Dear Parents,

Thank you for your interest in our tuition based preschool program. Completed enrollment applications and other required documents need to be returned together to the Early Childhood Center. Partially completed applications will not be accepted. There is no implied guarantee of childcare or preschool location with enrollment.

Requirements:

- Completed placement contract
- Child Information Record
- Health appraisal form filled out by physician and parent
- Record of up to date immunizations from your Healthcare provider
- Copy of birth certificate
- Verification of residence - This verification can be:
  - A copy of a current utility bill or email statement (gas, electric, water, etc),
  - An assessment/property tax statement,
  - A copy of a rental/lease agreement (must include landlord’s telephone number),
  - Or a copy of the signed buy/sell agreement from closing documents.
- $50 enrollment fee + first tuition payment

Please return all items together. Applications will be reviewed and parents will be notified of placement status in August 2020. Your child will not be placed until all items have been received.

We look forward to serving your family this upcoming year.

Sincerely,

Lee Westervelt, Principal
Early Childhood Center

WWW.JPSONLINE.ORG
2950 Baldwin St. Hudsonville, MI 49426  (Phone) 616.777.6534  (Fax)616.457.8492
For the 2020/2021 school year the Jenison Public Schools ECC Preschool Program agrees to provide childcare services for the following named child:

Printed name of child

Date of Birth

Email address

Phone Number

Parent Signature - Person Responsible for Payment

Date

Part I: Contract of provisions provided by child care facility:
The Jenison Public Schools ECC Preschool is a State of Michigan Licensed program. The program is staffed according to applicable Licensing Rules for Child Care Centers, Effective June 4, 2008 through the Department of Human Services.

Staff Screening Policy
The ECC shall have the following administrative responsibilities regarding staff:
All program directors meet requirements for Child Day Care Licensing Centers. Prior to their selection as a staff member all employees are subject to an interview process which includes filling out an employment application and telephone reference checks. Jenison Public Schools also does a criminal police check on all new employees. All employees must submit a form to the Family Independence Agency to check for any child abuse and neglect. Finally, all new employees are made aware of existing child abuse and neglect laws, school policy regarding this subject matter and proper reporting procedures, along with new staff fingerprinting.

Program
JPS ECC shall provide a program of daily activities and relationships that offer opportunities for the developmental growth of each child in each of the major developmental areas. This is a quality preschool program that provides time for academics, indoor and outdoor activities, arts and crafts, healthy snacks and much more in a safe and caring environment.

Program Goals:
-To provide a safe and relaxed environment where the children's physical and emotional needs are met.
-To develop respect for others, self, the environment and materials.
-To help the children develop self-control and a clear understanding of the expectations in this environment.
-To provide a routine that allows for the type of activities that the children might be involved with if they were at home.
-To provide an opportunity to become independent and responsible through self-directed and individualized activities.
-To provide ample opportunity to develop coordination and large motor skills through physical activity and outdoor play.
-To learn how to participate and function well in a mixed age group.
Nutrition Services:
Milk is part of the program at no additional cost. Students are able to bring a packed lunch or purchase a hot lunch daily. The monthly menu is available on jenhudfood.org as well as the ECC website.

Additional Contract Provisions:
Upon signing this agreement, the parent, legal guardian or responsible adult and the JPS ECC Program agree to abide by all of the provisions contained in this contract. Parents are clearly stating their child is in good physical and mental health by signing this contract. You are confirming the following:
(a) The child is in good health with activity restrictions noted.
(b) The child's immunizations are up-to-date.
(c) The immunization record or appropriate waiver is on file with the child's school.

Program: Fees: (Circle Your Payment Option)
3-year-old Preschool (2 half days) $1,100 per year, $110/month, $27.50/week
4-year-old Preschool (4 half days) $2,100 per year, $210/month, $52.50/week
4-year-old Preschool (4 full days) $4,000 per year, $400/month, $100/week
4-year-old Preschool (5 full days) $5,000 per year, $500/month, $125/week

*This completed application is due with a $50 registration fee and one month of tuition (non-refundable). The balance of the tuition can be paid in full or with a monthly or weekly payment options. A $20 per week late fee is assessed for delinquent accounts. Habitual late pick-ups may result in a meeting with the director or additional fees.

The signer of this application contractually agrees to assume all financial obligations and responsibilities including, but not limited to, the timely payment of tuition and fees (including late payment fees) for ___________ to attend JPS ECC Preschool. Failure to pay amounts owed may result in the discontinuation of services and possible legal action.

