



**ENCLOSED IS AN APPLICATION FOR CLAWSON SCHOOLS  
GSRP PROGRAM (OUR FREE 4-YEAR-OLD GREAT START READINESS  
PROGRAM) FOR SCHOOL YEAR 2024-2025**

**TO APPLY FOR THE GSRP PROGRAM:**

- 1. COMPLETE GSRP APPLICATION FORM**
- 2. SEND IN PROOF OF INCOME—PAGE 3. (PROOF OF INCOME IS REQUIRED FOR ALL FAMILIES APPLYING TO THE GSRP PROGRAM—EVEN IF THEY DO NOT QUALIFY BASED ON INCOME).**
- 3. COMPLETE CHILD ELIGIBILITY FORM AND CHECK ELIGIBILITY FACTORS, WHICH APPLY TO YOUR FAMILY – SEND IN DOCUMENTS**
- 4. COMPLETE INTAKE FORM**
- 5. EMAIL OR BRING IN A COPY OF YOUR CHILD’S BIRTH VERIFICATION**
- 6. COMPLETE IMMUNIZATION FORM**
- 7. COMPLETE EMERGENCY CARD – EVERY LINE MUST BE FILLED IN**
- 8. COMPLETE STUDENT DATA FORM**
- 9. SHOW PROOF OF RESIDENCY, MAY SEND IN ONE OF THE FOLLOWING:**
  - DRIVER’S LICENSE**
  - PAY STUB WITH YOUR CURRENT ADDRESS**
  - UTILITY BILL**
  - OTHER RECENT GOVERNMENT ISSUED DOCUMENTS LISTING THE ADDRESS AND NAME OF PARENT/GUARDIAN OF CHILD**
- 10. COMPLETE RESOURCE REQUEST AND SHARING FORM**
- 11. COMPLETE SCREENING CONSENT FORM**
- 12. COMPLETE HOME LANGUAGE SURVEY**

**ALL OF THE ABOVE ITEMS MUST BE  
SENT IN BEFORE A CHILD IS  
CONSIDERED FOR THE  
CLAWSON GSRP PROGRAM!**

**THE FIRST DAY OF THE 2024-2025 SCHOOL YEAR WILL BE  
MONDAY, SEPTEMBER 9<sup>th</sup> 2024**

Dear Parents/Guardians:

Enclosed is an application packet for our FREE GSRP 4-year-old school readiness program.

The GSRP program meets Monday through Thursday for 34 weeks beginning Monday, September 9<sup>th</sup>. The all-day sessions will meet from 8:30 am – 3:30 pm.

If interested in our GSRP program, please complete the following information. **We will begin enrolling students on Monday, January 8th** Please call Claire Prost at 248-655-4402 or Heather Kotz at 248-655-4414 if you have any questions.

GSRP ADMISSION POLICY:

Children enrolled in our GSRP free program must:

- Be 4 years of age by 9-1-2024
- Qualify for program based on low income and/or eligibility factors.
- If you are over income, we can start enrolling students March 1<sup>st</sup>, if there are still openings available and will pay tuition based on a sliding fee scale.
- Unless your child is age **AND** income eligible, children who live out of district and do not already have siblings that attend the Clawson School District will be enrolled starting August 1<sup>st</sup>, 2024, if there are still openings available.
- Children who turn 4 years of age between Sept. 1, 2024 – Dec. 1, 2024 may also apply, but will not be enrolled until Sept. 1, 2024 if there are still openings available.

Eligibility Factors are:

- Diagnosed disability or identified developmental delays
- Parent/guardian with low educational attainment or did not graduate
- Severe or challenging behavior
- Abuse or neglect of child or parent
- Primary home language other than English
- Environmental Risk factors are parental loss, sibling issues, teenage parent, homeless and high-risk neighborhood exposure to toxic substances.

RANKING OF GSRP APPLICATIONS:

Applications are reviewed and ranked by the following income categories:

- 0-50% poverty
- 51-100% poverty
- 101-150% poverty
- 151-200% poverty
- 201-250% poverty
- 251-300% poverty

Within income categories, applicants are ranked by additional eligibility factors.



**All of the following MUST be completed before your child will be considered for the Clawson GSRP program:**

1. GSRP Applications Form
2. Proof of Income – W2,1040 page of your tax return or 3 (2 if you don't have 3) consecutive pay stubs.
3. Child Eligibility Form – Check eligibility factors which apply and send in supporting data.
4. Intake Form
5. Email or bring in a copy of your child's birth verification
6. Immunization Record Form
7. Emergency Card
8. Student Data Form
9. Proof of residence
10. Resource request and sharing form
11. Screening Consent form
12. Home Language Survey

**IMMUNIZATIONS**

When registering your child, the State of Michigan requires that you show proof of immunizations. Immunization form is due at time of registration. Immunization waivers are no longer available through the school district. To complete the waiver, contact your child's pediatrician or Oakland County Health Department. Health forms are only valid for 1 year.

