benton Harbor Charter School Academy</b> 455 Riverview Drive, Suite 1 - Benton Harbor Phone - (269) 925-3807 ext. 164 Email - <a href="mailto:nicoleedale@choiceschools.com">nicoleedale@choiceschools.com</a> Website - <a href="http://www.bentonharborcharter.com">www.bentonharborcharter.com</a> <b>Full Day Program, Monday-Thursday</b> Transportation provided within District</p>	<p><b>Berrien Springs Public Schools</b> 430 W. Mars Street. - Berrien Springs Phone - (269) 473-0703 Email - <a href="mailto:jwallace@homeoftheshamrocks.org">jwallace@homeoftheshamrocks.org</a> or <a href="mailto:csherman@homeoftheshamrocks.org">csherman@homeoftheshamrocks.org</a> <b>Half Day Program, Monday-Thursday</b> <b>Full Day Program, Monday-Thursday</b> Transportation provided within District</p>
<p><b>Brandywine Community Schools</b> 1620 LaSalle Ave. - Niles Phone - (269) 684-6511 Email - <a href="mailto:mhigh@brandywinebobcats.org">mhigh@brandywinebobcats.org</a> Website - <a href="http://www.brandywinebobcats.org">www.brandywinebobcats.org</a> <b>Full Day Program, Monday-Thursday</b></p>	<p><b>Buchanan Community Schools</b> 109 Ottawa St. - Buchanan Phone - (269) 695-8409 Email - <a href="mailto:ejohnson@buchananschools.com">ejohnson@buchananschools.com</a> Website - <a href="http://www.buchananschools.com">www.buchananschools.com</a> <b>Full Day Program, Monday-Thursday</b> Transportation provided within District</p>	<p><b>Coloma Community Schools</b> 262 S. West Street - Coloma Phone - (269) 468-2424 Email - <a href="mailto:rpounders@ccs.coloma.org">rpounders@ccs.coloma.org</a> Website - <a href="http://ces.coloma.org">ces.coloma.org</a> <b>Extended Week Program, Monday-Friday</b> Transportation provided within District</p>
<p><b>Countryside Academy</b> 4722 Meadowbrook Road - Benton Harbor Phone - (269) 944-3319 ext. 219 Email - <a href="mailto:mbeckmann@countrysideacademy.org">mbeckmann@countrysideacademy.org</a> Website - <a href="http://www.countrysideacademy.org">www.countrysideacademy.org</a> <b>Full Day Program, Monday-Thursday</b> Transportation provided within District</p>	<p><b>Eau Claire Public Schools</b> 6238 West Main Street - Eau Claire Phone - (269) 461-6191 Email - <a href="mailto:jrumsey@eauclaireps.com">jrumsey@eauclaireps.com</a> Website - <a href="http://eauclaireps.com">eauclaireps.com</a> <b>Full Day Program, Monday-Thursday</b> Transportation provided within District</p>	<p><b>Watervliet Public Schools</b> 287 Baldwin Ave. - Watervliet Phone - (269) 463-0820 Email - <a href="mailto:twilliams@watervlietps.org">twilliams@watervlietps.org</a> Website - <a href="http://www.watervlietps.org">www.watervlietps.org</a> <b>Full Day Program, Monday-Thursday</b></p>

