Muskegon Heights Early Childhood Center
3028 Howden Street
Muskegon Heights, MI 49444
Phone: 231-830-3252 Fax: 231-830-3577

Dear Parent/Guardian,

Thank you for your interest in Muskegon Heights Early Childhood Center Preschool Programs. Enclosed is the application and checklist of documents needed in order to apply for the Head Start or GSRP Preschool Programs. Children must be three or four years old by December 1 (priority is given to those with birthdays on or before September 1). In addition, priority is given to our returning families and those who reside in the Muskegon Heights Public School District.

For your application to be considered complete, we will need a copy of the following:

- ☐ **Verification of 2022 family income (public assistance (SNAP, TANF or SSI), tax forms, W-2, unemployment, child support etc.)**
- ☐ **Child's birth certificate, affidavit of parentage, or hospital birth record**
- ☐ Proof of Residency (current utility bill)
- ☐ Insurance or Medicaid Card
- ☐ Immunization Record or Waiver is needed before your child's first day of program attendance
- ☐ If your child has an allergy, asthma, or another medical condition, we must have an Allergy/Special Diet Action Plan or a Medical Condition Action Plan on file before the student can attend school
- ☐ Health Appraisal (physical) due within 30 calendar days of your child's first day of progam attendance
- ☐ Dental Exam due within 45 calendar days of your child's first day of progam attendance

We will be happy to make copies for you at our office.

Please return the completed application with supporting documents by email to: Bridget Gilbert, Enrollment Specialist at bgilbert@muskegonisd.org, or in-person to our enrollment office located at Edgewood Elementary.

Filling out this application packet does not ensure placement into the program. You will be notified by letter upon acceptance into the program. If you have further questions, please call the Enrollment Specialist at 231-830-3252.

Sincerely,
Deborah Morrow, Early Childhood Coordinator
MHECC Programs for MAISD

These materials were developed under a grant awarded by the Michigan Department of Education

ENROLLMENT APPLICATION — Applying for ☐ 23-24 Year OR ☐ 24-25 Year (Check 1 only)

Child's Name
(as printed on Birth Certificate)

First:_____

Middle:_____

Last:_____

Birth Date
/ /

Gender
M F

Race
Check all that apply
☐ American Indian or Alaska Native
☐ Asian
☐ Black/African American
☐ Native Hawaiian or Pacific Islander
☐ White
☐ Other_____

Hispanic/ Latino
☐ Yes
☐ No

English Proficiency
Proficiency
☐ Proficient ☐ Little
☐ Moderate ☐ None

Other Language
☐ None ☐ Spanish
☐ American Sign Language
☐ Other _____
Proficiency
☐ Proficient ☐ Little
☐ Moderate ☐ None

Special Needs
☐ **NO** ☐ **YES** ☐ **SUSPECTED**
☐ **IEP in Process** ☐ **Current IEP**
Concern:_____
IEP For: _____

Did this child attend Early Head Start?
YES NO

Primary Health Coverage
☐ Medicaid ☐ Private Ins. ☐ No Ins. ☐ Other_____

Doctor/Medical Home **Clinic Name**
Dr._____ _____

Dentist/Dental Home **Clinic Name**
Dr._____ _____

Adult 1

_____ _____
First Name Last Name

_____
Email

Birth Date
/ /

Gender
M F

Race
Check all that apply
☐ Am. Indian or Alaska Native
☐ Asian
☐ Black/African American
☐ Native Hawaiian or Pacific Islander
☐ White
☐ Other_____

Hispanic / Latino
☐ Yes
☐ No

English Proficiency
Proficiency
☐ Proficient ☐ Little
☐ Moderate ☐ None

Other Language
☐ None ☐ Spanish
☐ American Sign Language
☐ Other _____
Proficiency
☐ Proficient ☐ Little
☐ Moderate ☐ None

Highest Education Completed
☐High School Graduate ☐GED ☐Some College
☐College Degree ☐Highest grade completed _____

Employment Status
☐ Full Time ☐ Training/School ☐Seasonal
☐ Part Time ☐ Retired/Disabled ☐ Unemployed

