

April 5, 2024

Hello future Kindergarten parents and guardians,

More sunshine and thoughts of Spring means it's also time to start thinking about enrolling your child in Kindergarten for the upcoming school year. We, here at Atlanta Community Schools, are excited to welcome the **Graduating Class of 2037** and are looking forward to getting your enrollment process started.

Here are some things to keep in mind as we move forward:

- **Preschoolers** - Families with a child who is attending preschool or headstart in our building are still required to complete our enrollment paperwork.
- **Age Requirement** - A student must be at least five (5) years of age on September 1, 2024 to meet Michigan's eligibility requirement. Alternatively, if a student will be five (5) years of age not later than December 1, 2024, a student may enroll with a Waiver of Eligibility Requirement form.
 - If a student's birthday is December 2, 2019 or later, they cannot enroll in Kindergarten for the 2024-2025 school year.

What can you do now to prepare for your child's enrollment?

- Make sure you have a **birth certificate** for your child.
- Work with your child's pediatrician or local Health Department to make sure **immunizations** are current and up to date for school entry in advance. Get a copy of their immunization report to submit with enrollment.
 - If your child will need a Health Waiver for immunizations from District Health Department #4, please contact DHD4 directly to make an appointment after January 2024. Waivers need to be specific to Atlanta Community Schools. These appointments do fill up, please plan ahead.
- **Health Appraisal/Physical** – A health appraisal/physical is required for Kindergarten entry by the State of Michigan. Please make sure the information is documented (and includes the doctor's signature) on the green Health Appraisal form. We can accept a well visit report from a 4-year visit. *If you attended preschool in Atlanta, we can obtain this form from them and you do not need to fill out another one.*
- **Dental Exam/Oral Assessment** – An oral assessment is required for Kindergarten entry by the State of Michigan. Children are required to have a form signed by a dentist, dental hygienist, or local health department certifying that the child's teeth were examined or assessed within 6 months of enrollment.
- **Vision Screening** – A vision screening (acuity test) is required for Kindergarten entry by the State of Michigan. It is usually completed during an annual well visit with the pediatrician (though, DHD4 also does these). The Vision Screening needs to be completed no earlier than 6 months prior to the first day of school. Sometimes, hearing screenings are completed alongside vision screenings.

Please see the back of this letter for other helpful information. If you have any questions, please call Atlanta Community School's main office at 989-785-4842.

Welcome to the Huskie Pack!

Kindness always,

Melissa Cumper

K-12 Secretary
Atlanta Community Schools
989-785-4842
mcumper@atlantaschools.us

Kindergarten Round-up for 2024-2025

- Opportunity to turn in enrollment paperwork
- Learn how to prepare your student for Kindergarten
- See the Kindergarten classroom and school
- Meet the teacher & ask questions

Tuesday, April 30, 2024

5-6 p.m. or 6-7 p.m.

We hope all new Kindergarten families will join us!

All families will receive a bag with educational materials.

HELPFUL INFORMATION

Atlanta Community Schools

10500 County Rd 489
Atlanta, MI 49709

Website: www.atlantaschools.us

Facebook: Atlanta Community Schools

District Health Department #4

(vaccinations, waivers, screenings)

Atlanta Office
12480 State St

Atlanta, MI 49709

Phone: 989-785-4428

School Office

Phone: 989-785-4842

Fax: 989-785-2588

Principal

Mrs. Tawny Hisscock

thisscock@atlantaschools.us

K-12 Secretary

Mrs. Melissa Cumper

mcumper@atlantaschools.us

Transportation Director

Mrs. Rochelle Thornberg

989-306-2904

rthornberg@atlantaschools.us

Kindergarten Teacher

Mrs. Linda Busen

lbusen@atlantaschools.us

Stay tuned for a back-to-school packet mailed in August with information regarding school supplies, pick-up and drop-off procedures, free/reduced lunch forms, school calendar, and info for a Back-to-School Night.