<b>Community Based Organizations</b>		
<p><b>The Blessed Noah's Ark Day Care</b> 1844 Colfax Ave. - Benton Harbor Phone - (269) 252-5112 Email - <a href="mailto:tynishamurphy22@gmail.com">tynishamurphy22@gmail.com</a> <b>Full Day Program, Monday-Thursday</b> Transportation provided</p>	<p><b>The Children's Center - Niles</b> 210 Main Street - Niles Phone - (269) 683-0405 Email - <a href="mailto:kelsey@weloveourfamilies.com">kelsey@weloveourfamilies.com</a> Website - <a href="http://www.thechildrenscenterinc.com/preschool2.html">www.thechildrenscenterinc.com/preschool2.html</a> <b>Full Day Program, Monday-Thursday</b></p>	<p><b>The Children's Center - Peace Boulevard</b> 219 Peace Blvd - St. Joseph Phone - (269) 683-0405 Email - <a href="mailto:kelsey@weloveourfamilies.com">kelsey@weloveourfamilies.com</a> Website - <a href="http://www.thechildrenscenterinc.com/preschool2.html">www.thechildrenscenterinc.com/preschool2.html</a> <b>Full Day Program, Monday-Thursday</b></p>
<p><b>Immanuel EC Development Center</b> 9650 Church Street - Bridgman Phone - (269) 465-6031 ext. 114 Email - <a href="mailto:barba@immanuelbridgman.org">barba@immanuelbridgman.org</a> <b>Full Day Program, Monday-Thursday</b></p>	<p><b>Lylabugs &amp; Buttons</b> 1924 Territorial Road - Benton Harbor Phone - (269) 925-7167 Email - <a href="mailto:Lylabuttons@yahoo.com">Lylabuttons@yahoo.com</a> <b>Full Day Program, Monday-Thursday</b> Transportation provided</p>	<p><b>Montessori Children's Center</b> 1000 Miners Road - St. Joseph Phone - (269) 256-4456 Email - <a href="mailto:kelsey@weloveourfamilies.com">kelsey@weloveourfamilies.com</a> Website - <a href="http://montessorichildrenscenter.com/">montessorichildrenscenter.com/</a> <b>Extended Week Program, Monday-Friday</b></p>
<p><b>Stevensville United Methodist Children's Center</b> 5506 Ridge Road - Stevensville Phone - (269) 429-1069 Email - <a href="mailto:director2.sumcc@gmail.com">director2.sumcc@gmail.com</a> <b>Full Day Program, Monday-Thursday</b></p>	<p><b>Trinity Lutheran - Berrien Springs</b> 9123 George Avenue - Berrien Springs Phone - (269) 473-1811 Email - <a href="mailto:school@trinityberrien.org">school@trinityberrien.org</a> Website - <a href="http://www.trinityberrien.org/daycare">www.trinityberrien.org/daycare</a> <b>Full Day Program, Monday-Thursday</b></p>	<p><b>Trinity Lutheran Early Childhood Center</b> 613 Court Street - St. Joseph Phone - (269) 983-0040 Email - <a href="mailto:jennifer.revnnells@discovertrinity.org">jennifer.revnnells@discovertrinity.org</a> Website - <a href="http://www.trinitystjoe.org">www.trinitystjoe.org</a> <b>Full Day Program, Monday-Thursday</b></p>
<p><b>YMCA of Greater Michiana - BH/SJ YMCA</b> 3655 Hollywood Rd - St. Joseph Phone - (269) 428-9622 Email - <a href="mailto:kfreve@ymcagm.org">kfreve@ymcagm.org</a> Website - <a href="http://www.ymcagm.org/GSRP">www.ymcagm.org/GSRP</a> <b>Half Day Program, Monday-Thursday</b> <b>Full Day Program, Monday-Thursday</b> <b>Extended Week Program, Monday-Friday</b></p>	<p><b>YMCA of Greater Michiana - Northside Child Development Center</b> 2020 N. Fifth Street - Niles Phone - (269) 683-1982 Email - <a href="mailto:mskalla@ymcagm.org">mskalla@ymcagm.org</a> Website - <a href="http://www.ymcagm.org/GSRP">www.ymcagm.org/GSRP</a> <b>Half Day Program, Monday-Thursday</b> <b>Full Day Program, Monday-Thursday</b> <b>Extended Week Program, Monday-Friday</b> Transportation provided</p>	

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# BERRIEN COUNTY GSRP APPLICATION 2026-2027

Completing an application doesn't automatically enroll you into GRSP. All applications/enrollments are pending per review of qualifications and the state GSRP budget. All final notifications will come from teachers/sites prior to the fall start.

