CLIMAX-SCOTTS
COMMUNITY SCHOOLS

Dear Parents and Guardians:

Thank you for your interest in our preschool 3's program. We are excited to get to know you and your child. The 3's program is held on Tuesday and Thursday from 8:35-11:25.

The Climax-Scotts Pre-K Program offers a developmentally appropriate early childhood education program that meets the needs of the "whole child" and encourages the power of play. Play is the primary occupation of a child. The curriculum respects both the age and the individual needs and interests of each child. We provide a safe, healthy learning environment that will advance your child's physical and intellectual competence, communication and creativity. Social and emotional development is encouraged to nurture self-esteem, social responsibility and pro-social skills.

You may download the PreK Threes forms, or stop into the office to pick them up, but our enrollment date for collecting all forms is ***Monday, March 4th, beginning at 8:30 AM****.*

We cannot accept early drop-off forms, as the program is a first come, first served basis. We will have a waitlist for those that wish to be on it.

For your child to be considered to be part of the Threes program, the application must be complete with all documents as outlined. Dropping off completed forms does not guarantee a spot as space is limited, but you will be notified by **May 1st** *regarding acceptance to the program and tuition information.*

Questions? Please call the elementary school office at 269-497-2100
or email Cindy Amos at cindy.amos@csschools.net

Preschool 3's enrollment

Documents may be turned in at the elementary school office on March 4 at 8:30.

To complete enrollment we need

- ☐ Climax Scotts Pre - K 3's **Application**
- ☐ **$50 Deposit** (Applies towards Tuition)
- ☐ **Health Appraisal**
- ☐ **Child Information Records** (CIR)
- ☐ Picture & Technology usage and Release
- ☐ **Proof of Family Income** (recent W2 or check stub)

***Your spot is not secured until we have received all the information above**

Before the first day of school

- ☐ Legal Copy of Child's **Birth Certificate**
- ☐ Up to date **Immunization Records**
- ☐ Parent Notification of Licensing Notebook
- ☐ Handbook Acknowledgement

Climax-Scotts Pre-K Three Year Old Application

Child Information			
Child's Legal Last Name:	Child's First Name:	Gender:	DOB:

Family Information				
Child lives with:	Both Parents	Mother	Father	Other
(circle one)	Legal Guardian	Grandparents	Foster care	

Family or Legal Guardian Information			
Full Name:		Full Name:	
Parent Address:		Parent Address: (if different)	
Home Phone:		Home Phone:	
Cell Phone:		Cell Phone:	
e-mail:		e-mail:	

Household Size		
Name	Date of Birth	Relationship

Household Income					
Name	Amount	Frequency (circle one)			Employer:
You	$	Weekly	Monthly	Yearly	
Spouse	$	Weekly	Monthly	Yearly	
Children	$	Weekly	Monthly	Yearly	
Other	$	Weekly	Monthly	Yearly	
	$	Weekly	Monthly	Yearly	
TOTAL	$	Weekly	Monthly	Yearly	

Other Income	You	Spouse	Children	Other	Subtotal
Social Security					$
Public Assisstance					$
Retirement Pension					$
Food Stamps					$
Child Support					$
Alimony					$
Interest Income					$
				TOTAL	$

Climax-Scotts Three Year Old Pre-K
Sliding Scale Tuition Income Eligibility Guidelines

Household Size	Federal Poverty Level 50%	Federal Poverty Level 100%	Federal Poverty Level 150%	Federal Poverty Level 200%	Federal Poverty Level 250%
	ANNUAL INCOME	ANNUAL INCOME	ANNUAL INCOME	ANNUAL INCOME	ANNUAL INCOME
2	7,965	15,930	23,895	31,860	39,825
3	10,045	20,090	30,135	40,180	50,225
4	12,125	24,250	36,375	48,500	60,625
5	14,205	28,410	42,615	56,820	71,025
6	16,285	32,570	48,855	65,140	81,425
7	18,365	36,730	55,095	73,460	91,825
8	20,445	40,890	61,335	81,780	102,225
Sliding Scale Tuition	$20 per month $180 per year 75% discount	$35 per month $315 per year 56% discount*	$50 per month $450 per year 37% discount*	$65 per month $585 per year 19% discount*	$80 per month $720 per year 0% discount

(*approximate %)

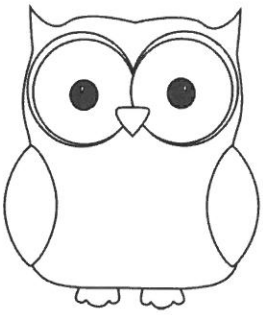
I affirm that the information provided on this application is true and correct to the best of my knowledge. I further agree to inform the Pre-K program if there is a significant change in my income. I understand if the tuition co-payment is not paid by the first of each month, the preschool policy for nonpayment will be enforced and my child will forfeit his/her slot to the next family on the waiting list.

Parent/Legal Guardian Signature_____ Date_____

Office Use:

Date Application Received:_____Staff Initial:_____

Eligible for sliding scale tuition:_____Amount/month:_____
First Month co-payment received:_____Cash/CheckK_____



Welcome to the Climax-Scotts Pre-K Three's Program!

Climax-Scotts Pre-K uses a developmental approach to teaching, taking in account that each child is a unique person with an individual pattern and timing of growth. The curriculum is also developed to provide continuity of care and assist children in transitioning from Pre-K threes' to Pre-K fours' and eventually into kindergarten.

Enrollment is open to any child who will be three by September 1st of the current school year.