General Information

Kindergarten

Breakfast – Breakfast is available before school and is free for every student. If you would like your student to participate in the breakfast program, but plan on bringing him/her to school, please arrive 20 minutes before school begins (not more than 20). This will ensure your student has time to eat and is ready to begin the school day.

Lunch – A monthly menu will be sent home for breakfast and lunch or can also be found on our school website. Lunch is free this year for all students. We ask that all parents fill out and return the Free and Reduced Lunch application at the start of the school year, even if you don't think you'll qualify. Thank-you.

Snack – Our snack program is self-funding, so we are only able to offer it with everyone's donations. I will send home a request for snacks each month. Unfortunately, we are unable to serve homemade goods. Snacks need to be pre-packaged goods. Thank-you for your help. Kindergarteners are hungry!

Notes – Please send a note to school if there are changes to your student's bus/dismissal schedule. If you are unable to do this, please call the school at your earliest convenience. If your student is absent from school, please send a note or call the school at 785-4842.

Friday Folders – Friday Folders will go home every Friday afternoon with completed work and other important information. Please review the contents over the weekend and send the folder back on Monday mornings. This is a safe place to put notes and money to be sure it is received promptly.

Necessary Items – A backpack should be carried to and from school daily. A change of clothes, water bottle, and a pair of gym shoes is also needed. In the winter, snow pants, winter coat, winter boots, hats, and mittens are also required. Your student will be issued a locker where these items can be stored. Please contact the school if you need help providing these items for your student.

School Supplies – Check the school website or school Facebook page in August for a list of suggested Kindergarten school supplies. Please contact the school if you need help providing these items for your student.

Atlanta Community Schools

2024-2025 Kindergarten Registration Checklist

Student Name: _____

Forms Enclosed

- School of Choice Application
(only needed if living out of district)
- Waiver of Age Eligibility Requirement
(only needed if student is turning 5 between 9/1 and 12/1)
- ACS Student Registration Form
- ACS Consent to Disclose Immunizations
- ACS Proof of Residency Form
- ACS Transportation Bus Route Info
(fill out even if planning on not using bussing)
- Home Language Survey
- Medical Authorization Form
- Dental Oral Health Assessment
(must be after March 1, 2024 and before the start of school)
- ACS Prior Care Form
- Health Appraisal
(with doctor's signature, a report from a 4-year-old well visit can be accepted)

Must Also Be Provided

- Birth Certificate
(a copy is acceptable)
- Court/Guardianship paperwork
(if applicable)
- Proof of Residency
(something with your name and physical address on it)
- Immunizations Record
(current & up to date, from doctor or health department)
- Vision Screening results
(must be after March 1, 2024 and before the start of school)
- Most recent IEP
(If your child receives special services, a copy of a current IEP is required)

Please bring completed forms and required documentation to the school office at Atlanta Community Schools. Call 989-785-4842 with any questions. Thank-you!

Welcome to the Huskie Pack!



Atlanta Community Schools
Schools of Choice Application

Date of Application: _____

Student Name: _____

Grade Entering in the current school year: _____ Date of Birth: _____

School Attended in previous school year _____

The school district in which you reside: _____

Parent/Guardian Name(s):

Street Address:

Phone (home): _____ Alternate phone number(s): _____

Email address: _____

Is a sibling currently attending Atlanta Community Schools as a Schools of Choice Student? Yes No

Name(s) and grades of siblings:

Has your child ever been expelled from any school district? Yes No

If yes, state the school, date, and reason:

Has your child ever been suspended from **any** school within the last two (2) years? Yes No

If yes, state the school, date, and reason:

Has your child ever been convicted of a felony? Yes No

If yes, explain and when:

Has your child ever been tested for specialized services? Yes No

Does your child receive specialized assistance in school? Yes No

I give my permission for the release of information to Atlanta Community Schools regarding **all** suspensions within the past two (2) years as well as any expulsions involving my child. Yes No