The attached health form is due the first day of school, Monday, Sept.9<sup>th</sup>, 2024. This form must be completed and signed by your child's doctor.

**There will be a PARENT MEETING in the beginning of September**, but exact time, location and date have not yet been set.

Clawson Schools also has programs and assessments available for children birth to age 5 whose parents may have concerns about developmental delays in the areas of speech and language, gross or fine motor, cognitive, and/or social-emotional development. Call Julie Carl at 248-655-4416.

If you have any questions or concerns, please call Claire Prost at 248- 655-4402.

Sincerely,

Claire Prost  
Clawson Preschool Coordinator



**MI Early  
Childhood  
Connect**



**Oakland Schools**

## Oakland County Early Childhood GSRP Paper Application

(Information gathered needs to be uploaded into MiECC once child is enrolled)

Intake School/Agency*	
Primary Phone Number*	
Family Name*	
Address*	
Apartment/Unit #	
City*	
State*	
Zip Code*	
Date Received*:	
Referral Source*	
<input type="checkbox"/> Agency <input type="checkbox"/> Parent <input type="checkbox"/> Guardian <input type="checkbox"/> Other	
Initial Contact Method	<input type="checkbox"/> Email <input type="checkbox"/> Phone <input type="checkbox"/> Walk In <input type="checkbox"/> Other: _____
How did you learn about us?	
<p>Authorization to Share (please read this statement in full)*:          Part of Oakland Schools is to support your family, which means we may refer you to another program or organization. Do you give permission to Oakland Schools to share the information you've given me today with affiliate/community organizations in order to best support your family? Information may also include the results of the Ages and Stages Questionnaire. This will remain in effect until the youngest child in the family turns five or your family requests, either verbally or in writing, that information sharing be stopped.</p>	
Parent/Guardian Signature*	

For which year are you hoping to have your child enrolled or be considered for services?	<input type="checkbox"/> 2023-2024 <input type="checkbox"/> 2024-2025
Desired Program Schedule	<input type="checkbox"/> Part Day <input type="checkbox"/> School Day - 4 days per week <input type="checkbox"/> School Day - 5 days per week
Child's Legal First Name* (should match birth verification document)	
Middle Name	
Child's Legal Last Name* (should match birth verification document)	
Suffix	
Date of Birth (month, date, year)* (should match birth verification document)	
Gender*	
Is Hispanic or Latino	<input type="checkbox"/> Yes <input type="checkbox"/> No
Race/Ethnicity * Select the one that you most identify with.	<input type="checkbox"/> American Indian/Alaskan Native <input type="checkbox"/> Asian <input type="checkbox"/> Black/African American <input type="checkbox"/> Native Hawaiian/Other Pacific Islander <input type="checkbox"/> White
Do you need transportation? (transportation is not available in all areas)	<input type="checkbox"/> Yes <input type="checkbox"/> No

## Determining Eligibility Factors

The questions contained in this document are sensitive for families. Now that enrollment prioritization is based on income level, and eligibility factors determine prioritization within the income levels, it is not as necessary to gather this information at the start of the school year. This information:

- Can be gathered throughout the year and reported in April on the Child Information and Staff Report (CISR) that is submitted to Oakland Schools and then to MDE.
- Is more easily gathered once a collaborative relationship with the family has been established.
- Can be gathered informally through confidential chats at drop-off or pick-up or at more formal conversations like the home visit and conferences.

The following questions are designed to find more information while being aware of how sensitive these areas are for families. This document can be used to take notes on information gathered from families and kept in the child file as evidence that the program seeks eligibility factor information with the goal of providing support to the child and family.

### Eligibility Factor Sample Questions

**Check the IEP / IFSP box in MiECC if any of the following are marked Yes:**

- Does your child have an individual education plan (IEP)? \_\_\_\_ Yes \_\_\_\_ No
- Did you child have an IFSP with a transition referral at age 3? \_\_\_\_ Yes \_\_\_\_ No
- Does your child have a chronic illness (example: asthma)? \_\_\_\_ Yes \_\_\_\_ No
  - If yes, please explain: \_\_\_\_\_
- Do you, a doctor, or other professional have any concerns regarding your child's development?  
\_\_\_\_ Yes \_\_\_\_ No
  - If yes, please explain: \_\_\_\_\_

