ZEELAND PUBLIC SCHOOLS
LEARNING FOR LIFE!

ZEELAND PUBLIC SCHOOLS
ENROLLMENT FORM – PRESCHOOL

DATE_____ **ZEELAND RESIDENT BOUNDARY SCHOOL**_____ **If no, which district** _____

STUDENT'S FULL LEGAL NAME _____
Last First Middle Nickname

ADDRESS _____ **CITY** _____ **ZIP** _____

GENDER: ___ MALE ___ FEMALE **DATE OF BIRTH** _____ **PHONE**_____

EARLY EDUCATION EXPERIENCE

Does your child currently have an IEP or IFSP? ___ Yes ___ No
Special Education? (ECSE, ASD, Infant Toddler, Early On) ___ Yes ___ No If yes, where? _____

RACE & ETHNICITY: NOTE BOTH PARTS OF THIS QUESTION MUST BE ANSWERED:

ETHNICITY: Is this student Hispanic/Latino? (choose one only)

___ No, not Hispanic or Latino
___ Yes, Hispanic or Latino *(A person of Cuban, Mexican, Puerto Rican, South or Central American or other Spanish culture, regardless of race)*

RACE: The question above is about ethnicity, not race. No matter what you selected, please continue to answer the following by marking one or more choices to indicate what you consider the student's race to be (required to meet state reporting guidelines).

___ American Indian/Alaska Native
___ Asian
___ Black or African American
___ Native Hawaiian or Other Pacific Islander
___ White

Is your child's native tongue a language other than English? ___ Yes ___ No
Is the primary language spoken in your child's home a language OTHER THAN English? ___ Yes ___ No
If yes, what language? _____ Has your child previously received ELL/ESL services? ___ Yes ___ No If yes, where? _____
If your child was born outside the USA, is he/she a refugee? ___ Yes ___ No If yes, country of immigration?_____
When did he/she ARRIVE in the US? ____/____/____ When did he/she FIRST ATTEND a US school? ____/____/____

PARENT/LEGAL GUARDIAN NAMES:

Last/First – PRIMARY HOUSEHOLD **E-mail**
Employer Name **Work Phone #**
Home Phone# **Cell Phone #**
Address

Last/First – PRIMARY HOUSEHOLD **E-mail**
Employer Name **Work Phone #**
Home Phone # **Cell Phone #**
City/Zip

Last/First – SECONDARY HOUSEHOLD **E-mail**
Employer Name **Work Phone #**
Home Phone# **Cell Phone #**
Address

Last/First – SECONDARY HOUSEHOLD **E-mail**
Employer Name **Work Phone #**
Home Phone # **Cell Phone #**
City/Zip

Is either parent actively serving in the military? ___ Yes ___ No Which branch? _____

SIBLING INFORMATION: Please list below siblings in the family who are living at home (ages 0-19)

Name	Birthdate	Gender	Grade	School Building

EMERGENCY CONTACT INFORMATION:
Please list in order additional emergency contacts if parents cannot be reached:

Emergency Contact Name	Relationship to Student	Home Phone	Work Phone	Cell Phone

MEDICAL INFORMATION:

Medically diagnosed/physician treated conditions: *(include only those under a doctor's care)* _____

_____

_____

Will prescribed medications be required at school? ___ Yes ___ No *(forms can be obtained from school office and must be completed by child's physician)*

Are you interested in childcare through our ZPS program? ___Yes ___No

Permission for my child to attend field trips: ___ Yes ___ No

Please Read and Sign - Information on this form will be kept confidential and released only according to the Family Rights and Privacy Act.

We/I agree to absolve Zeeland Public Early Childhood from all financial responsibility in case of injury or illness of our/my child, or in case of property damage incurred by our/my child. I authorize Zeeland Public Schools to share medical information for my child with staff members that are in contact with him/her.

_____

Signature (Legal Parent/Guardian) **Relationship to Student** **Date**

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

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 Zeeland Early Childhood Center, 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

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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 (mm/dd/yy) / /
ADDRESS (Number & Street)	(City)	(ZIP Code) MI	TODAY'S DATE (mm/dd/yy) / /
PARENT/GUARDIAN (Last, First, Middle)			HOME TELEPHONE NUMBER ( )
ADDRESS (Number & Street)	(City)	(ZIP Code) MI	WORK TELEPHONE 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 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 Problems: Date of Last Exam / /
☐	☐	☐	Other (please describe): _____
☐	☐		Does your child take any medication(s) regularly?