I understand transportation will be the responsibility of the parent/guardian. Yes No

I understand that misrepresenting or withholding information on the application may cause the application to be withdrawn or rejected. Yes No

I understand that Michigan High School Athletic Association (MHSAA) regulations apply to all high school age transfers. Yes No

Student's Name:

Parent/Guardian or Student's reason for transfer to a School of Choice:

Please note that the following applies to School of Choice applications for students who reside in an intermediate school district other than the Atlanta Community School District: If your application for schools of choice enrollment is accepted and if your child is eligible for special education programs and services according to statute or rule, or is a child with disabilities, as defined under the individuals with disabilities education act, Title VI of Public Law 91-230, actual enrollment **cannot** occur until Atlanta Community Schools reaches a written agreement with the district in which you reside. This agreement will address providing your child with a free appropriate public education and must also include, but is not limited to, an agreement on the responsibility for the payment of the added costs of special education programs and services for the pupil. **If such agreement is not reached, your application will not be accepted.*

By my signature below, I give my permission for the release of discipline information for

_____ (Student's name), to Atlanta Community Schools, and I certify that all of the information contained in this application form is complete and correct. I understand that any incorrect or inaccurate statement, including but not limited to the statement on suspensions and expulsions, will result in either non-admission or no further consideration of this application or if already admitted, immediate suspension and dismissal as a student.

Parent's/Guardian's Signature (required)

Date (required)

******OFFICIAL OFFICE USE ONLY******

The student has been **Accepted** **Rejected** to participate in the requested School of Choice program in Atlanta Community Schools.

Reason for rejection: Suspended within last two years Expelled Convicted of a felony
 105c Special Education Cooperative Agreement not reached

Atlanta Community Schools Signature (required)
Principal - Tawny Hisscock

Date (required)

Office use only:

Date application received: _____

Atlanta Community Schools

Application for Early Admission to Kindergarten & Waiver of Eligibility Requirement

According to Michigan Law, if a child residing in Atlanta Community Schools School District is not five years of age on September 1 at the start of the school year, but will be five years of age not later than December 1, the parent or legal guardian of that child may enroll the child in kindergarten for the current school year if the parent or legal guardian notifies the school district in writing that he or she intends to enroll the child in kindergarten.

The school district that receives this written notification may make a recommendation to the parent or legal guardian as to whether the child is not ready to enroll in kindergarten due to the child's age or other factors. Regardless of the district recommendation, the parent or legal guardian retains the sole discretion to determine whether or not to enroll the child in kindergarten if the student is five years of age not later than December 1.

Student Name: _____ Date of Birth: _____

Resident Address: _____

City: _____ Zip Code: _____

I have provided a copy of my student's birth certificate for verification of age.

I understand the kindergarten eligibility dates as stated above and am requesting that my child, whose birth date falls between September 1 and December 1, be allowed to enter kindergarten this school year. By signing this form, I hereby certify that the information contained therein is true and correct. I also understand that the enrollment process must be completed before my child may attend kindergarten.

Parent/Guardian's Signature: _____

Parent/Guardian's Printed Name: _____

Date: _____

ATLANTA COMMUNITY SCHOOLS STUDENT REGISTRATION FORM

BIRTH CERTIFICATE	IMMUNIZATION	PROOF OF RESIDENCY	IEP	NON-RESIDENT	504	DISABILITY	ATHLETICS
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STUDENT: _____ Gender: MALE FEMALE

First Name
Middle Name
Last Name

Age: _____ Date of Birth: _____ Birth City: _____ Birth State: _____

Federal Race: AMERICAN INDIAN/ALASKAN NATIVE HISPANIC or LATINO ETHNICITY?
 ASIAN YES
 BLACK or AFRICAN AMERICAN NO
 NATIVE HAWAIIAN or Other Pacific Islander LANGUAGE: _____
 WHITE ANCESTRY: _____