**Check the Severe or Challenging Behavior Box in MiECC if any of the following are marked Yes:**

- Has your child's behavior prevented participation in another group setting? \_\_\_\_ Yes \_\_\_\_ No
- Is your child in counseling or therapy? \_\_\_\_ Yes \_\_\_\_ No
- Has your child been expelled from preschool / child care center / other setting? \_\_\_\_ Yes \_\_\_\_ No

**Check the Primary Home Language Other than English Box in MiECC if any of the following are marked Yes:**

- Are there any languages other than English spoken in the home? \_\_\_\_ Yes \_\_\_\_ No
  - If yes, what language? \_\_\_\_\_
- What is your child's primary language? \_\_\_\_\_

**Check the Parent or Guardian with Low Educational Attainment Box in MiECC if any of the following are Less than High School or Evidence of Parent Literacy Need:**

- What is the highest level of education for the parents of the child?
  - Parent 1 (check all that apply):
    - Less than High School \_\_\_\_\_
    - GED \_\_\_\_\_
    - High school \_\_\_\_\_
    - College \_\_\_\_\_
  - Parent 2 (check all that apply)
    - Less than High School \_\_\_\_\_
    - GED \_\_\_\_\_
    - High school \_\_\_\_\_
    - College \_\_\_\_\_
- Are there any literacy resources, either for the child or parent, the family would be interested in?  
\_\_\_\_\_
- Who reads to the child in the home? \_\_\_\_\_

**Check the Abuse / Neglect of Child or Parent Box in MiECC if any of the following are Yes:**

- Have you or your child ever felt unsafe in your home? \_\_\_\_ Yes \_\_\_\_ No
  - If yes, please explain: \_\_\_\_\_
- Has anyone in your home been a victim of physical, sexual, or emotional abuse or neglect?  
\_\_\_\_ Yes \_\_\_\_ No
- Is there a history of substance abuse in the home (alcohol, drugs, prescription drugs)?  
\_\_\_\_ Yes \_\_\_\_ No
- Does anyone in the home have a violent or destructive temper? \_\_\_\_ Yes \_\_\_\_ No

**Check the Environmental Risk Box in MiECC if any of the following are Yes:**

- Has any of the following occurred for the child?
  - Divorce \_\_\_\_\_
  - Parental:
    - Death \_\_\_\_\_
    - Military leave \_\_\_\_\_
    - Incarceration \_\_\_\_\_
    - Chronic illness \_\_\_\_\_

- Living elsewhere due to school or work \_\_\_\_\_
- Grandparents raising child \_\_\_\_\_
- Foster child \_\_\_\_\_
- Frequent changes in custody \_\_\_\_\_
- Single parent \_\_\_\_\_
- Teen parent at the time the first child was born \_\_\_\_\_
- Sibling with:
  - Chronic illness \_\_\_\_\_
  - Challenging behavior \_\_\_\_\_
  - Disability \_\_\_\_\_
  - Death \_\_\_\_\_
- Do you consider yourself homeless? \_\_\_\_ Yes \_\_\_\_ No
- Did your family unexpectedly relocate in the last 6 months? \_\_\_\_ Yes \_\_\_\_ No
- How many times have you moved in the past 2 years? \_\_\_\_\_
- Are you residing with anyone other than your immediate family members? \_\_\_\_ Yes \_\_\_\_ No
- Residing in a neighborhood with:
  - High poverty \_\_\_\_ Yes \_\_\_\_ No
  - High crime \_\_\_\_ Yes \_\_\_\_ No
  - Limited access to critical community services \_\_\_\_ Yes \_\_\_\_ No
  - High death rates \_\_\_\_ Yes \_\_\_\_ No
  - Violence \_\_\_\_ Yes \_\_\_\_ No
- Daily exposure to:
  - Lead \_\_\_\_ Yes \_\_\_\_ No
  - Rodents \_\_\_\_ Yes \_\_\_\_ No
  - Insect infestations \_\_\_\_ Yes \_\_\_\_ No
  - Violence \_\_\_\_ Yes \_\_\_\_ No
  - Injury \_\_\_\_ Yes \_\_\_\_ No
  - Drug use \_\_\_\_ Yes \_\_\_\_ No
  - Crowded housing \_\_\_\_ Yes \_\_\_\_ No
  - Lack of utilities \_\_\_\_ Yes \_\_\_\_ No
  - No space for children's play \_\_\_\_ Yes \_\_\_\_ No
- Prenatal or postnatal exposure to toxic substances known to cause learning or developmental delays



