Grand Haven Area Public Schools

Child Services • Preschool / Open Door
106 S. Sixth Street • Grand Haven, MI 49417
(616) 850-6825 • children@ghaps.org

PRESCHOOL DEVELOPMENT CENTERS

2024/25 Preschool Registration

Child Name _____ **Birthdate** _____

Please check the appropriate box for your preferred class.

CENTRAL PRESCHOOL

106 S. SIXTH ST., GRAND HAVEN

Children must be a minimum of 3 years old (36 months) and are NOT required to be toilet trained to attend Central Preschool

☐ Tuesday/Thursday	(2 days per week)	**3 year olds**	9:00 AM – 12:00 PM
☐ Monday/Wednesday/Friday	(3 days per week)	**3 year olds**	9:00 AM – 12:00 PM

LAKE HILLS PRESCHOOL

18181 DOGWOOD DR., SPRING LAKE

Children must be a minimum of 3 years old (36 months) and are required to be toilet trained to attend Lake Hills Preschool

☐ Monday – Friday	(5 days per week)	**3 year olds**	9:00 AM – 12:00 PM

ROBINSON PRESCHOOL

11801 – 120TH AVE., GRAND HAVEN

Children must be a minimum of 3 years old (36 months) and are required to be toilet trained to attend Robinson Preschool

☐ Monday – Friday	(5 days per week)	**3 year olds**	9:00 AM – 12:00 PM

ROSY MOUND PRESCHOOL

14016 LAKESHORE DR., GRAND HAVEN

Children must be a minimum of 3 years old (36 months) and are required to be toilet trained to attend Rosy Mound Preschool

☐ Monday- Friday	(5 days per week)	**3 year olds**	9:00 AM – 12:00 PM

Age: 3 Years Old by September 1st. (Children born between September 2nd and December 1st are still eligible for PDP but will be put on a waiting list and will receive notification of enrollment prior to the start of school.)

Please Note: All classes listed are dependent on enrollment and staffing

Grand Haven Area Public Schools

Child Services • Preschool / Open Door
106 S. Sixth Street • Grand Haven, MI 49417
(616) 850-6825 • children@ghaps.org

2024/2025 Preschool Development Payment Information

Registration Fee $60 per family - Non Refundable Payment due with registration

☐ Cash ☐ Check #_____ ☐ Credit Card #_____ exp. _____ CC Type

Tuition and Payment Options

Session Payments		Monthly Payments
2 Days per week - $315.00 per session	or	$120.00 per month
3 Days per week - $420.00 per session	or	$155.00 per month
5 Days per week - $625.00 per session	or	$228.00 per month

Tentative Session Dates

Session 1	Sept. 3 – Nov. 22
Session 2	Nov. 25– Feb 28
Session 3	Mar. 3 – May 30

Payment Method: Please check one

☐ Cash/Check ☐ Credit Card #_____ exp. _____ CC Type

☐ Scholarship applicant

No registration fee or session payment due, pending scholarship application approval. Scholarship Application (the attached Ottawa County Early Childhood Application) must be turned in with registration. If approved, scholarships awarded may not cover your entire tuition cost. Proof of income is required. Please provide the most recent tax return document stating your Adjusted Gross Income or 3 of the most recent paystubs for all working adults in the household.

Payment Schedule: Please check one

☐ **Pay Per Session**

Payment Due Dates: (credit card will be automatically charged on these dates if you have chosen this payment method)

Session 1	September 3	**Session 2**	December 2	**Session 3**	March 3

☐ **Monthly Payment Plan**

By selecting the monthly payment plan, you will be paying an additional $48 over the course of the school year.
Payment Due Dates: (credit cards will be automatically charged on these dates if you have chosen this payment method)

Session 1	September 3	**Session 2**	December 2	**Session 3**	March 3
	October 7		January 6		April 7
	November 4		February 3		May 5

Grand Haven Area Public Schools

Preschool Student Enrollment Form

Student ID# _____

Date Received _____

Anticipated Start Date_____

English: Do you need documents translated into another language? Yes/No Which language?_____