Address: _____ Township: _____
Mailing Address (PO Box): _____ Home Phone: _____

Family 1 (with whom the student resides)

Name: _____	Name: _____
Relationship: _____	Relationship: _____
Mobile Phone: _____	Mobile Phone: _____
Work Phone: _____	Work Phone: _____
Email: _____	Email: _____
Occupation: _____	Occupation: _____
Active Duty? <input type="radio"/> YES <input type="radio"/> NO	Active Duty? <input type="radio"/> YES <input type="radio"/> NO
Employer: _____	Employer: _____

Family 2 (if applicable)

Name: _____	Name: _____
Relationship: _____	Relationship: _____
Mobile Phone: _____	Mobile Phone: _____
Work Phone: _____	Work Phone: _____
Email: _____	Email: _____
Active Duty? <input type="radio"/> YES <input type="radio"/> NO	Active Duty? <input type="radio"/> YES <input type="radio"/> NO
Ok for pick up? <input type="radio"/> YES <input type="radio"/> NO	Ok for pick up? <input type="radio"/> YES <input type="radio"/> NO
Ok to receive Student Records? <input type="radio"/> YES <input type="radio"/> NO	Ok to receive Student Records? <input type="radio"/> YES <input type="radio"/> NO
Mailing address: _____	

Where is the student currently residing?

- In a shelter With more than one family in a house or apartment
 In a motel, car or campsite With friends or relatives other than parent/guardian

If one of the above options are checked the student may be eligible for McKinney-Vento services.

Is the student living with parents or legal guardians? [] Yes [] No

***More items to be filled out on the back...**

Emergency Contacts

Name	Relationship	Primary Phone	Second Phone	Third Phone	Allow Pick Up

Allergies, medicine or other medical conditions: _____

Physician's Name: _____ Contact Number: _____

Emergency Medical Authorization

In the event reasonable attempts to contact me and emergency contacts have been unsuccessful, I, as the parent/legal guardian of the above student, do hereby authorize any and all emergency treatment necessary for my child that may be required due to sudden injury or illness. This release is completed and signed of my own free will with the purpose of authorizing medical treatment under emergency circumstances in my absence.

Parent/Guardian Signature

Date

Statement of Student Discipline

In accordance with the Safe Schools Act of 1996, Atlanta Community Schools requires that parents provide criminal and school disciplinary information. To implement that law, this district's board policy requires that the following questions be answered by parents/legal guardians who are enrolling new students to the school:

1. Is the student presently or ever been under suspension or expulsion from another school district? YES NO
If yes, please describe: _____
Name of School District: _____

2. Has the student been convicted or charged with any of the following crimes? (check any that applies)

<input type="radio"/> First Degree Murder	<input type="radio"/> Second Degree Murder	<input type="radio"/> First Degree Assault
<input type="radio"/> Forcible Rape	<input type="radio"/> Forcible Sodomy	<input type="radio"/> Robbery in the First Degree
<input type="radio"/> Distribution of Drugs to a Minor	<input type="radio"/> Arson in the First Degree	<input type="radio"/> Kidnapping (Class A Felony)

In accordance with the law, no student may be readmitted or enrolled in the school who has been convicted of or charge with an act that if committed by an adult would be one of the above. Nothing in the law shall prohibit the re-admittance or enrollment of any students if a charge has been dismissed, or when a student has been acquitted of any of the above offenses. This section does not apply to a student with disability, as identified under state eligibility criteria, who is convicted as a result of an action related to the student's disability.

I attest that all of the information stated in this form is correct and true.

Parent/Legal Guardian Signature

Date

*If item 1 is marked yes, and if item 2 has any check mark the enrollment is to be approved by the Superintendent.