Cell Phone
( ) _____
☐ **Opt In for Text Messages**

Home Phone
( ) _____

Child's Relationship
☐ Parent: Biological/Adopted/Step-Child ☐ Grandchild
☐ Foster Child ☐ Other Relative ☐Other: _____

Does this individual have custody?
Yes No

Does this individual live with the family?
Yes No

Does this individual provide financial support for the family?
Yes No

Current Teen Parent:
(Under 20 yrs of age)
Yes No

Adult 2

_____ _____
First Name Last Name

_____
Email

Birth Date
/ /

Gender
M F

Race
Check all that apply
☐ Am. Indian or Alaska Native
☐ Asian
☐ Black/African American
☐ Native Hawaiian or Pacific Islander
☐ White
☐ Other_____

Hispanic / Latino
☐ Yes
☐ No

English Proficiency
Proficiency
☐ Proficient ☐ Little
☐ Moderate ☐ None

Other Language
☐ None ☐ Spanish
☐ American Sign Language
☐ Other _____
Proficiency
☐ Proficient ☐ Little
☐ Moderate ☐ None

Highest Education Completed
☐High School Graduate ☐GED ☐Some College
☐College Degree ☐Highest grade completed _____

Employment Status
☐ Full Time ☐ Training/School ☐Seasonal
☐ Part Time ☐ Retired/Disabled ☐ Unemployed

Cell Phone
( ) _____
☐ **Opt In for Text Messages**

Home Phone
( ) _____

Child's Relationship
☐ Parent: Biological/Adopted/Step-Child ☐ Grandchild
☐ Foster Child ☐ Other Relative ☐Other: _____

Does this individual have custody?
Yes No

Does this individual live with the family?
Yes No

Does this individual provide financial support for the family?
Yes No

Current Teen Parent:
(Under 20 yrs of age)
Yes No

List all children and any other family members living in the same household **who are supported by the parent/guardian income** and related to the child's parents/guardians by blood, marriage or adoption or the child's authorized caregiver or legally responsible party. **DO NOT INCLUDE CHILD APPLICANT OR ADULT(S) LISTED ABOVE.**

First Name	Last Name	Birth Date	Gender	Race	Hispanic/Latino	English Proficiency	Other language	Other Language Proficiency
		___/___/_____						
		___/___/_____						
		___/___/_____						
		___/___/_____						
		___/___/_____						
		___/___/_____						
		___/___/_____						

See Reverse Side

FAMILY INFORMATION

Living Address	City	State	Zip Code	County	Is your mailing address the same as your living address?
		MI			Yes No

Acquiring/learning another language in addition to English	Homeless Family (See Student Residency Questionnaire)	Active Military	Referral	Does your family receive Public Assistance?	Does your family receive WIC?
Yes No	Yes No	Yes No **Military Veteran** Yes No	Referred by Child Welfare Agency (DHHS): Yes No OR Other Agency: Yes No If yes, _____	**SNAP** (food stamps) Yes No **SSI** (Supplemental Security Income) Yes No **TANF** (FIP) Yes No	Yes No

RISK FACTOR ASSESSMENT (Check all that apply)

✓	RISK FACTOR	DEFINITION
	Severe or challenging behavior	Child has been expelled from preschool or child care center.
	Primary home language other than English	English is not spoken in the child's home; English is not the child's first language.
	Parent/s with low educational attainment	Parent has not graduated from high school or is illiterate.
	Abuse/neglect of child or parent.	Domestic, sexual, or physical abuse of child or parent; child neglect issues.
	Environmental risk.	Parental loss due to death, divorce, incarceration, military service, or absence; sibling issues; teen parent (not yet age 20 when first child born); family is homeless or without stable housing; residence in a high-risk neighborhood (area of high poverty, high crime, with limited access to critical community services); or prenatal or postnatal exposure to toxic substances known to cause learning or developmental delays.

PARENT/GUARDIAN PERMISSION

Parent/Guardian Signature

I attest that I have submitted complete and accurate eligibility information including my income and living situation.

Signature: _____ Date: _____

Second Year Participation

I have reviewed and updated (if necessary) this application for my child's **second year** participation in the program.