Spanish: ¿Es usted un padre que necesita traducción de documentos? Si/No

Vietnamese: Bạn có phải là cha mẹ người sẽ cần dịch tài liệu? Có hay không Khong/Co

Child's Legal Name_____ **Grade** _____ **Gender** _____
(as shown on birth certificate) Last First Middle

Nickname/Goes by name?_____ **Date of Birth** _____ **City/State of Birth** _____

Is child a twin/triplet/etc? _____ **Main Phone** (_____)_____ **Resident County**_____
Unlisted Yes or No?

Address _____ **City** _____ **Zip** _____

Resident of GHAPS District? Yes/No No, Which District? _____

Previous School/District Name, Address, and Phone: _____

Has your student been expelled or suspended from a school inside/outside the State of Michigan? ☐ Yes ☐ No

Is either parent currently actively serving in the military? Yes/No Yes, which branch? _____

The US Department of Education requires that parents answer both Parts A and B. Please select an answer for both. If either part A or B is not answered, the Department of Education requires the school district to supply an answer on your behalf.

Part A – Ethnicity: Is this student Hispanic/Latino? (Choose only one)

☐ **No, not Hispanic/Latino**

☐ **Yes, Hispanic/Latino** (A person of Cuban, Mexican, Puerto Rican, South or Central American, or other Spanish culture of origin, regardless of race.)

Part B – Race: The question to the left is about ethnicity, not race. No matter what you selected, please continue to answer the following by marking one or more boxes to include what you consider your student's race to be. *(Required to meet state reporting guidelines.)*

☐ American Indian/Alaska Native ☐ Asian American ☐ White

☐ Native Hawaiian/Pacific Islander ☐ Black/African American

Parents/Step-parents/Guardians Residing in the Home:

Name			Name		
Relationship			Relationship		
Employer			Employer		
Work Phone			Work Phone		
Main Phone		Type:	Main Phone		Type:
Email			Email		

Is there a custody concern or current court order concerning this child? ☐No ☐Yes, if yes, please provide documentation.

Parents/Step-parents/Guardians Living Elsewhere: Joint Custody or Non-Custodial

Name			Name		
Relationship			Relationship		
Complete address					
Employer			Employer		
Work Phone			Work Phone		
Main Phone		Type:	Main Phone		Type:
E-mail			E-mail		

May we contact non-custodial family members in case of an emergency? Yes/No **May non-custodial family members have access to child's educational record?** Yes/No If you answered "No" to either of these questions, please provide legal documentation specific to this matter.

Emergency Contacts, in case parents/guardians cannot be reached (including Daycare Provider, if applicable):

Name	Relationship to Student	Daytime Phone

List other children in the family (use additional sheet as needed):				
Name	**Birthdate**	**Gender**	**Grade**	**School (if applicable)**

Special Education					
Has your child ever received Special Education services? ☐ No ☐ Yes, if yes, please provide copy of ***Current*** **Services Provided w/IEP.**					
SE Primary Disability _____	Speech? Y or N	OT/PT? Y or N	Social Work? Y or N	Section 504? Y or N	Other?

Language Survey

Is your child's native tongue a language other than English? ☐ No ☐ Yes If *Yes*, what language? _____

Is the *primary* language used in your child's home or environment a language other than English? ☐ No ☐ Yes
If *Yes*, what language? _____

Is the student a refugee? _____ Has the student ever received Bilingual/ELL services? _____ Are you a migrant agricultural worker/fisher?_____

Medically Diagnosed/Physician Treated Conditions? *(include only those conditions that are under a doctor's care):* _____

_____

Will medication be required at school? Yes / No If yes, please complete a medical form. Medication will not be administered without a completed form.

In the event of a serious accident or illness, I authorize the school district to transport, or call for an ambulance, my child to a hospital for emergency care. The hospital, their agents, or a licensed physician may administer such emergency medical treatment as they deem necessary. In addition, I authorize the school district to share medical information about my child with staff members that are in contact with him/her.