- Fetal Alcohol Syndrome \_\_\_\_ Yes \_\_\_\_ No
- Born addicted \_\_\_\_ Yes \_\_\_\_ No
- Environmentally-induced respiratory problems \_\_\_\_ Yes \_\_\_\_ No
- Other: \_\_\_\_\_ \_\_\_\_ Yes \_\_\_\_ No

**Other Parent/Guardians in the household (dependent on the household income)**

First Name*	
Last Name*	
Relationship to child*	

First Name*	
Last Name*	
Relationship to child*	

**Siblings/other children in the household**

First Name*	
Last Name*	
Date of Birth (month, date, year)*	
Gender*	

First Name*	
Last Name*	
Date of Birth (month, date, year)*	
Gender*	

First Name*	
Last Name*	
Date of Birth (month, date, year)*	
Gender*	

First Name*	
Last Name*	
Date of Birth (month, date, year)*	
Gender*	

First Name*	
Last Name*	
Date of Birth (month, date, year)*	
Gender*	

First Name*	
Last Name*	
Date of Birth (month, date, year)*	
Gender*	

First Name*	
Last Name*	
Date of Birth (month, date, year)*	
Gender*	

First Name*	
Last Name*	
Date of Birth (month, date, year)*	
Gender*	

Notes:

\*indicates a required field in MiECC



Child's Name: \_\_\_\_\_

**GSRP CHILD ELIGIBILITY FORM**

**PLEASE CHECK ALL FACTORS THAT APPLY:**

**Families that qualify based on extremely low income only need 1 risk factor to qualify for GSRP program.**

\_\_\_\_\_ **Low family income:**  
Family of 2: up to \$78,880  
Family of 3: up to \$99,440  
Family of 4: up to \$120,000  
Family of 5: up to \$140,560  
Family of 6: up to \$161,120  
Family of 7: up to \$181,680  
Family of 8: up to \$202,240

\_\_\_\_\_ **Diagnosed disability or identified developmental delay**  
(Child is eligible for special education services or child's developmental level is less than that of expected for his/her chronological age or chronic health issues cause development or learning problems).

\_\_\_\_\_ **Severe or challenging behavior**  
(Child has been expelled from preschool or child care center).

\_\_\_\_\_ **Primary home language other than English**

\_\_\_\_\_ **Parent/Guardian with low educational attainment**  
(Parent/Guardian did not graduate from high school)

\_\_\_\_\_ **Abuse or neglect of child or parent**

\_\_\_\_\_ **Environmental Risks (Only count as 1 risk factor)**

- **Parental loss due to death, divorce, incarceration, military service, or absence**
- **Sibling issues—chronic illness, behavior, disability or death.**
- **Teen parent (Not yet age 20 when first child was born)**
- **Family is homeless or without stable housing**
- **Residence in a high-risk neighborhood**
- **Prenatal or postnatal exposure to toxic substances known to cause learning or developmental delays.**

**I authorize that the eligibility factors that I have checked are true and will provide documentation as requested to verify these factors.**

\_\_\_\_\_ **Parent's/Guardian's Signature**

\_\_\_\_\_ **Date**

GSRP Staff Signature

Date



**Great Start School Readiness Program (GSRP) Intake Form**

Child's Name \_\_\_\_\_ Date of Birth \_\_\_\_\_

Parent(s)/Guardian(s) Name(s) \_\_\_\_\_

Address \_\_\_\_\_

Telephone (home) \_\_\_\_\_ Cell \_\_\_\_\_

How did you hear about the GSRP Program? \_\_\_\_\_

Has your child been in another preschool program? If yes, where? \_\_\_\_\_

Are you in need of assistance for the following? Please check all that apply:

\_\_\_\_\_ Housing

\_\_\_\_\_ Education or Training

\_\_\_\_\_ Medical/Health

\_\_\_\_\_ Food

\_\_\_\_\_ Employment

\_\_\_\_\_ Parent Education

\_\_\_\_\_ Clothing

\_\_\_\_\_ Child Care

**I certify that all of the information is true and accurate. I understand that this information is strictly confidential and any falsification may be grounds for my child becoming ineligible or being removed from the GSRP program.**

Parent's/Guardian's Signature \_\_\_\_\_ Date \_\_\_\_\_

**IMMUNIZATION RECORD**

\_\_\_\_\_  
**CHILD'S NAME**

\_\_\_\_\_  
**BIRTH DATE**

**PLEASE WRITE THE DATES YOUR CHILD HAS HAD THE FOLLOWING SHOTS:**

**DPT:**

- 1.
- 2.
- 3.
- 4.
- 5.

**POLIO:**

- 1.
- 2.
- 3.
- 4.

**HAEMOPHILUS INFLUENZAE TYPE B (HIB):**

- 1.
- 2.
- 3.
- 4.