**PROGRAM PREFERENCE**

- |   |  |   |
|---|--|---|
| <input type="checkbox"/> Benton Harbor Area Schools         | <input type="checkbox"/> Benton Harbor Charter School  | <input type="checkbox"/> Berrien Springs Public Schools |
| <input type="checkbox"/> The Blessed Noah's Ark             | <input type="checkbox"/> Brandywine Community Schools  | <input type="checkbox"/> Buchanan Community Schools     |
| <input type="checkbox"/> The Children's Center - Niles      | <input type="checkbox"/> The Children's Center - Peace | <input type="checkbox"/> Coloma Community Schools       |
| <input type="checkbox"/> Countryside Academy                | <input type="checkbox"/> Eau Claire Public Schools     | <input type="checkbox"/> Immanuel EC Development Center |
| <input type="checkbox"/> Lylabugs & Buttons                 | <input type="checkbox"/> Montessori Children's Center  | <input type="checkbox"/> Stevensville United Methodist  |
| <input type="checkbox"/> Trinity Lutheran - Berrien Springs | <input type="checkbox"/> Trinity Lutheran - St. Joseph | <input type="checkbox"/> Watervliet Public Schools      |
| <input type="checkbox"/> YMCA - Northside                   | <input type="checkbox"/> YMCA - BH/SJ YMCA             |   |

**CHILD INFORMATION**

Child's Legal Name: \_\_\_\_\_ Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_  
First Name Middle Name Last Name mm dd yyyy

Gender:  Male  Female

Ethnicity: Hispanic or Latino  Yes  No

Race: American  African American or Black  Indian or Alaska Native  Asian  Hispanic  
 Native Hawaiian or Pacific Islander  Caucasian or White  Two or more races

Address \_\_\_\_\_ City \_\_\_\_\_ Zip \_\_\_\_\_ County \_\_\_\_\_

Phone Number: \_\_\_\_\_ School District of Residence: \_\_\_\_\_

Did the child participate in Strong Beginnings in the 2025/2026 school year?  Yes  No

**FAMILY INFORMATION**

Child lives with:  Both Parents  Mother  Father  Joint Custody (if joint, Physical or Legal, Explain) \_\_\_\_\_  
 Legal Guardian  Grandparents  Foster Care  Other: Explain \_\_\_\_\_

Parent/guardian Name 1: \_\_\_\_\_  
 Parent/guardian date of birth: \_\_\_\_\_  
 Address: (if different from above): \_\_\_\_\_  
 Current Employer: \_\_\_\_\_  
 Employers Address: \_\_\_\_\_  
 Primary Phone#: \_\_\_\_\_  
 Alternative Phone#: \_\_\_\_\_  
 Email: \_\_\_\_\_

Parent/guardian Name 2: \_\_\_\_\_  
 Parent/guardian date of birth: \_\_\_\_\_  
 Address: (if different from above): \_\_\_\_\_  
 Current Employer: \_\_\_\_\_  
 Employers Address: \_\_\_\_\_  
 Primary Phone#: \_\_\_\_\_  
 Alternative Phone#: \_\_\_\_\_  
 Email: \_\_\_\_\_

**EMERGENCY CONTACTS other than parent/guardian**

- |    |      |                |      |       |              |                       |
|----|------|----------------|------|-------|--------------|-----------------------|
| 1. |      |                |      |       |              |                       |
|    | Name | Street Address | City | State | Phone Number | Relationship to child |
| 2. |      |                |      |       |              |                       |
|    | Name | Street Address | City | State | Phone Number | Relationship to child |



## INCOME & PROGRAM ELIGIBILITY FACTORS

Total household income: \$\_\_\_\_\_ Number in Household: \_\_\_\_\_  
If you do not provide this information, your child cannot be enrolled until after August 1.

Is the child experiencing homelessness?  Yes  No

Is the child in foster care?  Yes  No

Does the child have an Individualized Education Program (IEP)?  Yes  No  
If yes, a copy must be provided.

Parent/Guardian Signature \_\_\_\_\_ Date \_\_\_\_\_

### FOR OFFICE USE ONLY - For enrollment prioritization and PowerSchool documentation

#### % FPL Bracket:

- 01: 0-50%  
 Approved for GSRP by HS
- 02: 51-100%  
 Approved for GSRP by HS
- 03: 101-150%
- 04: 151-200%
- 05: 201-250%
- 06: 251-300%
- 08: 301-350%
- 09: 351-400%
- 10: 401-450%
- 11: 451% and above

#### Eligibility Factors:

- A: Homelessness (placed in FPL Bracket 01)
- B: Foster Care (placed in FPL Bracket 01)
- C: IEP (placed in FPL Bracket 01)

#### Automatic Enrollment:

- Strong Beginnings Participant

Date Application was Received: \_\_\_\_\_

Order in Which Application was Received: \_\_\_\_\_

Application Prioritization Rank #: \_\_\_\_\_

#### I verify that I have reviewed the following documentation with the family:

- Proof of Age** - Such as a birth certificate, passport, immigration record, or baptismal certificate
- Proof of Residency** - Such as a driver's license, rent receipt, utility bill, or letter from shelter or host (if between homes)
- IEP - If applicable

\_\_\_\_\_  
GSRP Staff Signature

\_\_\_\_\_  
Date of Verification

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# Berrien RESA Photo Release Form for GSRP Students

- I **give permission** for my son/daughter photo/image to be used. Please complete the form below
- I **do not give permission** for my son/ daughter photo/image to be used. However, please complete the Guardian's name and Minor's name sections as well as sign and date the form.