_____

Signature (Legal parent/guardian) Date

Grand Haven Area Public Schools is working towards sending school correspondence electronically. **If you do not wish to receive correspondence in this manner, please initial here_____** *If you do wish to receive electronic correspondence, please make sure you provided a valid email address on the first page of this form.*

☐ **How did you hear about our preschool programs**? ☐Family ☐Friend ☐Flyer ☐Mailing ☐Preschool Expo ☐OAISD ☐Other:_____

☐ **Kindergarten/Young Fives*:*** By checking this box I am intending to enroll my child for the upcoming school year under Section 6(4)(I)(iii) of the State School Aid Act (MCL 388.1606), which acknowledges my child will turn 5 years old between September 2nd - December 1st of this current year.

☐ **Photo Release:** By checking this box, I grant permission allowing GHAPS to publish my child's photo on all media including the district website.

☐ **Student Email:** By checking this box, I grant permission allowing school district to assign my child a district email address for use with technology devices (where age appropriate).

☐ **Preschool:** By checking the box, you are indicating that your child attended preschool during his/her pre-primary years.

Please Read and Sign:

Information on this form will be kept confidential and released only according to the Family Educational Rights and Privacy Act.

In order for a student to enroll in Grand Haven Area Public Schools, the parents or guardians must comply with the State of Michigan General School Laws, which require that students attend school in the district in which they live, with the exception of School of Choice approval. If it is found that a student's documents have been falsified to establish residency in the Grand Haven Area Public Schools district, that student will be immediately dismissed from school, in accordance with district policy.

In order to affirm this student's residency in the Grand Haven Area Public Schools district, I declare that this student physically resides at the address shown. I have presented documents to Grand Haven Area Public Schools confirming the parent/guardian's name and address is within the boundaries of the Grand Haven district. I declare that these documents are true and accurate. I am aware that deliberate falsification of information for school attendance purposes is unlawful and will result in the student's immediate dismissal from Grand Haven Area Public Schools.

_____ _____ _____

Signature (Legal Parent/Guardian) Relationship to Student Date

OFFICE USE ONLY

- ❑ Verification of Birthdate Use for Kindy
- ❑ Verification of residency
- ❑ Non-resident student application recv'd? _____
- ❑ Records Requested _____ Recv'd. _____
- ❑ Immunization records recv'd

Child Development Services of Ottawa County, Inc. — Lakeshore Head Start | Great Start Readiness Program — Michigan's Nationally Recognized Pre-K Program | Ottawa Area ISD — Learn. Serve. Lead. | Help Me Grow Ottawa | READY FOR SCHOOL

Ottawa County Early Childhood Application 2024-2025

(Please use this application to apply or receive information for early childhood programming in Ottawa County)

To apply online go to *hmgOttawa.org* and click **Contact Us**

CHILD INFORMATION

Application Date ____________________

Child's Legal Last Name	Child's First Name	M.I.	Nickname	Gender ☐Male ☐Female
Child's Birthday (month, day, year)	My child is transitioning from Early Head Start ☐YES ☐NO		My child is transitioning from Early On ☐YES ☐ NO	

Do you or your doctor have concerns about your child's development? (i.e. language, motor, behavior) ☐YES (Please explain) ☐ NO

Does your child have a current IEP or IFSP? ☐YES ☐ NO

HOUSEHOLD INFORMATION

ADDRESS			
Living Address: Street / Apartment	City / State / Zip	County	Phone Number
Mailing Address (**if different**): Street / Apartment	City / State / Zip	County	Phone Number

Which school district do you live in?
Please Choose from the following list

How many times have you moved in the last year?	Do you have a permanent residence? ☐ YES ☐ NO	Have you been homeless in the past year? ☐YES ☐ NO

Email Address:

I am interested in receiving Early Childhood information by ☐email ☐ text ☐both ☐neither