Class Sessions meet: TUESDAY and THURSDAY 8:30 - 11:30

How do I register for Climax-Scotts Pre-K threes'? Pick up a Pre-K application packet and fill out completely. The application and required documents must be returned to Climax-Scotts Elementary. Slots will be awarded on a first-come, first-served basis and will children will be considered officially enrolled when the first month tuition is received. Documents you will need for the application are:

1) Family income documented over 12 months (submit a or b along with any other documents you may have received)
   a. Last year's W-2 or Michigan Income Tax Return
   b. Pay stub with a year-to-date listed or written statement from employer
   c. TANF/child care reimbursement/food stamps
   d. Social security/SSI statement
   e. Unemployment statement
   f. Child support/ alimony/pension statement
2) Birth Certificate
3) Health Appraisal, signed by physician within past year
4) Current immunization record

Why do I need to fill out an application? All families who register for Pre-K threes' may qualify for reduced tuition on a sliding fee scale based on household size and income. Eligibility cannot be determined unless all documents have been submitted. All information is kept confidential under FERPA law. Families who qualify will be expected to pay a portion of their child's tuition based on a ***sliding fee scale*** (listed on the next page). Families will be responsible for the co-payment directly to the program. If the co-payment is not paid, the Pre-K policy for nonpayment will be enforced. The family will be notified of the outcome of their application in writing.

→→→→

Payments and co-payments- Checks should be made payable to Climax Scotts Community Education with a note indicating preschool payment. Tuition payments are due the first day of each month. If full tuition payments are not received within fifteen days of their due date, your child may not be allowed to continue attending and his/her spot will be forfeited to the next person on our waiting list. Money is refundable only if the family moves out of the area or the child can no longer attend for medical reasons. Should extended vacations or absences occur the continued monthly payment will be due to hold a slot for your child.

Then what happens? A Pre-K "Meet and Greet" will take place before regular classes begin. At the "Meet and Greet" you and your child will have the opportunity to meet your Pre-K teachers and staff, check out the classroom and submit additional paperwork.

*(Schedules subject to change based on enrollment numbers. If classes do not have a minimum number of students they may have to be cancelled. *We will make every effort to accommodate all those who register.* Children placed on a waiting list may be directed to another class. Class sizes will be limited to ensure a quality preschool experience.)

Climax-Scotts Community Schools

Where Students Are More Than A Test Score!

PICTURE & TECHNOLOGY USAGE RELEASE/SOCIAL MEDIA

Dear Parent/Guardian,

Periodically we use photos of students in publications, or we have requests for students to have their pictures taken for release to newspapers, television, social media, and other publications for the purpose of promoting our educational programs and celebrating student success. Please sign and return this form to give consent to have your child's photo published. This permission is for the time said student is enrolled at Climax-Scotts Jr. & Sr. High School unless revoked by student's parent(s).

STUDENT'S NAME:

____

PARENT/LEGAL GUARDIAN NAME:

____

Picture Release Consent:

I give consent for my child's picture to be used in school/community publications as deemed appropriate by the school.

Yes ____________ No ____________

I give consent for my child's picture to be used on official school social media.

Yes ____________ No ____________

Signature of Parent / Legal Guardian: Date:

_________________________________ ____________________

*9fŜYŶSyúl·Ꞁè Office * ммнрл 9l·ăű vw !ØŜyȸŜ Street **
*{ŎƵűűăΣ Michigan * 490yy*
Phone (269) пфmπ2млл Fax (269) пфmπнмнm*

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?	Birth History
☐	☐	☐	1	Allergies or Reactions (for example, food, medication or other)	
☐	☐	☐	2	Anaphylaxis	
☐	☐	☐	3	Does your child take any medication(s) regularly?	If yes, list medications
☐	☐	☐	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)	Are there any current or past diagnosis(es) ☐ Yes ☐ No
☐	☐	☐	10	Trouble with Passing Urine or Bowel Movements	If yes, please describe
☐	☐	☐	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)_____	

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		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	Additional 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 (check all that apply) ☐ No urgent needs ☐ Treated decay ☐ Untreated decay	Recommendations (check one) ☐ Routine care ☐ Referral - restorative care ☐ Referral - urgent needs
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.

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. 7-18) Previous edition 6-17 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.**	**( )**

Parent/Legal Guardian Initials:

_____I give permission to _____, licensed by the Department of Licensing and Regulatory Affairs 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

LARA is an equal opportunity employer/program.

AUTHORITY: 1973 PA 116
COMPLETION: Required
PENALTY: Rule Violation Citation.

BCAL-3731 (Rev. 7-18) Previous edition 6-17may be used.

PARENT NOTIFICATION OF THE LICENSING NOTEBOOK

Child Care Organizations Act, 1973 Public Act 116

Michigan Department of Licensing and Regulatory Affairs

All child care centers must maintain a licensing notebook which includes all licensing inspection reports, special investigation reports and all related corrective action plans (CAP). The notebook must include all reports issued and CAPs developed on and after May 27, 2010 until the license is closed.

- This center maintains a licensing notebook of all licensing inspection reports, special investigation reports and all related corrective action plans.
- The notebook will be available to parents for review during regular business hours.
- Licensing inspection and special investigation reports from at least the past two years are available on the Bureau of Community and Health Systems website at **www.michigan.gov/michildcare**.

I have read the above statement issued by _____ .
Name of Child Care Center

Child(ren)'s Name(s) _____

_____

Parent Name _____

Parent Signature _____ Date _____

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