GSRP 4-Year-Old Preschool Resource Packet

Welcome to the Great Start Readiness 4-Year-Old Preschool program at Kent City Elementary! We are excited to have you partner with us in your child's education!

Enclosed in this packet you will find details regarding the enrollment process as well as information and resources to help you prepare for preschool. Visit preschool.kentisd.org to complete the enrollment application.

In addition to the online enrollment application, the following documents are also needed to enroll your child in the Great Start Readiness Program 4-Year-Old Preschool program:

1) _____ Proof of Residence (utility bill, tax bill, lease agreement, etc)
2) _____Birth Certificate
3) _____Immunization Record
4) _____Health Appraisal Form
5) _____Proof of Income for Everyone Living in the Household

**Please bring the health appraisal form to your physician to complete before returning to school. Health appraisal forms must be signed by a physician.

Students must be 4-years-old by September 1. If your child is turning 4 years old between September 2 and December 1, please contact the Elementary office at 616-678-4181 to obtain an age waiver.

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

Kent County Preschool Intake Application

Do you, the parent or guardian, agree to the release of this information to be shared by Kent Intermediate School District, local school district programs and with Head Start for Kent County, and Help Me Grow and other Early Childhood Services, for navigating the appropriate educational programs and support for your family? Yes ☐ No ☐

Child's Legal Name:

First:	MI:	Last:
DOB:		Sex Assigned at Birth: ☐ M ☐ F
Gender Preference ☐ M ☐ F ☐ Un-binary		

Address:

Is the child or family homeless, living in a shelter, motel/hotel, transitional housing, doubled up or unsheltered? Yes ☐ No ☐ *If yes, please circle the living situation for this child from the choices above.*		
Street Address:	Apt/Suit/PO Box:	Zip:
City:	County:	
School District:		

Primary Adult/Guardian's Legal Name:

First:		Last:	
DOB:	Gender: ☐ M ☐ F	Do you have email: Yes ☐ No ☐ If yes please list **If no email entered we will be communicating via US mail.** email:	
Mobile Phone:	Opt into Text Messaging?	Home Phone:	Work Phone:
Relationship to Child:		Do you have custody of the child: Yes ☐ No ☐	
Does the child live with you? Yes ☐ No ☐			

Work Status	**Work Days**	**Work Hours**
Not Employed ☐	Weekdays ☐	1st ☐
Full Time ☐	Weekends ☐	2nd ☐
Part Time ☐	Weekdays and Weekends ☐	3rd ☐

School Status

Not Attending School ☐	Classroom ☐	Daytime ☐
Full Time ☐	Online ☐	Evening ☐
Part Time ☐	Classroom and Online ☐	Daytime and Evening ☐

Kent County Preschool Intake Application

Secondary Adult/Guardian's Legal Name: (if applicable)

First:		Last:	
DOB:	Gender: ☐ M ☐ F	Do you have email: Yes ☐ No ☐ If yes please list **If no email entered we will be communicating via US mail.** email:	
Mobile Phone:	Opt into Text Messaging?	Home Phone:	Work Phone:
Relationship to Child:		Do you have custody of the child: Yes ☐ No ☐	
Does the child live with you? Yes ☐ No ☐			

Work Status	**Work Days**	**Work Hours**
Not Employed ☐	Weekdays ☐	1st ☐
Full Time ☐	Weekends ☐	2nd ☐
Part Time ☐	Weekdays and Weekends ☐	3rd ☐

School Status

Not Attending School ☐	Classroom ☐	Daytime ☐
Full Time ☐	Online ☐	Evening ☐
Part Time ☐	Classroom and Online ☐	Daytime and Evening ☐

Alternate Contact:

First:		Last:	
DOB:	Gender: ☐ M ☐ F	Do you have email: Yes ☐ No ☐ If yes please list email:	
Mobile Phone:	Home Phone:	Work Phone:	
Relationship to Child:			

Application Assistant Contact

First:	Last:	
Do you have email: Yes ☐ No ☐ If yes please list email:		
Mobile Phone:	Home Phone:	Work Phone:
Organization you represent		

Kent County Preschool Intake Application

Child Information:

Is this child Hispanic/Latino? Yes ☐ No ☐
Which one of the following groups describes the child's race? Please select at least one. ☐ America Indian or Alaska Native ☐ Asian ☐ Black or African-American ☐ Native Hawaiian or Other Pacific Islander ☐ White
Does this child have severe or challenging behavior? Yes ☐ No ☐
Did this child ever experience abuse? Yes ☐ No ☐
Has this child ever experienced any environmental risk? Yes ☐ No ☐
Does this child have a diagnosed disability? Yes ☐ No ☐ If yes, please explain the child's disability
Does this child have an active IEP? Yes ☐ No ☐
Does this child have asthma, food allergies, other allergies, seizures or other medical conditions? Yes ☐ No ☐ *If yes, please explain the medical condition and the name the doctor the child sees for this medical condition.*
Is this child in foster care or court ordered relative placement? Yes ☐ No ☐