I, \_\_\_\_\_, give the GSRP school/site, Berrien RESA and its affiliated programs permission to use the photo/image/video of the minor named below and grant the GSRP school/site and Berrien RESA all rights to use these photo/image/video in any medium for educational, promotional, advertising or other purposes that support the mission of the District. I agree that all rights to the photo/image/video belong to GSRP/Berrien RESA.

Guardian's Name: \_\_\_\_\_

Minor's Name: \_\_\_\_\_

Parent/Guardian's Signature: \_\_\_\_\_

Date: \_\_\_\_\_

Address: \_\_\_\_\_

Phone: \_\_\_\_\_

Email: \_\_\_\_\_

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# GSRP Underage Consideration

**\*\*\*\*Only complete if your child will turn 4 after September 1 - December 1\*\*\*\***

GSRP Underage Eligibility Consideration-Special Circumstances for Children turning 4 **after** September 1st - December 1st.

I understand that a child who turns 4 years old **after** September 1st - December 1<sup>st</sup> can be considered for enrollment in the Free Preschool in Berrien County by requesting this Special Consideration.

I also understand that the intention of the Great Start Readiness Preschool program is to be provided the year before a child enters kindergarten, therefore I am requesting that eligibility for enrollment into a Great Start Readiness Preschool program be considered for my child because I plan to request early entry into kindergarten the following year.

\_\_\_\_\_ and \_\_\_\_\_  
Child's full name Date of Birth

I understand that this does not guarantee my child a classroom placement in GSRP for the school year and that I will be notified of the enrollment status after **September 1**.

\_\_\_\_\_  
Parent Signature

\_\_\_\_\_  
Date

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2/2/26

# CHILD INFORMATION RECORD

State of Michigan - Department of Lifelong Education, Learning, and Potential - 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.

<b>For Provider Use Only:</b>		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	Primary Phone ( )	Parent/Legal Guardian's Name (Optional)	Primary Phone ( )
Home Address (if not child's address)	2 <sup>nd</sup> Phone (if applicable) ( )	Home Address (if not child's address)	2 <sup>nd</sup> Phone (if applicable) ( )
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/or Special Instructions? No <input type="checkbox"/> Yes <input type="checkbox"/> If yes, explain: (Attach additional sheets, if necessary.)			

CCL-3731 (Rev. 6/7/2024) Previous editions 7-18, 4-21, & 3-22 may be used

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.	( )
5.	( )	6.	( )

**Parent/Legal Guardian Initials:**

\_\_\_\_\_ I give permission to \_\_\_\_\_, licensed by the Department of Lifelong Education, Advancement, and Potential, to secure emergency medical treatment 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

CCL-3731 (Rev. 6/7/2024) Previous editions 7-18, 4-21, & 3-22 may be used



**MDHHS-3305, HEALTH APPRAISAL**  
Michigan Department of Health and Human Services (MDHHS)  
(Revised 7-24)

**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 1. Section 4 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).**

**SECTION 1 – 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 2 – 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. Anaphylaxis	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	3. Does your child take any medication(s) regularly?	If yes, list medications
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	4. Hay Fever, Asthma, or Wheezing	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	5. Eczema or Frequent Skin Rashes	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	6. Convulsions/Seizures	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	7. Heart Trouble	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	8. Diabetes	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	9. Frequent Colds, Sore Throats, Earaches (4 or more per year)	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"/>	10. Trouble with Passing Urine or Bowel Movements	If yes, describe



<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	11. Shortness of Breath	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	12. Speech Problems	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	13. Menstrual Problems	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	14. Dental Problems Date of Last Exam           OR Date of Last Assessment	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	15. Other (describe)	

Reason for Medication

Concussion History

Parent/Guardian Signature

Date

Was the health history reviewed by a health professional?