Reason for Medication

_____ / /
Parent/Guardian Signature Date

Birth History:

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

If yes, please describe:

If yes, list medications: ⇨

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	Visual Acuity			
			Muscle Imbalance			
		Date: / /	Other:			
☐	☐	HEARING	Audiometer			
			Other:			
		Date: / /				
☐	☐	URINALYSIS	Sugar			
			Albumin			
		Date: / /	Microscopic			
☐	☐	BLOOD LEAD LEVEL	Level _____ ug/dl ⇨			
		Date: / /				

No	Yes	Was child tested for:	Test results:	Normal	Referred	Under Care
☐	☐	HEIGHT & WEIGHT	Height			
			Weight			
☐	☐	Other: _____	Other			
☐	☐	HEMOGLOBIN / HEMATOCRIT	⇨			
☐	☐	BLOOD PRESSURE	Reading: _____			
☐	☐	TUBERCULIN	Type: _____			
		Date: / /	Neg.: ☐ Pos.: ☐ _____ mm			

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 (Circle Type)	DATE ADMINISTERED MM/DD/YYYY	
Hepatitis B (HepB)	1	3
	2	
DTaP/DTP/DT/Td	1	4
	2	5
	3	6
Tdap	1	
Haemophilus Influenzae type b (HIB)	1	3
	2	4
Polio (IPV/OPV)	1	3
	2	4
Pneumococcal Conjugate (PCV7/PCV13)	1	3
	2	4
Rotavirus (RV1/RV5)	1	3
	2	
Measles,Mumps, Rubella (MMR)	1	2
Varicella (Chickenpox)	1	2

History of Chickenpox Disease? ☐ Yes ☐ No If yes, date:

VACCINES (Circle Type)	DATE ADMINISTERED MM/DD/YYYY	
Hepatitis A (HepA)	1	2
Influenza (IIV/LAIV)	1	3
	2	4
Meningococcal (MCV4 / MPSV4)	1	2
Human Papillomavirus (HPV9/HPV4/HPV2)	1	3
	2	
	Type of Vaccine(s)	Date of Vaccine(s)
OTHER Vaccines Specify Date & Type	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.

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 _____ (child's name)'s teeth. As a result of this examination, my recommendation for treatment is: _____

Dentist's Signature | / / Date

PHYSICIAN'S SIGNATURE

Examiner's Signature | / / Date | ***Examiner's Name (Print or Type)*** | Degree or License

Number & Street | City | MI 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 well-child care 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.

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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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Zeeland Public Schools
Non-Consent Form 2018-2019

Dear Parent or Guardian,

At Zeeland Public Schools, we regularly promote the accomplishments of our students and staff. This may include, but is not limited to, class projects, artworks, athletic activities, honor roll, specialized awards and school events.

To keep the public informed of the positive individuals and events in our district, ZPS utilizes district-wide newsletters, video presentations, press releases, and online at zps.org and ZPS social media sites including Facebook and Twitter.

If you as a parent or guardian feel uncomfortable with your child's name, photograph or work being published in print or electronic form by Zeeland Public Schools, you have the right to ask that the information be withheld. Under the Family Educational Rights and Privacy Act, such request must be in writing.

Below is a form providing you the opportunity to withhold your child's information. Please return this form to your child's school office as soon as possible. This form is only required if you wish to have your child's information withheld. By not submitting this form, you agree to the district's responsible use of names, photos and works.

This request is only applicable for the 2018-19 academic year. Requests must be made each year to ensure complete accuracy.

Thank you.

As a parent or guardian of a child at Zeeland Public Schools:

_____ I do **not** consent to the use of my child's name or photo in any print or electronic form by Zeeland Public Schools during the 2018-19 academic year.

Please note: if you agree to allow your child's name or photo be published, you can disregard this form.

_____ _____
Student Name Grade (2018-19)

_____ _____
Teacher's Name Date
Signature of parent or guardian