HOUSEHOLD- PLEASE LIST ALL MEMBERS

						Circle One			
Last Name	First Name	M.I.	Date of Birth	Relationship to Child	Sex ☐M ☐F	High School Grad ☐	Non-Grad ☐	GED ☐	Employed? ☐Yes ☐No
Last Name	First Name	M.I.	Date of Birth	Relationship to Child	Sex ☐M ☐F	High School Grad ☐	Non-Grad ☐	GED ☐	Employed? ☐Yes ☐No
Last Name	First Name	M.I.	Date of Birth	Relationship to Child	Sex ☐M ☐F	High School Grad ☐	Non-Grad ☐	GED ☐	Employed? ☐Yes ☐No
Last Name	First Name	M.I.	Date of Birth	Relationship to Child	Sex ☐M ☐F	High School Grad ☐	Non-Grad ☐	GED ☐	Employed? ☐Yes ☐No
Last Name	First Name	M.I.	Date of Birth	Relationship to Child	Sex ☐M ☐F	High School Grad ☐	Non-Grad ☐	GED ☐	Employed? ☐Yes ☐No

Total # in household:	Previous 12 months of income: $

List any parent(s) not living in above household: Name________________________________ Relationship to child:_______________________

VERIFICATION OF 12 MONTHS OF INCOME MUST BE ATTACHED IN ORDER TO PROCESS YOUR APPLICATION A copy of your 2022 Tax Return, W2's, verification of Child Support, Unemployment and/or Disability Income

Check box if family is receiving any of the following services:
☐ MDHS Child Care Reimbursements ☐ SSI ☐ FIP Payments ☐Work First ☐ Child is a Foster Child

Name	Amount: $ ☐yearly ☐monthly ☐weekly	Description
Name	Amount: $ ☐yearly ☐monthly ☐weekly	Description

TRANSPORTATION INFORMATION (if available)			
Pick Up Location ☐ Home ☐Childcare	**If Childcare,** Name:	Address	Phone
Drop Off Location ☐Home ☐Childcare	**If Childcare,** Name	Address	Phone
Are you able to self-transport? ☐YES ☐NO			

PARENT INFORMATION

Are parents able to speak English? ☐YES ☐ NO		Primary language spoken in home		Secondary language spoken in home	
Does either parent have a disability? ☐YES _____ ☐NO		Is either parent on Active Military Duty? ☐YES _____ ☐ NO		Is either parent incarcerated? ☐YES_____ ☐ NO	
Has child lost a parent or sibling due to death? ☐YES ☐ NO	Has child been abused/CPS involved? ☐YES ☐ NO	Do you have a chronically ill family member? ☐YES ☐ NO	Are you a recent immigrant/refugee? ☐YES ☐ NO	Do you have a current/history of domestic violence? ☐YES ☐NO	Substance abuse/ addiction? ☐YES ☐NO
How did you hear about this program?					

IF I CANNOT BE REACHED, PLEASE CONTACT:		
Name	Phone Number	Relationship to child
Address		City / State / Zip

I hereby release this information to be shared by Help Me Grow-Ottawa, Ottawa Area Intermediate School District, Child Development Services - Lakeshore Head Start and any location preference indicated below.

Additionally, if I do not qualify for tuition free preschool programs, I give the Ottawa Area Intermediate School District permission to give my application to tuition assistance programs (Ready for School) Yes/No

NOTE: APPLICATION MUST BE SIGNED IN ORDER TO BE PROCESSED

Signature of Parent/Guardian: Date:

Check all options for which you are interested in applying:

- ☐ Home-Based Services (Parents as Teachers/ Early Head Start)
- ☐ Childcare
- ☐ Three Year Old Preschool Location preference_____
- ☐ Four Year Old Preschool Location preference_____
- ☐ Other_____

See Early Childhood Program Options and Income Guidelines to help in making your choice at hmgOttawa.org.

If this is an agency referral please fill out the following:

Contact Person: _____

Agency: _____

Phone/Email: _____

Please return application to:

Grand Haven Area Public Schools
Child Services Department
106 S. 6th Street
Grand Haven, MI 49417
or
children@ghaps.org

For more information:
616-850-6825

*__Filling out this application does not guarantee acceptance in programs__.