Superintendent/Principal

Date

Atlanta Community Schools

Consent for Disclosure of Personally Identifiable Information and 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 and immunization 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 _____ Atlanta Community Schools _____ to release my Child's immunization record and personally identifiable information 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: _____

ATLANTA COMMUNITY SCHOOLS
School Admissions
(Proof of Residency Form)

In order to register a resident student, the parent, legal guardian or the student shall provide proof of residency or proof that a waiver has been requested as outlined below and shall complete all admission requirements as determined by Board policies, rules and regulations. Resident students who cannot provide adequate proof of residency may request a waiver in accordance with state law. Students who do not meet the residency requirements may apply for admission in accordance with state law regarding admission of nonresident students.

At least one (1) of the following criteria shall be used in determining student residency:

1. The student physically resides and is domiciled in the district. The domicile of a minor child shall be the domicile of a parent or court-appointed legal guardian.

2. The student is otherwise proven to be legally domiciled within the district.

In order to satisfy the District's residency requirements, the student, parent or court-appointed legal guardian must provide one (1) or more of the following items as proof of residency:

- | | |
|---------------------------|-------------------------------|
| 1. Property Tax Statement | 5. Legal property description |
| 2. Driver's License | 6. Rental Agreement |
| 3. Utility Bill/Agreement | 7. Telephone Bill |
| 4. Real Estate contract | 8. Other _____ |

STUDENT INFORMATION
Name of student: _____
Address of student: _____
Name of Parent/legal guardian: _____
Address of Parent/legal guardian: _____ (If different than above)

Parent/Legal Guardian Signature

Date

ATLANTA COMMUNITY SCHOOLS
TRANSPORTATION
BUS ROUTE INFORMATION

Date: _____

Student(s) Name: _____ Current Grade _____

Address: _____

Parent/Guardian Name: _____ Phone # _____

Parent/Guardian Name: _____ Phone # _____

Description of House: _____

Not Needed at This Time AM PM

TRANSPORTATION USE ONLY

Authorized person will meet the bus. _____

Authorized person will wave from doorway.

Student is allowed off the bus with an older sibling: _____

Student gains access into home.

Student is old enough to be at HOME, ALONE without a parent, guardian or caretaker present.

Parent Notified: () _____ Date _____

Bus Route # am _____ time: _____

Bus Route # pm _____ time: _____

Teacher Notified: () _____ Date _____

Rochelle Thornberg, Transportation Supervisor
989-785-4785 Office
989-306-2904 cell

STATE BOARD OF EDUCATION
APPROVED HOME LANGUAGE SURVEY*

The _____ is collecting information regarding the language background of each of its students. This information will be used by the district to determine the number of children who should be provided bilingual instruction according to Sections 380.1151 – 380.1158 of the School Code of 1976, Michigan's Bilingual Education Law. Would you please help by providing the following information?

Thank you very much for your cooperation.

Name of Student _____ Grade _____ Age _____

School Building _____

1. Is your child's native tongue a language other than English?

Yes

No What is that language? _____

2. Is the primary language¹ used in your child's home or environment a language other than English?

Yes

No What is that language? _____

Signature of Parent
or Guardian

Address

Date

¹"Primary language" means "dominant language used by a person for communication."

*Translation of this survey form in Spanish, Arabic, French, Italian, and Ojibwa is available at the Office of Field Service.

EMERGENCY MEDICAL AUTHORIZATION PERMIT

Whenever my child is involved in a school activity and I am unavailable or otherwise unable to provide authorization directly, I grant to the school principal or his/her designee the authority to act for me and to provide any required consents and authorization for the delivery of emergency medical care, diagnoses, and treatment, including surgical intervention, if necessary, on behalf of my minor child listed below and to do all other necessary things as I might or could do to provide for the child's health and safety, if I were present.

This authorization is valid for the current school year or until such time as I withdraw the authorization.