Parent/Guardian Initials: _____ Date_____

FOR PROGRAM USE ONLY (OPTIONAL)

Additional comments to assist with Eligibility:

Type of eligibility interview conducted: ☐In-Person ☐Audio or Video Call	Explain why the interview was not in-person:
Staff Signature:	Date:

CHILD INFORMATION RECORD

State of Michigan - Department of Licensing and Regulatory Affairs - Child Care Licensing Bureau

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	Primary Phone ( )	Parent/Legal Guardian's Name (Optional)		Primary Phone ( )
Home Address (if not child's address)	2nd Phone (if applicable) ( )	Home Address (if not child's address)		2nd 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? Yes ☐ No ☐ If yes, explain: (Attach additional sheets, if necessary.)				

CCL-3731 (Rev. 3/17/2022) Previous editions 7-18 & 4-21 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.

CCL-3731 (Rev. 3/17/2022) Previous editions 7-18 & 4-21 may be used

Parent / Guardian Authorizations

Head Start, GSRP, and Early Head Start provide many different services to children and families to help prepare children for Kindergarten success. Advance authorization is needed for the following actions and services:

Yes __ No __ Health procedures by trained staff or outside agency personnel that may include height and weight measurements, blood pressure reading, testing for hearing, vision, hemoglobin, temperature checks, and dental screening. None of these procedures involve the drawing of blood. Employees of Public Health - Muskegon County & District Health Department #10 have permission to screen my child for hearing and/or vision and bill Medicaid if applicable.

Yes __ No __ A blood lead test by trained staff or outside agency personnel involving a slight poke to the child's finger to draw one or two droplets of blood. The child's blood lead test results, including limited personally identifiable information regarding the child, will be transmitted to the Michigan Care Improvement Registry database at the Michigan Department of Health and Human Services.

Yes __ No __ My child's immunization record may be released to the Michigan Department of Health and Human Services and/or local health department which includes limited personally identifiable information regarding your child. This information will be used to improve the quality and timeliness of immunization services and assist schools in complying with Michigan law.

Yes __ No __ Developmental, mental health, behavioral, and/or educational observations, screenings, assessments and consultation services by school staff or outside agency personnel.

Yes __ No __ Exchange child-related information with public schools, community agencies including the MAISD and WSESD, health, mental health, and dental care providers, and the U.S. Department of Health and Human Services for income verification/program participation purposes.

Yes __ No __ Exchange child-related information, including but not limited to child assessment and health information, with another school as the child transfers to another early childhood program or transitions from pre-school into Kindergarten.

Yes __ No __ Transportation of my child(ren) for what is to be considered routine program operations, such as picking up or dropping off a child from school, field trips, agency appointments, and health visits. A parent or guardian must accompany the child when transporting for an appointment/health visit.

Yes __ No __ Program use of photographs, videos, and/or other media of child for news stories, advertising, staff training, and media-related purposes. Child names or other identifying information will not be used without further permission. I understand other parents may take pictures or video during school events which is outside of the control of school staff.

I agree to the above statements and give authorization to program staff and outside agency personnel to provide the services and child information identified above.

_____ _____

Child's Name **(Please print clearly)** Child's Date of Birth

_____ _____

Parent/Guardian Signature Date of Signature

Program Year: 2023-2024

Student Residency Questionnaire

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

District: _____ Head Start: _____ GSRP:_____ EHS:_____

Student Name: _____ Birth date: _____

Foster Child: ___Yes ___ No If Yes, how long has this foster child lived with you? _____

Please list all of your preschool and school-aged children currently living with you: (continue on back if more space is needed)

Name: _____ Birth date: _____ School: _____

Name: _____ Birth date: _____ School: _____

Information provided on this form is confidential.

What is your current living situation? *(Based on your situation, your child may be eligible for additional services)*

_____ **I own or rent my own home/apartment.** If you checked this box, **STOP HERE,** skip remainder of the form and **sign and date at the bottom.**

_____ **Sharing the housing of other persons due to:** (check one)

☐ Loss of housing due to eviction, foreclosure, or other economic hardship (such as job loss)

Explain: _____

☐ Long-term, cooperative living arrangement to save money or a similar reason

_____ **At a motel, hotel, campground or similar setting due to:** (check one)

☐ Lack of alternative adequate accommodations

☐ It being a convenient living arrangement, or waiting for apartment or house to be ready

