WAYNE RESA
Leading... Learning for All
SERVICE
LEADERSHIP
COLLABORATION
EXCELLENCE

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

GSRP CHILD APPLICATION FORM

For office use only

Program/Location: _____

Teacher: _____

Student UIC#: _____

Date of Enrollment: _____ ***Date Dropped:*** _____

Program Year:

20____ - 20____

PARENTS/GUARDIANS COMPLETE THIS SECTION

CHILD'S NAME: _____ **BIRTHDATE:** _____ **SEX: F** ☐ **M** ☐

CHILD'S ADDRESS: _____ **CITY:** _____ **ZIP:** _____

HOME TELEPHONE: _____ **ALTERNATE TELEPHONE:** _____

BIRTH CERTIFICATE#: _____ **BIRTHPLACE (city, state or nation):** _____

Special Needs: _____ Diagnosed: ☐ Yes ☐ No

Does the child have an IEP? _____ Date of IEP: _____ Inclusive Classroom specified? ☐ Yes ☐ No

Parent/Guardian Name: _____ Relationship to Child: _____

Age at 1st Pregnancy: _____ (Father) / _____ (Mother) Marital Status: ☐ Single ☐ Married ☐ Separated ☐ Divorced

Race: _____ (see chart below) Child Ethnicity: Hispanic ☐ Yes ☐ No

American Indian or Alaska Native; Asian; White; Black/African-American; Native Hawaiian or Pacific Islander

List *ALL* household members for which you are <u>financially</u> responsible

NAME	BIRTHDATE	NAME	BIRTHDATE

Type of MEDICAID Insurance: _____ **Case #:** _____ **Child's Recipient ID#:** _____

OTHER Medical Insurance: (Type): _____ **Policy Number:** _____

☐ **NO health insurance**

PARENTS/GUARDIANS COMPLETE THIS SECTION

IF NOT PARENT, PROOF OF GUARDIANSHIP CASE#: _____

	FATHER	MOTHER	Foster Parent(s)/Stepparent(s) or Guardian(s)/Relationship
Name:			
Home Address:			
Home Phone:			
Cell Phone:			
Birthdate:			
Home Language:			
Highest Grade or Degree completed:			
Occupation:			
Employer:			
Business Phone:			
Work/School Schedule: ***(Days & Times)***			

The above information is true and correct to the best of my knowledge. I understand that if any of this information changes, or is found to be incorrect, I am obligated to immediately notify this program. I understand that the above information and all information contained in the child's folder will remain **CONFIDENTIAL.** I hereby make application for my child to be enrolled in a Wayne County Great Start Readiness Program based on all the information on the Child's Application Form.

_____ _____

Parent's Name (print) **Parent's Signature** **Date**

STAFF COMPLETE THIS SECTION

At the time of registration, was proof provided of:

Birth Certificate (date received:_____)

Letters of Guardianship (date received:_____)

Income (date received:_____)

Immunization (date received:_____)

Health Appraisal (date received:_____)

Parent has been informed of Head Start Eligibility? ☐ Yes ☐ Not Applicable

Head Start Referral Release Form completed? ☐ Yes (please attach) ☐ Not Applicable

Date child entered the United States (if birth documents are from a foreign country): _____

RISK FACTORS: *STAFF COMPLETE THIS SECTION*

CHECK ALL THAT APPLY:	***TYPE OF DOCUMENTATION*** *(i.e., parent report, pay stub, IEP, etc.)*
☐ **1. Low family income: Quintile # ___**	
☐ **2. Diagnosed disability**	
☐ **3. Severe or challenging behavior**	
☐ **4. Primary home language other than English**	
☐ **5. Parent/guardian with low educational attainment**	
☐ **6. Abuse/neglect of child or parent**	
☐ **7. Environmental risk**	

_____ _____

Staff Signature **Date** **Signature of ECS Reviewing Form** **Date**

Student Emergency Information

Student's Last Name	First name
Birthdate:	Home Phone:
Entry Date	Exit Date:

****Please list the first three contacts you would like us to call in case of an emergency, after we contact the parent/guardian.** (These will be the people to whom we may release your child. Please note they will be required to show picture identification.