Authorized _____ Date _____
Signature of Parent/Guardian

Child's Name _____
(Last) (First) (Middle)

School _____ Grade _____ Teacher _____

Birthdate _____ Sex _____ Telephone _____

Parent or Guardian Names _____

Home Address _____

Mother's Employment _____ Telephone _____

Father's Employment _____ Telephone _____

Doctor Preferred _____ Telephone _____

Doctor's Address _____

Dentist Preferred _____ Telephone _____

Dentist's Address _____

Insurance Company _____ I.D. No. _____

Important Medical Information

Allergies _____

Current Medications or Treatments _____

Previous Operations or Hospital Confinements _____

Other: _____

MDHHS-6067, KINDERGARTEN ORAL HEALTH ASSESSMENT

Michigan Department of Health and Human Services (MDHHS)

(New 8-23)

SECTION 1 – STUDENT INFORMATION

Child's Name (Last, First, Middle)

Date of Birth

Address (Number, Street, City, Zip Code)

Home/Cell Phone Number

Parent/Guardian Name (Last, First, Middle)

Parent/Guardian Email

School Name

SECTION 2 – DENTAL EXAM OR ASSESSMENT RECOMMENDATIONS

(Licensed dental professional must complete this section)

Date of Service

Type of Service

Dental Exam

Dental Assessment

Findings (Check all that apply)

No findings

Treated decay

Untreated decay

Recommendations (Check **one**)

Routine care

Referral for dental treatment

Referral for urgent dental care

Provider Type (Check **one**)

Dentist

Dental Therapist

Dental Hygienist

Provider Signature

Agency/Local Health Department

Provider Name (Print)

Phone Number

Additional Comments

The Michigan Department of Health and Human Services (MDHHS) does not discriminate against any individual or group on the basis of race, national origin, color, sex, disability, religion, age, height, weight, familial status, partisan considerations, or genetic information. Sex-based discrimination includes, but is not limited to, discrimination based on sexual orientation, gender identity, gender expression, sex characteristics, and pregnancy.

Atlanta Community Schools Prior Care Form

To assist the school in having the most complete information about children enrolling in kindergarten, please complete the following information about your child.

Child's First Name: _____ Middle Name: _____

Last Name: _____ Child's Date of Birth: _____

What was your child's primary form of care in the last year? (Check up to 3 relevant choices).
If the child was primarily at home during the last year, please check **No Prior Care**.

- Great Start Readiness Program (GSRP)** (State funded program age 4 by Sept 1st)
- Head Start** (Federally funded program ages 3 & 4)
- Early Childhood Special Education Classroom** (School based preschool for special needs students with an IEP)
- Young Fives/Developmental Kindergarten** (Plan is for child to attend regular Kindergarten next year)
- Child Care-Home Based** (Operated out of a private home)
- Private Child Care Center** (Commercial business that may be independent or part of a chain)
- Registered Family/Relative Child Care** (Family or relative care provider receiving state assistance to provide care)
- Tuition-Based Preschool** (Full or half day of instruction and learning)
- No Prior Care Program** (Stay at home for care)
- Kindergarten** (Child has been retained for a second year of kindergarten)

Parent Signature: _____ Date: _____

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

Yes	No	Resolved	# Is your child having any of the problems listed below?	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	1 Allergies or Reactions (for example, food, medication or other)	Birth History: Are there any current or past diagnosis(es) <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, please describe: If yes, list medications: Was the health history reviewed by a health professional? <input type="checkbox"/> Yes <input type="checkbox"/> No Examiner's Initials: _____
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	2 Hay Fever, Asthma, or Wheezing	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	3 Eczema or Frequent Skin Rashes	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	4 Convulsions/Seizures	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	5 Heart Trouble	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	6 Diabetes	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	7 Frequent Colds, Sore Throats, Earaches (4 or more per year)	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	8 Trouble with Passing Urine or Bowel Movements	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	9 Shortness of Breath	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	10 Speech Problems	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	11 Menstrual Problems	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	12 Dental Problems: Date of Last Exam / /	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Other (please describe): _____	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Does your child take any medication(s) regularly?	
			Reason for Medication	
			_____ / /	
			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