Grand Haven Area Public Schools

Child Services Department
106 S. Sixth Street, Grand Haven, MI 49417
Phone: 616.850.6825
www.ghaps.org Children@ghaps.org

Parent Notification of the Licensing Notebook Requirement
Child Care Organizations Act, 1973 Public Act 116

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 at our individual Preschool Program Sites and at our Child Services Office.
- Licensing inspection and special investigation reports from the past two years are available on the Bureau of Children and Adult Licensing website at **www.michigan.gov/michildcare**.

☐ I have read the above statement issued by Child Services Department of Grand Haven Area Public Schools

Parent Signature:_____ **Date:**_____

Parent Handbook

The Preschool Development and Great Start Readiness Program Handbooks are available in our Child Services office or on our website at https://www.ghaps.org/our-district/departments/child-services/preschool/. I understand and agree to abide by the policies and procedures outlined in the handbook.

Parent Signature:_____ **Date:**_____

Enrollment Checklist

Please provide the following to complete registration:

Great Start Readiness & Preschool Development Scholarship Students Only:
- ☐ A completed Application form including proof of income

Preschool Development Only:
- ☐ Completed Registration forms
- ☐ Payment for your registration fee **or** a completed scholarship application including proof of income

All Preschool Programs
- ☐ A Health Appraisal form signed by a parent/guardian and your child's physician. (attached)
- ☐ A complete Immunization Record or a waiver signed by the Ottawa County Health Department
- ☐ A copy of your child's Birth Certificate
- ☐ Your child's Emergency Card (Child Information Record). All sections must be complete. (attached)
- ☐ A copy of your Driver's License

These documents are **required** in order to complete registration and begin preschool.

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.)	

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 Child Services Department, 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

BCAL-3731 (Rev. 6-17) Previous editions 4-16, 6-15 and 7-12 may be used until September 30, 2018.

Grand Haven
Area Public Schools

Student Residency Questionnaire

This questionnaire is intended to address the McKinney-Vento (homeless) Act 42 U.S.C. 11435. You are receiving this form because you have indicated, or it was made known to the school, that your child may be in need of some assistance. The answers to this confidential residency questionnaire help determine the services your student may be eligible to receive such as (but not limited to): school supplies, clothing, tutoring, and/or other services. Please complete this questionnaire and return it in to your child's teacher.

Name of Student ____

Birth date ____________________________ Gender ______Building________________________ Grade _____

Name of Parent(s)/Legal Guardian(s) ____

Address ____

City _______________________________________ Zip _____________ Phone ___________________________

1. Is your current address a temporary living arrangement? ☐ Yes ☐ No
2. If a temporary living arrangement, is it due to loss of housing, economic hardship, or other similar circumstances? ☐ Yes ☐ No
3. Are you a Refugee/Migrant? ☐ Yes ☐ No

If you answered NO to all the above questions, simply sign and date the bottom of the form.

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

- -

Where is student presently living?

- ☐ In a motel/hotel.
- ☐ In a shelter or other transitional housing.
- ☐ In a car, park, campground, public space, abandoned building, or substandard housing.
- ☐ Moving from place to place.
- ☐ With more than one family in a house or apartment. Who residing with? ____________________________
- ☐ With an adult that is not a parent or legal guardian. Who residing with? ____________________________
- ☐ Alone, without an adult. Who residing with? ____________________________
- ☐ In Foster Care.
- ☐ Other (please explain)____

____

Signature of Parent/Legal Guardian/Person Enrolling Student Date

Student History Form

Date: _____

Child's Name: _____ Birthdate: _____

Home Address: _____ Home Phone: _____

_____

FAMILY BACKGROUND

Father (Male Caretaker's Name): _____ Age: _____

Cell Phone: _____ Email: _____

Place of Work: _____ Work Phone: _____

Mother (Female Caretaker's Name): _____ Age: _____

Cell Phone: _____ Email: _____

Place of Work: _____ Work Phone: _____

MEDICAL HISTORY OF CHILD

Present Health (please check all that apply)