*Contact's name Address	Relationship to Child	Phone Number	Alternate Phone Number
*Contact's name Address	Relationship to Child	Phone Number	Alternate Phone Number
*Contact's name Address	Relationship to Child	Phone Number	Alternate Phone Number

Medical/Dental

Name of Child's Physician or Health Clinic	Physician's Phone Number Address
Name of Hospital Preferred for Emergency Treatment	City of Hospital Preferred for Emergency Treatment
Name of Child's Dentist	Dentist's Phone Number

Please put an "x" in the appropriate box. Give specifics when indicated.

☐ 1. Anemia
☐ 2. Contact lens/glasses
☐ 3. Bone/Joint condition: _____
☐ 4. Diabetes
☐ 5. Heart Condition: _____
☐ 6. Seizure Disorder
☐ 7. Urinary Problems
☐ 8. Asthma
☐ 9. Special blood condition _____
☐ 10. Non-life threatening allergies (reaction):
Med/drug _____
Food _____
Insect _____
Other _____

☐ 11. Life threatening allergies (reaction):
Food _____
Insect _____
Other _____
☐ 12. Medications needed or used:
_____
_____
☐ 13. Other conditions or problems:
_____
_____
_____
☐ 14. None Known (Important to check if no known concerns.)

Date of Last DTaP (Diphtheria, tetanus, pertussis shot) _____

Field Trips: I hereby give consent to the Dearborn Heights School District #7 GSRP for my child to be transported in a vehicle and/or participate in field trips. ☐ Yes ☐ No	
Signature of Parent/Guardian	**Date**

Dearborn Heights School District #7's Media Release Form

Dearborn Heights School District #7 is working hard to improve district communications via the local cable station and an improved district web site. These two communication mediums will provide our district additional opportunities to showcase and highlight the activities and educational work of our talented students and staff. **Please sign and return the Media Release Form indicating if you approve or deny your son/daughter's participation in the activities listed below. Please return the completed form to the school office.** Thank you!

****

Dearborn Heights School District #7's Media Release Form

Section I

☐ I give my permission Dearborn Heights SD#7 to **post/print my son/daughter's photo** or school work **along with his/her full name**, on the District web site, in video broadcasts or in any printed publications.

(or)

Section II

☐ I give my permission to Dearborn Heights SD#7 to post/print my son/daughter's photo or school work on the District web site, in video broadcasts or in any printed publications.
Note: If this box is checked, student names will NOT accompany photos.

(or)

Section III

My son or daughter is DENIED PERMISSION TO (check all that apply):

- ☐ Create art work or a written document that may be published on the District Web Site
- ☐ Appear in a photo that may be published on the District Web Site
- ☐ Appear in video broadcasts
- ☐ Appear in printed publications

Section IV

Student's Name: _____ Grade:_____

Parent/Guardian Signature: _____ Date: _____

☐ I, the student, age 18 or older, DENY my permission for publishing.

Student's Name: _____ Date: _____

This form MUST be returned to the school office. Thank you

Great Start Readiness Program
Dearborn Heights SD#7

Child's Name: _____ Date: _____

Sign-In/Sign-out Agreement

My designee or I agree to sign my child in and out of the program. My child will not be released to anyone not listed on the emergency information card without prior approval and picture identification.

_____ Parent/Guardian Initials

Parental Health Statement

I attest that my child, _____, is in good physical health and there are not changes in his/her physical condition.

He/She is physically able to participate in the activities provided in the preschool program.

_____ Parent/Guardian Initials

Outdoor Playgrounds:

The playground surface materials and/or playground in your child's preschool building in D#7 may or may not meet current Michigan Day Care Licensing Standards.

I will allow my child, _____, to play on the playground provided at Madison

Elementary School for the _____ school year.

