Learning for the Future
Argentine Early Childhood Center

Register early for Preschool 2018-2019 School Year

Registration starts on
Thursday, March 15 2018
OPEN HOUSE
9:00—4:00

Enrollment information will be available on
March 1, 2018
We have many programs to choose from
Please stop in the office for more information.
Free preschool for those that qualify!

Programs Offered

- Linden's "*Parents as Teachers*" *Birth to 5 year old Program*
  Free program for Linden Community School Families
- *Infant & Toddler Tuition base classrooms*
- *3 & 4 Year Old Tuition Based Preschool*
- *Great Start School Readiness Program*
  (Free Preschool Program for 4 year old)
- *GCCARD Early Head Start*
- *GCCARD Head Start*
- *Summer Eagle Club Camp*
- *Eagle Club Before and After School Program*

All programs are located at:

Argentine Early Childhood Center
8483 W. Silver Lake
Linden, MI 48451
Please call 810-591-0320

"These materials were developed under a grant awarded by the Michigan Department of Education."
Linden's "Parents as Teachers" program is supported by the United Way of Genesee County.

ARGENTINE EARLY CHILDHOOD CENTER
PROGRAM REQUEST FORM 2018-19

Student: _____ **Sex:** ☐ M ☐ F
Last Name First Name Middle Name

Address: _____ **City:** _____
Number Street Apt.

Zip Code: _____ **Cell Phone:** _____ **Date of Birth:** _____
Area Code Month Day Year

Please print parent/guardian name(s):_____

PROGRAM ENROLLMENT

Infant/Toddler Mon.- Fri. 7:00-5:00
This program has a 4 day per week minimum

- ☐ Mon-Fri. $200 per week
- ☐ Four days per week $60 per day

Preschool Plus 3 years old Mon. – Fri. 7:00-5:00

- ☐ Full Day Preschool & Care
  - o Mon-Fri $165 per week

Preschool Plus 4 years old Mon. – Fri. 8:00 – 5:00

- ☐ Full Day Preschool & Care
  - o Mon-Fri $165 per week

Preschool Classes 3 and 4 year olds

- ☐ 3 year old AM
  Mon/Wed/Fri (9:00-11:30)
  $165 per month
- ☐ 3 year old PM
  Mon/Wed (12:30-3:00)
  $135 per month
- ☐ 4 year old AM
  Mon/Wed/Fri (9:00-11:30)
  $165 per month
- ☐ 4 year old PM
  Mon/Tues-Wed/Thurs (12:30-3:00)
  $215 per month

No enrollment fee for the GSRP Program
Please choose one, but we cannot guarantee that will be the spot you get.

- ☐ 4 yr GSRP AM Mon/Tues/Wed/Th (8:30-11:30)
- ☐ 4 yr GSRP PM Mon/Tues/Wed/Th (12:30-3:30)
- ☐ 4 yr GSRP All day Mon/Tues/Wed/Th (8:30-3:30)

GSRP PRESCHOOL – 4 DAYS/WEEK
ALL DAY AND HALF DAY

Great Start Readiness Preschool (GSRP) The Great Start Readiness Program is a state funded free preschool program for 4 year olds of qualifying families. Children accepted into the program should be four by December 1, 2018 and meet state guidelines.

Please visit ***geneseepreschool.org*** to fill out preschool interest forms

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PROGRAM FEES

- ☐ **Enrollment Fee (non-refundable)** $ 70.00
  Administration Fee 2nd child $20
- ☐ **Infant Toddler Program** $_____
  First week of tuition
- ☐ **Preschool Plus Program** $_____
  First week of tuition
- ☐ **Preschool Classes** $_____
  Last month tuition (May 2019)

TOTAL DUE $_____

☐ Cash ☐ Check No: ____ ☐ Visa/Master Card

DATE PAID _____
***Notice of withdraw from any program less than 10 days prior to the start date of that program, will result in all dues paid to be non-refundable**