Parent, Legal Guardian or Responsible Adult
Signature
______________________________  Signature
______________________________
Printed Name
______________________________
Printed Name
______________________________
Relationship to Child
Director of JPS Early Childhood Center
______________________________

Please number your top three choices in order of preference.
3 Year Old Preschool:
M/W AM _____ M/W PM _____ $1,100 Monday - Thursday AM _____ $2,100
T/TH AM _____ T/TH PM _____ $1,100 Monday - Thursday PM _____ $2,100
4 Year Old Preschool:
All Day Monday-Thursday _____ $4,000
All Day Monday-Friday _____ $5,000

Teacher Preference: ____________________________

*$50 registration fee and one month of tuition is due at enrollment (non-refundable).
There is no implied guarantee of childcare or building location of preschool with enrollment.
**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.

<table>
<thead>
<tr>
<th>For Provider Use Only:</th>
<th>Date of Admission</th>
<th>Date of Discharge</th>
</tr>
</thead>
<tbody>
<tr>
<td>Name of Child (Last, First, Middle Initial)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Address (Number and Street, Building/Apartment Number)</td>
<td>City</td>
<td>State</td>
</tr>
<tr>
<td>Parent/Legal Guardian’s Name</td>
<td>Home Phone</td>
<td>Parent/Legal Guardian’s Name (Optional)</td>
</tr>
<tr>
<td>Home Address (if not child’s address)</td>
<td>Cell Phone</td>
<td>Home Address (if not child’s address)</td>
</tr>
<tr>
<td>City</td>
<td>State</td>
<td>Zip Code</td>
</tr>
<tr>
<td>Email Address (optional)</td>
<td></td>
<td>Email Address</td>
</tr>
<tr>
<td>Employer Name</td>
<td>Work Phone</td>
<td>Employer Name</td>
</tr>
<tr>
<td>Name of Child’s Physician or Health Clinic</td>
<td></td>
<td>Physician’s or Health Clinic’s Phone Number</td>
</tr>
<tr>
<td>Hospital Preferred for Emergency Treatment (optional)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Allergies, Special Needs and Special Instructions (Attach additional sheets, if necessary.)</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**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.

See Reverse Side
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) TODAY'S DATE (mm/dd/yy)
PARENT/GUARDIAN (Last, First, Middle) HOME TELEPHONE NUMBER
ADDRESS (Number & Street) (City) (ZIP Code) WORK TELEPHONE NUMBER

SECTION I - HEALTH HISTORY

<p>| | | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
<td>No</td>
<td></td>
</tr>
<tr>
<td>Is your child having any of the problems listed below?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>☐ ☐ ☐ 1 Allergies or Reactions (for example, food, medication or other)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>☐ ☐ ☐ 2 Hay Fever, Asthma, or Wheezing</td>
<td></td>
<td></td>
</tr>
<tr>
<td>☐ ☐ ☐ 3 Eczema or Frequent Skin Rashes</td>
<td></td>
<td></td>
</tr>
<tr>
<td>☐ ☐ ☐ 4 Convulsions/Seizures</td>
<td></td>
<td></td>
</tr>
<tr>
<td>☐ ☐ ☐ 5 Heart Trouble</td>
<td></td>
<td></td>
</tr>
<tr>
<td>☐ ☐ ☐ 6 Diabetes</td>
<td></td>
<td></td>
</tr>
<tr>
<td>☐ ☐ ☐ 7 Frequent Colds, Sore Throats, Earaches (4 or more per year)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>☐ ☐ ☐ 8 Trouble with Passing Urine or Bowel Movements</td>
<td></td>
<td></td>
</tr>
<tr>
<td>☐ ☐ ☐ 9 Shortness of Breath</td>
<td></td>
<td></td>
</tr>
<tr>
<td>☐ ☐ ☐ 10 Speech Problems</td>
<td></td>
<td></td>
</tr>
<tr>
<td>☐ ☐ ☐ 11 Menstrual Problems</td>
<td></td>
<td></td>
</tr>
<tr>
<td>☐ ☐ ☐ 12 Dental Problems: Date of Last Exam</td>
<td></td>
<td></td>
</tr>
<tr>
<td>☐ ☐ ☐ Other (please describe):</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Birth History:

Are there any current or past diagnosis(es) ☐ Yes ☐ No
If yes, please describe:

Does your child take any medication(s) regularly? ☐ Yes ☐ No
Reason for Medication

Was the health history reviewed by a health professional? ☐ Yes ☐ No
Examiner's Initials:

Parent/Guardian Signature Date

SECTION II - PHYSICAL EXAMINATION, INSPECTION, TESTS AND MEASUREMENTS

Required for Child Care and Head Start / Early Head Start

Tests and Measurements

<table>
<thead>
<tr>
<th>No</th>
<th>Test Results:</th>
<th>Normal</th>
<th>Referred</th>
<th>Under Care</th>
</tr>
</thead>
<tbody>
<tr>
<td>VISION</td>
<td>Visual Acuity</td>
<td>☐ ☐ ☐ ☐</td>
<td>☐ ☐ ☐</td>
<td>☐ ☐ ☐</td>
</tr>
<tr>
<td>HEARING</td>
<td>Audimeter</td>
<td>☐ ☐ ☐</td>
<td>☐ ☐ ☐</td>
<td>☐ ☐ ☐</td>
</tr>
<tr>
<td>URINALYSIS</td>
<td>Sugar</td>
<td>☐ ☐ ☐</td>
<td>☐ ☐ ☐</td>
<td>☐ ☐ ☐</td>
</tr>
<tr>
<td>TUBERCULIN</td>
<td>Type:</td>
<td>☐ ☐ ☐</td>
<td>☐ ☐ ☐</td>
<td>☐ ☐ ☐</td>
</tr>
<tr>
<td>BLOOD LEAD LEVEL</td>
<td>Level ____________ ug/dl</td>
<td>☐ ☐ ☐</td>
<td>☐ ☐ ☐</td>
<td>☐ ☐ ☐</td>
</tr>
</tbody>
</table>

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

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.*

<table>
<thead>
<tr>
<th>VACCINES (Circle Type)</th>
<th>DATE ADMINISTERED</th>
<th>VACCINES (Circle Type)</th>
<th>DATE ADMINISTERED</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hepatitis B (HepB)</td>
<td>1 3</td>
<td>Hepatitis B (HepA)</td>
<td>1 2</td>
</tr>
<tr>
<td></td>
<td>2</td>
<td>Influenza (IV/IAV)</td>
<td>1 3</td>
</tr>
<tr>
<td>DTaP/DTP/DT/Td</td>
<td>1 4</td>
<td>Meningococcal (MCV4/ MCV4)</td>
<td>1 2</td>
</tr>
<tr>
<td></td>
<td>2 5</td>
<td>Human Papillomavirus</td>
<td>1 2</td>
</tr>
<tr>
<td></td>
<td>3 6</td>
<td>(HPV9/HPV4/HPV2)</td>
<td>1 3</td>
</tr>
<tr>
<td>Tdap</td>
<td>1</td>
<td>OTHER Vaccines</td>
<td>Type of Vaccine(s) Date of Vaccine(s)</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>1</td>
</tr>
<tr>
<td>Haemophilus Influenza</td>
<td>1 3</td>
<td></td>
<td>2</td>
</tr>
<tr>
<td>Type b (Hib)</td>
<td>2 4</td>
<td></td>
<td>3 6</td>
</tr>
<tr>
<td>Polio (IPV/OPV)</td>
<td>1 3</td>
<td></td>
<td>2</td>
</tr>
<tr>
<td>Pneumococcal Conjugate</td>
<td>1 3</td>
<td></td>
<td>2</td>
</tr>
<tr>
<td>(PCV7/PCV13)</td>
<td>2 4</td>
<td></td>
<td>3 6</td>
</tr>
<tr>
<td>Rotavirus (RV1/RV5)</td>
<td>1 3</td>
<td></td>
<td>2</td>
</tr>
<tr>
<td>Measles, Mumps, Rubella</td>
<td>1 2</td>
<td></td>
<td>2</td>
</tr>
<tr>
<td>Varicella (Chickenpox)</td>
<td>1 2</td>
<td></td>
<td>2</td>
</tr>
</tbody>
</table>

History of Chickenpox Disease? □ Yes □ No If yes, date: Parent/Guardian refused immunizations: □

I certify that the immunization dates are true to the best of my knowledge

Health Professional's Signature

SECTION IV - RECOMMENDATIONS

(Required for Child Care and Head Start/Early Head Start)

□ □ 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: □ 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, Restriction, 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.

*********************************************************