**MMR:**

- 1.
- 2.

**PNEUMOCOCCAL CONJUGATE (PCV):**

- 1.
- 2.
- 3.
- 4.

**HEPATITIS B:**

- 1.
- 2.
- 3.

**VARICELLA (chicken pox vaccine)**

- 1.

**or if your child has had chickenpox, please list date and year:**

\_\_\_\_\_.

# Required Immunizations for Michigan Childcare/Preschool Attendance

Communicable disease rules are the minimum standard for preventing disease outbreaks in child care settings.

To be protect patients from all diseases we have the power to prevent, healthcare providers in Michigan should follow the

2014 Recommended Immunization Schedule at [www.cdc.gov/vaccines](http://www.cdc.gov/vaccines) or [www.michigan.gov/immunize](http://www.michigan.gov/immunize)

\*\* All doses of vaccines must be given with appropriate spacing between doses and at appropriate ages to be considered valid.

Age →	Childcare/Preschool Entry Requirements						
	Birth through 1 month	2 months through 3 months	4 months through 5 months	6 months through 15 months	16 months through 18 months	19 months through 4 years	5 years
Vaccine** ↓	None	1 dose DTaP	2 doses DTaP	3 doses DTaP	3 doses DTaP	4 doses DTaP	None
Diphtheria, Tetanus, Pertussis	None	1 dose DTaP	2 doses DTaP	3 doses DTaP	3 doses DTaP	4 doses DTaP	None
Pneumococcal Conjugate (PCV7 and/or PCV13)	None	1 dose	2 doses	3 doses	4 doses OR age appropriate complete series	1 dose on or after 24 mo OR age appropriate complete series	None
<i>H. influenzae</i> type b	None	1 dose	2 doses	2 doses	1 dose on or after 15 months of age OR age appropriate complete series	3 doses	None
Polio	None	1 dose	2 doses	2 doses	2 doses	3 doses	None
Measles,* Mumps,* Rubella*	None	None	None	None	1 dose on or after 12 months of age	3 doses	None
Hepatitis B*	None†	1 dose	2 doses	2 doses	2 doses	3 doses	None
Varicella* (Chickenpox)	None	None	None	None	1 dose on or after 12 months of age OR current lab immunity OR reliable history of disease	3 doses	None

\*Current laboratory evidence is acceptable instead of immunization with that antigen.

† Hepatitis B may be administered as early as birth.

This table represents the minimum required immunizations for childcare centers



# When Do Children and Teens Need Vaccinations?

Age	HepB Hepatitis B	DTaP/Tdap Diphtheria, tetanus, pertussis (whooping cough)	Hib Haemophilus influenzae type b	-IPV Polio	PCV Pneumococcal conjugate	RV Rotavirus	MMR Measles, mumps, rubella	Varicella Chickenpox	HepA Hepatitis A	HPV Human papillo- mavirus	MCV4 Meningococcal conjugate	Influenza Flu
Birth	✓											
2 months	✓ (1-2 mos)	✓	✓	✓	✓	✓						
4 months	✓	✓	✓	✓	✓	✓						
6 months		✓	✓			✓						
12 months												
15 months	✓ (6-18 mos)	✓ (0-18 mos)	✓ (12-15 mos)	✓ (6-18 mos)	✓ (12-15 mos)		✓ (12-15 mos)	✓ (12-15 mos)	✓ (2 doses given 6 mos apart at age 12-23 mos)			
18 months												
19-23 months		Catch-up	Catch-up	Catch-up	Catch-up		Catch-up	Catch-up				✓  (One dose each fall or winter to all people ages 6 mos and older)
4-6 years		✓		✓			✓	✓				
7-10 years			Catch-up									
11-12 years		Catch-up Tdap		Catch-up								
13-15 years			Catch-up (Tdap)				Catch-up	Catch-up	✓✓✓	✓✓✓	✓	
16-18 years							Catch-up	Catch-up	Catch-up	Catch-up	✓	

**Please note:** Cases of pertussis (whooping cough) have increased in children, teens, and adults in the last few years. Tragically, some infants too young to be fully protected by vaccination have died. Ask your doctor or nurse if your children have received all the pertussis shots needed for his or her age. Also, if you haven't had your pertussis shot, you need to get one.

**What is "Catch-up?"** If your child's vaccinations are overdue or missing, get your child vaccinated as soon as possible. If your child has not completed a series of vaccinations on time, he or she will need only the remainder of the vaccinations in the series. There's no need to start over.