_____ _____
Parent/Guardian Signature Staff Signature

_____ _____
Date Date

Great Start Readiness Preschool
Dearborn Heights School District #7

G.S.R.P Program Tracking System

Child's name: _____

Parent's name: _____

Address: _____

Phone Number: _____

School Attending: _____

Please list three (3) alternate telephone numbers in case you relocate in the future.

_____ _____ _____

Your participation in a Michigan Department of Education Preschool Program requires information on the school performance of your child for three years. You will receive a telephone call from the Dearborn Heights School District #7 program staff each spring for the next three years. Information shared will be reported to the Michigan Department of Education without the use of names. This information will be used to evaluate the impact of the GSRP program on your child's academic progress.

_____ _____

Parent's Signature Date

Written information Packet Documentation

Child's Name (Last, /First) _____ Center's Name: _____

A written information packet has been provided at the time of enrollment. The packet included all of the following information:

- Criteria for admission and withdrawal
- Schedule of operation, denoting hours, days, and holidays during which the center is open and services are provided.
- Discipline Policy
- Food Service Program
- Program philosophy
- Typical daily routine
- Parent notification plan for accidents, injuries, incidents, illnesses
- Exclusion policy for child illnesses
- Tuition Policy
- Notification of the availability of the center's licensing notebook
    - The licensing notebook contains all the licensing inspection and special investigation reports and related corrective action plans
    - The licensing notebook is available to parents during regular business hours
    - Licensing inspection and special investigation reports from at least the past two years are available on the child care licensing website at www.michigan.gov/michildcare.

I certify that I received all of the above items.

_____ _____

Parent/Guardian Signature Date

Dearborn Heights School District No. 7

Home Language Survey

The Dearborn Heights school District No. 7 is collecting information regarding the language back ground of each of its students. This information will be used by the district to determine the number of children who should be provided bilingual instruction according to Sections 380.1152-380.1157 of the School Code of 1995, Michigan's Bilingual Education Law. Please provide the following information.

Name of Student: _____ Grade: _____ Date of Birth: _____

Parent/Guardian Name: _____

Address: _____

Phone: _____ email address: _____

1. Is your child's first-learned or home language other than English?
   YES _____ NO _____ What is that language? _____
2. What language is most frequently spoken in your home? _____
3. Can your child understand and /or speak a language other than English?
   YES _____ NO _____ What is that language? _____
4. Was your child born outside the United States? YES ____ NO ____
   If you answer "NO" to question 4., you are done with the survey. Just sign and date.
   If yes, in what country? _____ Date entered U.S.A.? _____
5. If your child was born out of the United States have they attended any school in the USA for any three years?
   YES ____ NO _____
   If, Yes, please provide the following names, state and dates attended.
   School _____ State _____ Dates attended _____
   School _____ State _____ Dates attended _____
   School _____ State _____ Dates attended _____

Parent/Guardian Signature: _____ Date: _____

McKinney–Vento Eligibility Questionnaire

Name of School _____

Name of Student _____ Gender Birthdate _____

This questionnaire is intended to address the McKinney-Vento Act 42 U.S.C. 11435. The answers to this residency information to help determine the services the student may be eligible to receive.

1. **Is your current address a temporary living arrangement? ◯ Yes ◯ No**
2. **Is this temporary living arrangement due to loss of housing or economic hardship? ◯ Yes ◯ No**

If you answered NO, you may stop here.

If you answered YES to the above questions, please complete the remainder of this form.

Where is the student presently living (check one box)

- ◯ **In a motel**
- ◯ **In a shelter**
- ◯ **With more than one family in a house or apartment**
- ◯ **Moving from place to place**
- ◯ **In a place not designed for ordinary sleeping accommodations (re: car, park, campsite)**

Name of Parent(s) Legal Guardian (s) _____

Address _____ Zip _____ Phone _____

Signature of Parent /Legal Guardian _____ Date _____