_____ **In an emergency or transitional shelters (domestic violence or homeless shelters or transitional housing)**

_____ **In a primary nighttime residence that is a place not designed for or ordinarily used as a regular sleeping accommodation for humans**

_____ **In cars, parks, public spaces, abandoned buildings, substandard housing, bus/train stations, or similar setting**

How long do you anticipate living at this location? _____

Current Address: _____

_____ _____

Parent/Guardian/Unaccompanied Youth Signature ***Date***

---------- OFFICE USE ONLY ----------

_____ PowerSchool _____ Food Service _____ McK-V Coordinator _____ Building Placed

To: Pioneer Resources Transportation

Head Start of Muskegon/Oceana

REQUEST FOR HEAD START TRANSPORTATION

Date:_____ *Center:* _____

From: _____ *Phone #* _____

Session: AM PM AD HMLS

Please note: Filling out this form does not guarantee bussing.

CHILD INFORMATION

(Completed by Parent)

LAST NAME: _____ **FIRST NAME:** _____ **MIDDLE:** _____

CHILD'S HEIGHT_____ **CHILD'S WEIGHT**_____

BIRTHDATE: _____ **YEAR IN PROGRAM: 1 or 2 (circle one)**

MOTHER'S NAME: _____ **DAYTIME PHONE:** _____

FATHER'S NAME: _____ **DAYTIME PHONE:** _____

DOCTOR'S NAME: _____ **DAYTIME PHONE:** _____

HOSPITAL PREFERENCE: _____

PICKUP/DROP OFF INFORMATION

BUS STOP PICKUP ADDRESS: _____

CITY: _____ **ZIP CODE:** _____ **PHONE:** _____

BUS STOP DROP OFF ADDRESS: _____

CITY: _____ **ZIP CODE:** _____ **PHONE:** _____

EMERGENCY INFORMATION

EMERGENCY CONTACT PERSON: _____ **PHONE:** _____

EMERGENCY CONTACT PERSON: _____ **PHONE:**_____

AUTHORIZED SIGNATURE: _____ **DATE:** _____

PIONEER RESOURCES USE ONLY:

BUS# _____ PICK UP TIME _____ DROP OFF TIME _____ SESSION: AM PM AD HMLS

APPROVED _____ SCHOOL_____

DENIED _____ REASON FOR DENIAL _____

*REQUESTS MUST BE EMAILED AND CONFIRMED BY 12:00 PM ON THURSDAY FOR TRANSPORTATION SERVICES TO BEGIN THE FOLLOWING MONDAY.

Updated 1/12/23

Head Start of Muskegon/Oceana

Dear Parents/Guardians:

Please answer the following questions about your child enrolling in preschool.

Child's Name: _____ Date of Birth ___/___/___ Date: _____

Questionnaire for an assessment of your child's risk for tuberculosis

(Please answer the following questions by marking an "X" in the appropriate column to the left.)

YES	NO	
___	___	1. Has a family member or contact (someone you live with) had tuberculosis disease?
___	___	2. Has a family member had a positive TB skin test result?
___	___	3. Was your child born in a high risk country (countries **other than** the United States, Canada, Australia, New Zealand, or western or northern Europe).
___	___	4. Has your child traveled and had contact with resident populations to a high risk country for more than one week (high risk countries equal countries **other than** the United States,

Parent's signature: _____

PLEASE RETURN THIS FORM TO YOUR LOCAL PRESCHOOL OFFICE

FOR STAFF USE - IF ANY OF THE ABOVE QUESTIONS ANSWERED "YES," PLEASE FORWARD THIS FORM TO THE CHILD'S HEALTHCARE PROVIDER

Dear Healthcare Provider:

There has been much discussion regarding the Tuberculin Skin Test (TST) as it relates to the physical examination for Preschool program children. In an effort to effectively use resources and knowing that our community has become a low-risk community in regard to tuberculosis infection, based on the American Academy of Pediatrics 2015 Red Book recommendations, a screening questionnaire is being used to assess which children are at risk and who, subsequently, should be tested with a Tuberculin Skin Test (TST).

Please feel free to use the results of this questionnaire to help determine if a child needs testing.

Sincerely,

Karl F. Nicles, M.D.
Robington Woods, D.O.