Failure to remit payments on time may result in late fee assessment of $10 and/or removal from program(s). All cash payments must be exact amount due. **Check payable to: LINDEN COMMUNITY SCHOOLS. Non-sufficient fund checks will be assessed a $10 fee.**

- 4 Star Quality Rating - This rating exemplifies high quality programs from the Michigan Department of Education
- Licensed facility
- Reasonable Rates
- Low student/staff ratios
- CPR-First Aid certified
- Certified staff in early childhood
- Ages and Stages Developmental screenings
- TS Gold On line Documentation
- Library- students check out books weekly
- Computer Lab
- Gross Motor Room
- Gym
- Security Door

GCCARD Early Head Start and Head Start

This is a federally funded preschool program for qualifying families.
Early Head Start is for children 6 weeks to 3 years old
Head Start is for 3 and 4 years olds
Please call about qualifications **810-235-5613**.
Please visit ***geneseepreschool.org*** to fill out preschool interest form
You may also call 591-KIDS for more information

SCHOOL USE ONLY
Entrance Date: _____
Student ID: _____

Argentine Elementary Early Childhood Programs

Linden Community Schools

Student Enrollment Form

STUDENT INFORMATION (PLEASE PRINT)

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.

Student's Legal Last Name: _____ First Name: _____ Middle: _____

Street Address: _____ City: _____ Zip Code: _____

County of Residence: _____ Grade Enrolling: _____ Date of Birth: _____/_____/_____

Age: _____ Multiple Birth Status: ☐ Single ☐ Twin ☐ Triplet ☐ Quad ☐ Male ☐ Female

Resident School District: _____

Previous School Attended _____ City/State: _____

Has your child ever attended Linden schools? ☐ Yes ☐ No If yes, when? _____

Ethnicity/Race/Home Language:

1. Is this student Hispanic/Latino? (Choose one) ☐ No, not Hispanic/Latino ☐ Yes, Hispanic/Latino – (a person of Cuban, Mexican, Puerto Rican, South or Central American, or other Spanish culture or origin regardless of race)

2. Choose all that apply ☐ Asian ☐ African American ☐ Hispanic ☐ Native American ☐ Pacific Islander ☐ White

Is your child's native tongue a language other than English? ☐ Yes ☐ No

If yes, what language? _____

Is the primary language used in the child's home environment a language other than English? ☐ Yes ☐ No

If yes, what is that language? _____

Academic Needs:

Has your child ever received special education services in previous years or has IEP? ☐ Yes ☐ No
If yes, indicate year:

If yes, please indicate the types of services he/she received (Circle all that apply)
☐ Speech ☐ OT/PT ☐ Social Work ☐ ECSE

Has your child participated and or received services from any of the following programs? Please circle all that applies:

☐ Early On ☐ Early Head Start ☐ Head Start

☐ "Linden's Parents as Teachers" ☐ SKIP ☐ GSRP ☐ Other_____

PARENT/LEGAL GUARDIADIAN INFORMATION (PLEASE PRINT)

Parents live: ☐ *Together* ☐ *Separately* *Student Resides with:* _____

Court Ordered Custody Restrictions: ☐ Yes ☐ No ☐ Not Applicable

If Yes, parent must provide most recent court documents.

Linden Community Schools cannot enforce custody restrictions without a court order on file in the principal's office.

Mother/Legal Guardian's Name:

Legal Last Name: _____ First Name: _____ Middle: _____

Street Address: _____ City: _____ Zip Code: _____

Please check the preferred number to be used during school hours:

Cell Phone: _____ -_____ -_____ Home Phone: _____ -_____ -_____ Work Phone: _____ -_____ -_____

Email to be used for communications: _____

Father/Legal Guardian's Name:

Legal Last Name: _____ First Name: _____ Middle: _____

Street Address: _____ City: _____ Zip Code: _____

Please check the preferred number to be used during school hours:

Cell Phone: _____ -_____ -_____ Home Phone: _____ -_____ -_____ Work Phone: _____ -_____ -_____

Email to be used for communications: _____

EMERGENCY CONTACT

Parent/Guardians will be contacted first, please indicate three other individuals if parents/guardians are not available. Only the listed persons on this form will be permitted to pick up your child from school.