Examiner's Initials

Yes       No

**SECTION 3 - PHYSICAL EXAMINATION, INSPECTION, TESTS AND MEASUREMENTS**

Required for Child Care and Head Start / Early Head Start

**Test and Measurements**

Yes	No	Was child test for	Tests and results	Normal	Referred	Under Care
<input type="checkbox"/>	<input type="checkbox"/>	Vision	Visual Acuity	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
		Date	Muscle Imbalance	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
			Other	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	Hearing	<input type="checkbox"/> Audiometer (R= Right, L=Left)			
		Date	<input type="checkbox"/> OAE (R= Right, L=Left)			
			<input type="checkbox"/> Other (R= Right, L=Left)			
<input type="checkbox"/>	<input type="checkbox"/>	Urinalysis	Sugar	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
			Albumin	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
			Microscopic	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	Blood Lead Level	Level           ug/dl	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
		Date				

**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.

<input type="checkbox"/>	<input type="checkbox"/>	Height & Weight	Height	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
			Weight	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	Other	Other	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	Hemoglobin/Hematocrit	⇒	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	Blood Pressure	Reading	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Complete pediatric tuberculosis risk assessment available at:  
[https://www.michigan.gov/documents/mdhhs/4\\_MI\\_Pediatric\\_TB\\_Risk\\_Assessment\\_661537\\_7.pdf](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 4 – IMMUNIZATIONS**

Statements such as "UP-TO-DATE" or "COMPLETE" will not be accepted. Admission to school may be denied based on this information.\*

Vaccines (Select Type)	Date Administered (mm/dd/yy)		
Hepatitis B (HepB)	1.	2.	3.
	4.		
DTaP/DTP/DT/Td	1.	2.	3.
	4.	5.	6.
Tdap	1.		
<i>Haemophilus Influenzae</i> type b (HIB)	1.	2.	3.
	4.		
Polio (IPV/OPV)	1.	2.	3.
	4.		
Pneumococcal Conjugate (PCV)	1.	2.	3.
	4.		
Rotavirus (RV1/RV5)	1.	2.	3.
Measles, Mumps, Rubella (MMR/MMRV)	1.	2.	3.
Varicella (Chickenpox), (Var, MMRV)	1.		
Hepatitis A (HepA)	1.	2.	3.

Influenza (IIV/LAIV)	1.	2.	3.
	4.		
Meningococcal (MCV4, MenABCWY)	1.	2.	3.
Meningococcal B (Bexsero, Trumenba, MenABCWY)	1.	2.	3.
Human Papillomavirus (HPV)	1.	2.	3.

**Additional 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 provider office for medical waiver forms and through your local health department for nonmedical waiver forms.

History of Chickenpox Disease? If yes, date  
 Yes     No

Parent/Guardian refused recommended immunizations at visit.

I certify that the immunization dates are true to the best of my knowledge

Health Professional Signature      Title      Date

**SECTION 5 - 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?  
 Yes     No

If yes, explain

Should the child's activity be restricted because of any physical defect or illness?  
 Yes     No

Check all that apply

<input type="checkbox"/> Classroom	<input type="checkbox"/> Playground	<input type="checkbox"/> Gymnasium
<input type="checkbox"/> Swimming Pool	<input type="checkbox"/> Competitive Sports	<input type="checkbox"/> Other

If yes, explain degree of restriction(s)

Other Recommendations

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**SECTION 6 - DENTAL EXAM OR ASSESSMENT RECOMMENDATIONS**

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Child's Name \_\_\_\_\_ Type of Service  
 Dental Exam  Dental Assessment

Findings (Check all that apply)  
 No findings  Treated Decay  Untreated Decay

Recommendations (Check one)  
 Routine Care  
 Referral for dental treatment  
 Referral for urgent dental care

Provider Signature \_\_\_\_\_ Date \_\_\_\_\_

Check one  
 Dentist  Dental Therapist  Dental Hygienist

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**SECTION 7 - PHYSICIAN'S SIGNATURE**

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Examiner's Name (Print) \_\_\_\_\_ Degree or License \_\_\_\_\_ Telephone Number \_\_\_\_\_

Examiner's Signature \_\_\_\_\_ Date \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_  
**MI**

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.

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