Family Information:

Parental Status: ☐ One Parent/Guardian ☐ Two Parent/Guardian
Have all parent(s)/guardian(s) graduated from high school/secondary school or received a GED? Yes ☐ No ☐
Are all parent(s)/guardian(s)literate in their native language? Yes ☐ No ☐
Was either parent of the child ever abused? Yes ☐ No ☐
Primary language spoken at home:
Does the family need a translator?
Number of family members in the household supported by the parents/guardians (all adults and children):
Is there anyone in the family receiving SSI Benefits? Yes ☐ No ☐
Is there anyone in the family receiving Cash Assistance (TANF-Child Only Payments)? Yes ☐ No ☐
Is there anyone in the family receiving SNAP benefits? Yes ☐ No ☐
What is the family's yearly gross income before taxes?
Is at least one parent/guardian an active duty member of the United States military? Yes ☐ No ☐

Kent County Preschool Intake Application

Other Info:

Does this child need before school care? Yes ☐ No ☐
Does this child need afterschool care? Yes ☐ No ☐
Is this child enrolled in any school or other programming? Yes ☐ No ☐N If yes, what program?
Does this child have any siblings? Yes ☐ No ☐
Is the sibling enrolled in any school or other programming? Yes ☐ No ☐ If yes, what program?
Is this child a sibling of a child that is now enrolled or returning next school year? Yes ☐ No ☐
Preferred Session: ☐AM ☐PM ☐ Full Day
Site Preference: (We will try to accommodate one of your site preferences. However, placement at one of your preferred sites is not guaranteed)
Bussing Address (bussing is not guaranteed)
Drop off Address (If different from bussing)
Pick Up Adders (If different from bussing)
Can the Parent/Guardian transport if no bussing is available? Yes ☐ No ☐

How did you hear about Preschool?

☐ Agency: Newsletter	☐ Agency: Person	☐ Billboard	☐ Business: Flyer	☐ Business: Poster
☐ Clinic: Flyer	☐Clinic Person	☐ Clinic Video	☐ Doctor's Office: Flyer	☐Doctor's Office: Person
☐ Flyer	☐ Friend	☐ Home Visit	☐ Yard Sign	☐ Facebook/Social Media
☐ Newspaper	☐ Radio	☐School: Newsletter	☐School: Robo Call	☐ School Yard Sign
☐ WIC				

Is there anything else you would like us to know about your child to ensure the best possible preschool placement?

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?
☐	☐	☐	1	Allergies or Reactions (for example, food, medication or other)
☐	☐	☐	2	Anaphylaxis
☐	☐	☐	3	Does your child take any medication(s) regularly?
☐	☐	☐	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)
☐	☐	☐	10	Trouble with Passing Urine or Bowel Movements
☐	☐	☐	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) _____

Birth History

If yes, list medications

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

If yes, 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 mm/dd/yy		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 and Recommendation (Check all that apply)
☐ No Urgent Needs ☐ Routine Care Needed ☐ Treated Decay
☐ Restorative/Urgent Needs for Dental Care ☐ Untreated Decay ☐ Further Referral for Specialist

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.

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PERMISSION TO PHOTOGRAPH/VIDEOTAPE

I give my permission for my child to be included in photos and/or videos while participating in any preschool activities including field trips.

_____ YES _____NO

I give permission for photos and/or videos of my child to be used in classroom and/or school building displays.

_____ YES _____NO

I give permission for photos and/or videos of my child to be used on the internet including the classroom, school district, and/or Kent ISD websites.

_____ YES _____NO

I give permission for photos and/or videos of my child to be used for print or presentation materials that may be shared with other program staff or educators for the purpose of training or program promotion.

_____ YES _____NO

Notes:

Child's Name _____

Parent/Guardian Signature _____

Teacher's Name_____ Date_____

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

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Income Verification Documentation

At the present time I do not have documented earned income.

Please note that this documentation satisfies the requirement for GSRP income verification.

_____ _____

Child's Name Date

_____ _____

Parent's Name (Please Print) Parent's Signature

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Verification of Living Situation

At the present time my family is experiencing homelessness. We are living in a shelter, hotel/motel, transitional housing, doubled up or unsheltered.

_____	_____
Child's Name	Date
_____	_____
Parent's Name (Please Print)	Parent's Signature

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