☐ In good health ☐ Hearing problems ☐ Vision problems ☐ Speech problems

☐ Trouble sleeping ☐ Allergies ☐ History of significant illness [specify] _____

Present Medication (please check all that apply)

☐ No medication ☐ Medication for asthma ☐ Medication for allergies

☐ Ritalin: ____milligrams taken _____times daily

☐ Other medications _____ Purpose _____

☐ Other medications _____ Purpose _____

Describe any hospitalizations, operations, other injuries or illnesses:

_____

_____

DEVELOPMENTAL HISTORY (please check all that apply)

Pregnancy (Optional)

☐ Normal ☐ Smoked during pregnancy ☐ Drank alcohol [more than the occasional drink]

☐ Used drugs ☐ Took medications ☐ Threatened miscarriage

( ) Other important information: _____
_____

Delivery: Birth Weight _____

☐ Normal ☐ Blue or yellow at birth ☐ Needed incubator

☐ Baby had to stay in hospital (

☐ Birth defect or medical problem [specify] _____

_____

Preschool Years

☐ Walked alone at less than 12 months ☐ Talked on time

☐ Walked at 12 to 15 months ☐ Talked early

☐ Walked later than 15 months ☐ Talked late

SOCIAL/EMOTIONAL DEVELOPMENT (please check all that apply)

☐ Cries often ☐ Very Active ☐ Confident ☐ Insecure

☐ Easily upset ☐ Shy around others ☐ Easily frustrated ☐ Plays well with others

☐ Happy ☐ Has a bad temper ☐ Easy to discipline ☐ Moody/temperamental

☐ Disregards rules ☐ Has regular playmates ☐ Prefers to play alone ☐ Demands adult attention

Family concerns which may be influencing your child at present (Optional):

_____
_____
_____
_____

ADDITIONAL INFORMATION

_____
_____
_____
_____

Parent/Guardian signature: _____

Parent/Guardian Print Name: _____

Date: _____

Grand Haven
Area Public Schools

Grand Have Area Public Schools
Grand Haven, MI 49417 www.ghaps.org

Field Trip Permission Form

Student's Name _____ Teacher _____

I give permission for my child to attend various field trips during the school session. I understand the teacher/office will notify me of all details of each trip. I understand that transportation for field trips may be by walking, school bus, public transportation, or I may be asked to self-transport my child to the event. I give permission for transportation (if needed) of my child either by walking, school bus or public transit to field trip events. I also understand that prior to each field trip, I must sign a separate permission form for that field trip. I understand that I can withdraw this release at any time by notifying, in writing, my child's teacher.

If there is a field trip you would not want your child to participate in, please call or send a note to the teacher.

☐ Yes, I give permission
☐ No, please call to discuss

Signature of Parent/Guardian*:* _____ **Date:** _____

Printed Name of Parent/Guardian: _____

Grand Haven
Area Public Schools

Parent/Child Survey

Child's Name: _____ Age: _____

1. What are your child's favorite toys or games? (include inside and outside activities)

2. What are your child's favorite books?

3. How often do you read to your child?

4. How much time does your child spend watching TV or playing video games daily?

5. What are your child's strengths?

6. What activities are difficult for your child?

7. Any other information to help me get to know your child?

Parent Signature: _____ Date: _____

Grand Haven
Area Public Schools

Preschool Development Program
Parent/Guardian Participation Agreement

I recognize and embrace my role as an active partner in the education of my child. I understand that it is my responsibility to enhance my child's social, emotional, physical and academic growth through participation in the following:

- Provide interaction with a sit down activity 3 times a week.
- Be involved in my child's "school life" throughout the year by: talking with my child about his/her day: communicating with my child's teachers; volunteering my time and talent to the classroom; and supporting and participating in school events.
- Reading one or more books to my child each day. Because reading is one avenue through which children learn compassion, courage, hope, responsibility and patience.
- Promote my child's self-esteem by: giving him/her opportunities to build competence and confidence; acknowledging their work and displaying it for others to see; letting him/her share in family responsibilities and decisions.
- Pay attention to the types of music, video and television programs that my child is listening to, playing and watching to be sure that they are age appropriate.
- Being mindful of adult language and activities in the presence of my child. Children are sponges and will absorb what they hear and see.
- Read all newsletters and notices provided by my child's teacher.
- Ensure that my child is attending and on time for all classes.
- Call my child's teacher if my child will be absent from school.
- Enjoy my child as we grow and learn together.

_____ _____

Parent/Guardian Signature Parent/Guardian Signature

_____ _____

Child's Name Date

Grand Haven
Area Public Schools

Photograph/Videotape/Name Usage Permission Form

The Preschool Development Program (PDP), Great Start Readiness Program (GSRP), the Grand Haven Area Public School District (GHAPS), the Grand Haven Schools Foundation (GHSF) and the Ottawa Area Intermediate School District (OAISD) uses photos and/or names of students in classroom and educational related activities. Photos and/or names may be used for newsletters, classroom/school/GHAPS/ GHSF/OAISD website, educational presentations, news releases and articles, district *Spotlight* newspaper and other periodicals, television news reports, video productions, promotional brochures and materials, annual and informational reports and other educational purposes.

I give permission for my child/child's name to be included in photographs and videos while participating in any program activities and field trips.

☐ **YES** ☐ **NO**

I give permission for photographs of my child to be posted in the classroom or within other program displays.

☐ **YES** ☐ **NO**

I give permission for photographs/name of my child to be used with promotional brochures and materials, annual and informational reports and newspaper/periodical articles.

☐ **YES** ☐ **NO**

I give permission for photographs/videos/name of my child to be used on the classroom, district, OAISD, and/or GHSF web sites, or other social media.

☐ **YES** ☐ **NO**

I give permission for videos of my child to be shown to other program staff/parents.

☐ **YES** ☐ **NO**

_____

Child's Name (printed)

_____

Parent/Guardian Name (printed)

_____ _____

Parent/Guardian Name (signature) **Date**

_____

Teacher

Grand Haven
Area Public Schools

Preschool Development Program

Student Goals

Parents are a major part of the learning process and we want to ensure that our students are moving forward in their kindergarten readiness skills. With this in mind, please list a goal in each of the areas below that you would like to see your child moving toward.

Child's Name: _____ Age: _____

Academic Goal (ex: writing, reading, listening, problem solving, fine/gross motor)

Social-Emotional Goal (ex: play well with others, independence, sense of self)

Parent Signature: _____ Date: _____

Grand Haven Area Public Schools

Preschool Development Program (PDP)

Authorization for Application of Sunscreen

I, _____, do hereby authorize **Preschool Development Program**

(Print Parent/Guardian's name)

staff to topically apply any of the following NON-AEROSOL sunscreens listed below to my child

_____.
(Print Child's Name)

I understand that I must supply the sunscreen for my child (***please put child's name on bottle***).

I will hold ***Preschool Development Program (PDP)***, its district, its directors, its teachers, and its staff harmless in the event of any adverse reaction resulting from the application of any of the sunscreens below between the dates of

09/01/2024 and 05/31/2025

Authorized Sunscreens: Supplied by Parent

_____

_____

_____

_____
Parent Signature

_____
Date

Our program does not supply sun screen, the parent is responsible for providing non-aerosol sunscreen for their child.

Grand Haven
Area Public Schools

Education Service Center
1415 Beechtree Street, Grand Haven, MI 49417
Phone: 616.850.5000

Consent for Disclosure of Immunization Information to Local and State Health Departments

Immunizations are an important part of keeping our children healthy. Schools and State and Local health departments must monitor immunization levels to ensure that all communities are protected from potentially life-threatening diseases and, if necessary, respond promptly to an emerging public health threat. It is important that disease threats be minimized through the monitoring of students being immunized.