1. ☐ Stepfather ☐ Stepmother ☐ Grandparent ☐ Other: _____

Last Name: _____ First Name: _____

Home Phone: _____ -_____ -_____ Cell Phone: _____ -_____ -_____ Work Phone: _____ -_____ -_____

2. ☐ Stepfather ☐ Stepmother ☐ Grandparent ☐ Other: _____

Last Name: _____ First Name: _____

Home Phone: _____ -_____ -_____ Cell Phone: _____ -_____ -_____ Work Phone: _____ -_____ -_____

3. ☐ Stepfather ☐ Stepmother ☐ Grandparent ☐ Other: _____

Last Name: _____ First Name: _____

Home Phone: _____ -_____ -_____ Cell Phone: _____ -_____ -_____ Work Phone: _____ -_____ -_____

STUDENT MEDICAL INFORMATION

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.

Name of Child's Physician or Health Clinic: _____

Hospital Preferred for Emergency Treatment: _____

Physician/Health Clinic Phone: _____

Does your child have a known medical condition(s):_____

Does your child have a known allergy:_____

Medication child is currently taking:

_____

Is it necessary for school personnel to administer the prescription medication to your child? ☐ *Yes ☐ No

*If school personnel will be responsible for administering prescription medication to the child, a written authorization from your child's physician must be provided prior to any medication being administered by Linden Community Schools' staff members. It is the responsibility of the parent/guardian to supply all medication to the school

_____I hereby give permission for any and all necessary medical attention to be administered to my child in the event of an accident, injury, sickness, etc., under the direction of the school, principal, nurse, and/or office personnel, until such time I may be contacted. If a situation is life threatening, I authorize the officials of Linden Community Schools to arrange emergency transportation to the closest hospital. I further authorize any duly licensed physician to administer care to my child. I also hereby assume the responsibility for payment of any such treatment.

_____ I do not give permission to Argentine Early Childhood Center, Licensing and Regulatory Affairs to secure emergency medical and or emergency surgical treatment for the named minor child in care. I understand I assume responsibility for all emergency medical care.

Parent/Guardian Signature: _____

Relationship to Child: _____ **Today's Date:** _____

As the parent/legal guardian, I affirm all information provided above is true and accurate, and this student and I reside at the listed address.

ALERTS: By court order only (copy on file), the following person(s) are not permitted to pick up this child:_____

Siblings and/or other children living in the home:

Name:_____Grade:_____Sibling: ☐ Yes ☐ No

Name:_____Grade:_____Sibling: ☐ Yes ☐ No

Name:_____Grade:_____Sibling: ☐ Yes ☐ No

Name:_____Grade:_____Sibling: ☐ Yes ☐ No

EARLY CHILDHOOD REGISTRATION CHECKLIST

Required Documentation

The following must be turned in before the student is accepted into any program:

- ☐ Early Childhood Application
- ☐ Fill out the Preschool Interest Form at www.geneseepreschool.org
- ☐ Payment of Enrollment Fees and Initial Tuition (First week of infant/toddler room and preschool plus **or** last month, May 2019, of preschool)
- ☐ Registration/Emergency Form
- ☐ Student's Original Birth Certificate

We need this information BEFORE the Open House in August

- ☐ Health Appraisal completed by physician
- ☐ Immunization Record (Official State of Michigan Immunization Record. **Waivers** need to come from doctor's office or health department)

Genesee County Health Department will be scheduled to do a vision and hearing screening during the school year.

PLEASE NOTE:

We respectfully request completed packages to be turned in as soon as possible.
Registration Office Hours: 9:00 a.m. to 3:00 p.m.

If you are not available to turn in your package during these times, prior arrangements can to be made in advance by calling 810-591-0320.

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			

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?

Parent/Guardian Signature Date ☐ 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.

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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.