Muskegon Area ISD's Health Advisory Committee for Early Childhood Programs
(Revised January 2018)

Nutrition Questionnaire

(Completed by Parent)

Child's Name: _____ Sex: M F Birthdate:_____

Parent Names: _____ Phone#: _____

1. What kind of eater is your child? Excellent Good Picky Poor
   Describe your child's eating habits: _____
2. Is your child on a special diet and why? No Yes _____
3. Does your child have any food allergies/intolerances? No Yes _____
4. Does your child take any vitamin, mineral, or herbal supplements? No Yes _____
5. Do you have any size, shape, growth or nutrition concerns about your child?
   No Yes _____
6. How often does your child eat from each of the following food groups per day?
   a) Dairy Foods: 0 1 2 3 4 5 6
      Eats Most Often: Milk (Skim, 1%, 2%, Whole) Cheese Yogurt
   b) Protein Foods: 0 1 2 3 4 5 6
      Eats Most Often: Meat Chicken Peanut Butter Eggs Beans Fish
   c) Grains: 0 1 2 3 4 5 6
      Eats Most Often: Bread Rice Pasta Cereal Tortillas
   d) Fruits: 0 1 2 3 4 5 6
      Eats Most often:_____
   e) Vegetables: 0 1 2 3 4 5 6
      Eats Most Often: _____
   f) Beverages: 0 1 2 3 4 5 6
      Drinks Most Often: Water Milk Fruit Juice Pop Other
   g) Snacks: 0 1 2 3 4 5 6
      Eats Most Often:_____
   h) Fast Food (per week): 0 1 2 3 4 5 6
      Eats Most Often:_____
7. Has your child lost or gained weight over the past month? No Yes _____ gained/lost pounds
8. Has your child had any major change in her/his appetite over the past month? No Yes
   _____
9. Does your child have dental, chewing, or swallowing problems that make it difficult to eat?
   No Yes _____
10. How many meals/day does your child eat? _____ How many snacks/day does your child eat? _____
11. What are your child's/family mealtimes like? When _____
    With Who _____ Where _____
12. Does your child often have: Diarrhea? No Yes Constipation? No Yes
13. Does your child and/or family enjoy any physical activities? No Yes If so, what are they?
    _____
14. Does your child currently receive WIC? No Yes

_____

Parent/Guardian Signature **Date**

Staff Use Only (Optional to fill in on Form, Must be Entered in ChildPlus)

Date of Measurements: _____Child's Height: _____ Child's Weight: _____

Center Name and Room _____

Muskegon/Oceana Early Childhood Programs **DATE RECEIVED AT CENTER**

DENTAL EXAMINATION

PART 1 **(COMPLETED BY PARENT OR STAFF)**

PATIENT NAME: **DATE OF BIRTH**

PARENT/GUARDIAN NAME:

ADDRESS: **CITY:** **STATE:** **ZIP:**

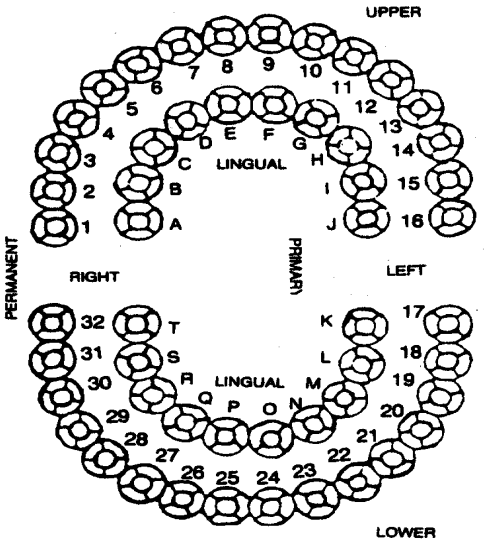
PHONE:

HEALTH PROFESSIONAL PLEASE COMPLETE PART 2, 3, 4, & 5

PART 2

EXAM DATE	TOOTH	SURFACE	MATERIAL	DESCRIPTION OF WORK

PART 3



DIAGNOSTIC CODE

Solid Area Indicates Filling Present

Zebra Stripes Indicates Decay Present

Verticle Line Indicates To Be Extracted

"X" Indicates Missing Tooth

PLEASE CHECK SERVICES PROVIDED

_____ Fluoride

_____ Prophylaxis

_____ Instruction in oral hygiene

_____ Restoration of decayed teeth

_____ Pulp therapy

_____ Extraction

PART 4 - ADDITIONAL INFORMATION:

PART 5 - PLEASE CHECK ONE:

_____ Work for this child has been completed and 6 months checkup is recommended.

_____ Additional work is required and noted in Part 4, additional inforamtion.

NEXT APPOINTMENT: **DATE:** **TIME:**

SIGNATURE OF HEALTH PROFESSIONAL **OFFICE** **DATE**

HEALTH APPRAISAL

DATE REC at CNTR

Dear Parent or Guardian: The following information is requested so that the school can work with parents to meet the physical, intellectual and emotional needs of the child. Fill out the information 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: ____/____/_____

Address: _____ (NUMBER & STREET) _____ (CITY) MI _____ (ZIP CODE) Today's Date: ____/____/_____

Parent/Guardian: _____ (LAST) _____ (FIRST) _____ (MIDDLE) Telephone: (____)_____ (HOME)

Address: _____ (NUMBER & STREET) _____ (CITY) MI _____ (ZIP CODE) Telephone: (_____)_____ (WORK)

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 a 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?

Reasons for medications:

_____ *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:* _____

HEALTH APPRAISAL

DATE REC at CNTR

Dear Parent or Guardian: The following information is requested so that the school can work with parents to meet the physical, intellectual and emotional needs of the child. Fill out the information 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: ____/____/_____

Address: _____ (NUMBER & STREET) _____ (CITY) MI _____ (ZIP CODE) Today's Date: ____/____/_____

Parnet/Guardian: _____ (LAST) _____ (FIRST) _____ (MIDDLE) Telephone: (____)_____ (HOME)

Address: _____ (NUMBER & STREET) _____ (CITY) MI _____ (ZIP CODE) Telephone: (____)_____ (WORK)

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 a 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?

Reasons for medications:

_____ *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 Date:_____/_____/_____	Visual Acuity			
			Muscle Imbalance			
			Other:			
☐	☐	HEARING Date:_____/_____/_____	Audiometer			
			Other:			
☐	☐	URINALYSIS Date:_____/_____/_____	Sugar			
			Albumin			
			Microscopic			
☐	☐	BLOOD LEAD LEVEL** Date:_____/_____/_____ @12 mos. Date:_____/_____/_____ @ 24 mos. Date:_____/_____/_____ @>36 mos	Level: _____ µg/dL			

NO	YES	Was child tested for:	Test results:	Normal	Referred	Under Care
☐	☐	Height & Weight	Height _____ Weight_____			
☐	☐	HEAD CIRCUMFERENCE	Head Circumference _____			
☐	☐	HEMOGLOBIN/HEMATOCRIT	→			
☐	☐	BLOOD PRESSURE	Reading _____			
☐	☐	TUBERCULIN Date:_____/_____/_____	Type:_____ 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	DATE ADMINISTERED MM/DD/YYYY	
Hepatitus B (Hep B)	1	3
	2	
DTaP/DTP/DT/Td/Tdap Circle Type	1	5
	2	6
	3	7
	4	8
Haemophilus Influenzae Type b (HIB)	1	3
	2	4
Polio – IPV (circle type)	1	3
	2	4
Pneumococcal Conjugate (PCV7)	1	3
	2	4
Rotavirus (Rota)	1	3
	2	4
Measles, Mupms, Reubella (MMR)	1	2
Varicella (Chickenpox)	1	2

History of Chickenpox disease? ☐ YES ☐ NO If yes, date:

VACCINES	DATE ADMINISTERED MM/DD/YYYY	
Hepatitus A (Hep A)	1	2
Influenza TIV/LAIV	1	3
	2	4
Meningococcal MCV4 / MPSV4	1	2
Human Papillomavirus (HPV)	1	3
	2	4
Other 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 providers office for medical waiver forms and through your local health department for non-medical 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

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 activities 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 RECOMMENTATIONS (OPTIONAL)

I have examined _____'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**

DATE OF NEXT APPOINTMENT: _____

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 schedule of well-child care required by EPSDT and the latest immunizations scheduled 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 Human Services, Education, Community Health; 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