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www.cdc.gov/vaccines/imz/downloads/pdf/11-1111

## CHILD INFORMATION RECORD

State of Michigan - Department of Licensing and Regulatory Affairs - Child Care Licensing Bureau

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	Primary Phone ( )	Parent/Legal Guardian's Name (Optional)	Primary Phone ( )
Home Address (if not child's address)	2 <sup>nd</sup> Phone (if applicable) ( )	Home Address (if not child's address)	2 <sup>nd</sup> Phone (if applicable) ( )
City	State	Zip Code	City State Zip Code
Email Address (optional)		Email Address (optional)	
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/or Special Instructions? Yes <input type="checkbox"/> No <input type="checkbox"/> If yes, explain: <small>(Attach additional sheets, if necessary.)</small>			

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See Reverse Side

**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 Clawson Preschool, 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.						AUTHORITY: 1973 PA 116 COMPLETION: Required PENALTY: Rule Violation Citation.	

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**CLAWSON PUBLIC SCHOOLS**  
**STUDENT DATA FORM** (please print)

Student# _____	Year of Grad. _____
Entry Date _____	Schools of Choice _____
Resident District _____	

School to attend: \_\_\_\_\_ Entering Grade: \_\_\_\_\_

Student's **Legal** Name: \_\_\_\_\_ Gender:  Male  Female  
*(As shown on birth certificate)* Last First Middle Name

Birth date: \_\_\_\_\_ Birth Place: \_\_\_\_\_ Country of Birth: \_\_\_\_\_  
Month / Day / Year City or Township

Address: \_\_\_\_\_  
Number Street Apt. # City Zip Code

Primary Phone Number \_\_\_\_\_

**Ethnicity/Race Information** (collected for statistical purposes only)

**Part A.** Is this student Hispanic/Latino? (Choose only one)

No, not Hispanic/Latino

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

The above question is about ethnicity, not race. No matter what you selected above, please continue to answer the following by marking one or more boxes to indicate what you consider your student's race to be.

**Part B.** What is the student's race? (Check all that apply)

American Indian/Alaska Native  Asian  Black/African American  Native Hawaiian/Other Pacific Islander  White

**MEDICAL CONDITIONS/PROBLEMS: check all that apply**

# If checked a medical plan must be on file in your child's school office

<input type="checkbox"/> ADD/ADHD	<input type="checkbox"/> Headaches	<input type="checkbox"/> Seizure disorder #
<input type="checkbox"/> Asthma #	<input type="checkbox"/> Heart Condition	<input type="checkbox"/> Other Allergy: _____
<input type="checkbox"/> Bee Sting Allergy #	<input type="checkbox"/> Nose bleeds	<input type="checkbox"/> Other Medical Conditions: _____
<input type="checkbox"/> Diabetes#	<input type="checkbox"/> Peanut Allergy #	

\*Takes medication regularly? Please indicate medication and how often taken \_\_\_\_\_

\*If taken during school hours, please contact school and obtain an Authorization for Medication form to be completed by the student's physician and parent or guardian.

**LAST SCHOOL ATTENDED:**

School Name \_\_\_\_\_ Grade \_\_\_\_\_

Address \_\_\_\_\_ Date Entered \_\_\_\_\_ Date Left \_\_\_\_\_

City \_\_\_\_\_ State & Zip \_\_\_\_\_ Phone Number \_\_\_\_\_

**SERVICES YOUR CHILD RECEIVED AT PRIOR SCHOOL:**

Does your child have a 504 plan? Yes \_\_\_\_\_ No \_\_\_\_\_ (Please provide a copy of the 504 plan)

Does your child have an IEP (Individual Education Plan) Yes \_\_\_\_\_ No \_\_\_\_\_ (Please provide a copy of the IEP and MET)

Eligibility (if known) \_\_\_\_\_

**Information about Parents / Guardians:**

	<u>Female Parent/Guardian in Household</u>	<u>Male Parent/Guardian in Household</u>	<u>PARENT Living Elsewhere</u>
<b>Name:</b>			
<b>Relationship to child:</b>			
<b>Cell Phone:</b>			
<b>Work Phone:</b>			
<b>Email:</b>			
<b>On Full-time Active Military Duty?</b>	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Parent Living Elsewhere Address: _____ (Should this person receive mailings?) <input type="checkbox"/> Yes <input type="checkbox"/> No      Are custody papers on file with Clawson Public Schools <input type="checkbox"/> Yes <input type="checkbox"/> No Clawson Public Schools <b>cannot enforce</b> custody restrictions without a court order on file.			