No	Yes	Was child tested for:	Test results:	Normal	Referred	Under Care	No	Yes	Was child tested for:	Test results:	Normal	Referred	Under Care
<input type="checkbox"/>	<input type="checkbox"/>	VISION Date: / /	Visual Acuity Muscle Imbalance Other: _____				<input type="checkbox"/>	<input type="checkbox"/>	HEIGHT & WEIGHT Other: _____	Height Weight Other: _____			
<input type="checkbox"/>	<input type="checkbox"/>	HEARING Date: / /	Audiometer Other: _____				<input type="checkbox"/>	<input type="checkbox"/>	HEMOGLOBIN / HEMATOCRIT BLOOD PRESSURE	Reading: _____			
<input type="checkbox"/>	<input type="checkbox"/>	URINALYSIS Date: / /	Sugar Albumin Microscopic				<input type="checkbox"/>	<input type="checkbox"/>	TUBERCULIN Date: / /	Type: _____ Neg.: <input type="checkbox"/> Pos.: <input type="checkbox"/> _____ mm			
<input type="checkbox"/>	<input type="checkbox"/>	BLOOD LEAD LEVEL Date: / /	Level _____ ug/dl				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		VACCINES (Circle Type)	DATE ADMINISTERED MM/DD/YYYY	
Hepatitis B (HepB)	1	3	Hepatitis A (HepA)	1	2
	2		Influenza (IIV/LAIV)	1	3
				2	4
DTaP/DTP/DT/Td	1	4	Meningococcal (MCV4 / MPSV4)	1	2
	2	5			
	3	6	Human Papillomavirus (HPV9/HPV4/HPV2)	1	3
Tdap	1			2	
<i>Haemophilus Influenzae</i> type b (HIB)	1	3	OTHER Vaccines Specify Date & Type	Type of Vaccine(s)	Date of Vaccine(s)
	2	4		1	
Polio (IPV/OPV)	1	3		2	
	2	4	3		
Pneumococcal Conjugate (PCV7/PCV13)	1	3	<i>Indicate and attach physician diagnosis or laboratory evidence of immunity as applicable</i>		
	2	4	*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.		
Rotavirus (RV1/RV5)	1	3			
	2		Parent/Guardian refused immunizations: <input type="checkbox"/>		
Measles, Mumps, Rubella (MMR)	1	2			
Varicella (Chickenpox)	1	2			
History of Chickenpox Disease? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, date: _____					
I certify that the immunization dates are true to the best of my knowledge					
_____			_____		____/____/____
<i>Health Professional's Signature</i>			Title		Date

SECTION IV - RECOMMENDATIONS

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

No	Yes	
<input type="checkbox"/>	<input type="checkbox"/>	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:
<input type="checkbox"/>	<input type="checkbox"/>	Should the child's activity be restricted because of any physical defect or illness? If yes, check and explain degree of restriction(s): <input type="checkbox"/> Classroom <input type="checkbox"/> Playground <input type="checkbox"/> Gymnasium <input type="checkbox"/> Swimming Pool <input type="checkbox"/> Competitive Sports <input type="checkbox"/> 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

_____ / _____ / _____
Date

Dentist's Signature

PHYSICIAN'S SIGNATURE

_____ / _____ / _____
Date

Examiner's Signature

Examiner's Name (Print or Type) Degree or License

Number & Street City MI ZIP Code Telephone

Information required for:

Early On - Hearing and Vision Status; Diagnosis; Health Status

Child Care Licensing - Physical Exam, Restrictions, Immunizations

Head Start/Early Head Start - Determination that child is up-to-date on a schedule of age-appropriate preventive and primary health care, including medical, dental, and mental health. The schedule must incorporate the well-child care visit required by EPSDT and the latest immunizations schedule recommended by the Centers for Disease Control and Prevention, State, tribal, and local authorities. An EPSDT well-child exam includes height, weight, and blood tests for anemia at regular intervals based on age.

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.