Sharing immunization and personally identifiable information including the student's name, date of birth, gender, and address with local and state health departments will help to keep your child safe from vaccine preventable diseases. The Family Educational Rights and Privacy Act (FERPA), 20 U.S.C. § 1232g, requires written parental consent before personally identifiable information from your child's education records is disclosed to the health department. If your child is 18 or over, he or she is an "eligible student" and must provide consent for disclosures of information from his or her education records.

You may withdraw your consent to share this information in writing at any time.

I authorize ***Grand Haven Area Public Schools*** *to release my child's immunization record to the Michigan Department of Health and Human Services and Local Health Department. I understand this information will be used to improve the quality and timeliness of immunization services and to help schools comply with Michigan Law. This includes any immunization information and limited personally identifiable information from the school.*

Student's Name:_____ Date of Birth: __/__/__

Signature of Parent/Guardian
or Eligible Student: _____ Date:__/__/__

Printed Parent/Guardian Name: _____

Rev.8/2/18

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

No	Yes	Was child tested for:	Test results:	Normal	Referred	Under Care
☐	☐	HEIGHT & WEIGHT	Height			
			Weight			
		Other: _____	Other			
☐	☐	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 (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 _____ 's teeth. As a result of this examination, my recommendation for treatment is: _____

child's name

_____ ___/___/___

Dentist's Signature Date

PHYSICIAN'S SIGNATURE

_____ ___/___/___ _____ _____

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

_____ _____ MI _____ (___) _____

Number & Street City 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.

****

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.

Grand Haven Area Public Schools

Child Services Department

106 S. Sixth Street, Grand Haven, MI 49417
Phone: 616.850.6825
www.ghaps.org Children@ghaps.org

Welcome to Preschool Development!
Please keep this page for your records

We are looking forward to a fantastic 2024/2025 school year! Please feel free to call the Child Services office at 616-850-6825 or email children@ghaps.org if you have any questions or need assistance completing your registration packet.

Dates to Remember: *(Dates subject to change due to district calendar)*

09/3/24……Start Date (Monday/Wednesday/Friday class begin 09/4/24)
09/3/24 - 11/22/24……Session 1
11/25/24 - 02/28/25……Session 2
03/03/25 - 05/30/25……Session 3

Payment due dates: Please note your preference on your registration packet

Per session payments:

Session 1	September 3	**Session 2**	December 2	**Session 3**	March 3

Monthly payments:

By selecting the monthly payment plan, you will be paying an additional $48 over the course of the school year.

Session 1	September 3	**Session 2**	December 2	**Session 3**	March 3
	October 7		January 6		April 7
	November 4		February 3		May 5

Session/Monthly Payment amounts

	Session Payments:	Monthly Payments:
2 Days per week	$315.00 per session	$120.00 per month
3 Days per week	$420.00 per session	$155.00 per month
5 Days per week	$640.00 per session	$228.00 per month

Scholarship applicants

No registration fee or session payment due pending scholarship application approval. Scholarship Application (the attached Ottawa County Early Childhood Application) must be turned in with registration packet. If approved, scholarships awarded may not cover your entire tuition depending on the number of days per week you have chosen to attend. Proof of income is required. Please provide the most recent tax return document stating your Adjusted Gross Income or 3 of the most recent paystubs for all working adults in the household.

Enrollment Checklist

Please provide the following with your registration packet. These documents are **required** in order to complete registration and begin preschool.

- ☐ A completed registration form turned in to the Child Services office
- ☐ Payment for your registration fee **or** a completed scholarship application including proof of income
- ☐ A Health Appraisal form signed by a parent/guardian and your child's physician. (attached)
- ☐ A complete Immunization Record or a waiver signed by the Ottawa County Health Department
- ☐ A copy of your child's Birth Certificate
- ☐ Your child's Emergency Card (Child Information Record). All sections must be complete. (attached)
- ☐ A copy of the enrolling Parent/Guardian's Driver's License

Please keep this page for your records