**Emergency Contact Information:**

When parent/guardian is unavailable, please list four adults to whom the child can be released from school due to illness and/or provide transportation. Adults may be asked to present identification. List in order of preference. PLEASE PRINT LEGIBLY

NAME \_\_\_\_\_ RELATIONSHIP TO CHILD \_\_\_\_\_ PHONE: (\_\_\_\_) \_\_\_\_\_

NAME \_\_\_\_\_ RELATIONSHIP TO CHILD \_\_\_\_\_ PHONE: (\_\_\_\_) \_\_\_\_\_

NAME \_\_\_\_\_ RELATIONSHIP TO CHILD \_\_\_\_\_ PHONE: (\_\_\_\_) \_\_\_\_\_

NAME \_\_\_\_\_ RELATIONSHIP TO CHILD \_\_\_\_\_ PHONE: (\_\_\_\_) \_\_\_\_\_

**Other children that reside in the home:**

Child's Name	Birth Date	Relationship	Grade

Please note any problems or concerns, which would assist the school in working with your child:

\_\_\_\_\_

I affirm that as the parent/legal guardian, all information provided above is true and accurate, and that my child and I reside at the listed address. I understand any false information provided by me, may subject me to legal penalties for perjury.

\_\_\_\_\_  
Parent/Legal Guardian signature

\_\_\_\_\_  
Date

CLAWSON PUBLIC SCHOOLS  
HOME LANGUAGE SURVEY

The Clawson Public Schools district 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 380.1152-380.1157 of the School Code of 1995, Michigan's Bilingual Education Law.

Today's Date \_\_\_\_\_ School \_\_\_\_\_

Name of student \_\_\_\_\_  
First Middle Last

Student birth date: \_\_\_\_\_ Grade \_\_\_\_\_ Country of birth \_\_\_\_\_

1. Is your child's native tongue a language other than English?  Yes  No  
(The child's native tongue/language is the language most often spoken by the student.)  
If yes, what is that language? \_\_\_\_\_
2. Is the **primary** language used in your child's home or environment a language other than English?  
(The primary language is the dominant language used at home regardless of the language spoken by the student.)  
 Yes  No  
If yes, what is that language? \_\_\_\_\_
3. Did your child attend school in another country?  Yes  No  
If yes: How many years? \_\_\_\_\_ Which country? \_\_\_\_\_
4. Has your child been enrolled in a school in the United States?  Yes  No  
If yes, when did your child first enroll in that school? Month \_\_\_\_\_ Year \_\_\_\_\_
5. What language (or languages) does your child read? \_\_\_\_\_
6. What language (or languages) does your child write? \_\_\_\_\_
7. Has your child ever been in a bilingual or English as a Second Language program? \_\_\_\_\_
8. If so, what was the last grade in which he/she was enrolled in that program? \_\_\_\_\_

I understand that my child, \_\_\_\_\_, will receive English language proficiency testing if he/she speaks a language other than English. I will be notified if my child qualifies for English as a Second Language program services. I understand that at that time I have the right to refuse English as a Second Language program services for my child. However, I can request services at a later date.

\_\_\_\_\_  
Parent or Guardian signature

\_\_\_\_\_  
Date



## Screening Consent Form

The Ages and Stages Questionnaire-3 (ASQ-3) is a screening tool that asks questions about your child's overall and social emotional development, looking at how children are doing in the important areas of communication, physical ability, problem solving, and personal-social skills.

These screens can help identify your child's strengths as well as any areas where your child may need support. The screening should take about 10-20 minutes to answer questions about your child.

Your individual information is protected to ensure confidentiality. Information is entered on a web-based database that is secure and password protected. Identifying information from the screen will be seen only by the developmental screening specialist, who scores your screening and provides the results to you and the teacher.

General information about the ages and results of children's screening scores are computed at the Oakland Intermediate School District in order to better understand the strengths and challenges of the children living in Oakland County.

I have read the above description and give Great Start Oakland and Clawson Schools consent to screen my child(ren).

- Yes, I do wish to participate
- No, I do NOT wish to participate

\_\_\_\_\_  
Parent/Guardian Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Child's name

\_\_\_\_\_  
Child's name (if applicable)

This material was developed under a grant awarded by the Michigan Department of Education



Child's Name \_\_\_\_\_

### **Resource Request and Sharing Form**

We understand that having a young child can create a lot of questions for a family. From the time a family is expecting a child to the time the child enters Pre-Kindergarten there are a lot of changes in the growth and development of the child and the family. With much change, there can be unanswered questions. Please use as much or as little of the following space to share any questions you have about the growth and development of your child or changes your family has experienced. We will use the information to share resources we are aware of that align with your questions.

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If you are aware of any resources that are beneficial for other families in our program, please let us know about them in the following space.

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## Getting to Know More about Your Child

Tell us more about your child to help us support the transition into school. Enrollment is not determined based on responses to these questions.

Please circle the interest areas in our classroom that you think your child will enjoy the most:

Block Area	House Area	Art Area
Toy Area	Reading and Writing Area	Sand and Water Area
Woodworking Area	Movement & Music Area	Computer Area
	Outdoor Area	

### Experiences with Language(s)

What language(s) does your family speak? \_\_\_\_\_

How much experience (exposure) has your child had with the(se) languages? \_\_\_\_\_

Is your child growing up with two languages? \_\_\_\_\_ If so, what are the languages? \_\_\_\_\_

Can you tell me about your child's use of English (if at all)? \_\_\_\_\_

### Experiences:

What are some of the ways your child plays at home? \_\_\_\_\_

Does your child play with children from other households? \_\_\_\_\_ If yes, how? \_\_\_\_\_

Has your child ever used: scissors? \_\_\_\_\_ Glue? \_\_\_\_\_ Crayons? \_\_\_\_\_ Paint? \_\_\_\_\_ Pencil? \_\_\_\_\_

What other school-type experience has your child had? \_\_\_\_\_

Approximately how many hours does your child spend daily watching TV? \_\_\_\_\_

Approximately how many hours does your child spend daily playing video games? \_\_\_\_\_

Approximately how many hours does your child spend daily on the computer or a tablet? \_\_\_\_\_

### Eating Habits:

At what time does your child eat breakfast? \_\_\_\_\_ Lunch? \_\_\_\_\_ Dinner? \_\_\_\_\_

Between meal snacks? \_\_\_\_\_ Does your child feed himself/herself? \_\_\_\_\_

Food Favorites: \_\_\_\_\_

Food Dislikes: \_\_\_\_\_

Food Allergies: \_\_\_\_\_

What foods does your child eat at home? \_\_\_\_\_

**CLAWSON PRESCHOOL  
PARENTAL RELEASE FORM**

Dear Parent/Guardian:

Occasionally, for educational purposes, pictures or videotaped recordings will be made in classrooms and/or of students in other schools programs. Some of the pictures or recordings may be used in presentations or used on local cable or broadcast stations or in local newspapers. Your child's name may be mentioned with either a picture or in the videotaped recordings.

**PLEASE CIRCLE DO OR DO NOT IN THE FOLLOWING STATEMENTS:**

I DO/DO NOT give permission for \_\_\_\_\_  
(Student's Name)  
to be included in any videotaped recordings.

I DO/DO NOT give permission for \_\_\_\_\_  
(Student's Name)  
to be photographed for the news media or special programs and/or presentations.

I DO/DO NOT give permission for \_\_\_\_\_  
(Student's Name)  
photographs and/or videotaped recordings to be put on school related websites.

I understand my child's name may be used in conjunction with any pictures(s) used.

\_\_\_\_\_  
Parent/Guardian Signature

\_\_\_\_\_  
Date

## CHILD PLACEMENT CONTRACT

Note: This contract is required of all licensed child care centers by R400.5105b of the Michigan Administrative Code. The Michigan Department of Consumer and Industry Services is required to inspect the child care center and enforce the contract based on the terms provided in this contract.

Clawson Public Schools agrees to provide child care services for the following named child:

\_\_\_\_\_  
(Printed Name of Child)

\_\_\_\_\_  
(Date of Birth)

~~Printed Name of Child~~

The Clawson Public Schools, as a licensed child care facility, will provide the following provisions of the Michigan Administrative Code as required by R 400.5105b:

### **R400.5102 Licensee.**

Rule 102. (2) A licensee shall have the following administrative responsibilities regarding staff:

- (b) Develop and implement a written screening policy for all staff and volunteers including parents who have contact with children.

### **R400.5106 Program.**

Rule 106. (1) A center shall provide a program of daily activities and relationships that offers opportunities for the developmental growth of each child in all of the following areas:

- (a) Physical development, including large and small muscle.
  - (b) Social development, including communication skills
  - (c) Emotional development, including positive self-concept.
  - (d) Intellectual development
- (2) A center shall permit parents to visit the program for the purpose of observing their children at all times.
- (3) A center operating with children in attendance for 5 or more hours per day shall provide for daily outdoor play, unless prevented by inclement weather conditions.
- (4) A center shall provide child under school age in attendance for 5 or more continuous hours a day with an opportunity to rest.
- (5) A center shall provide children less than 3 years of age with an opportunity to rest regardless of the number of hours in care.
- (6) A center shall permit children under 12 months of age to eat and sleep on demand.

**[R 400.5205 and R 400.5209 apply only to children from birth to 2 ½ years of age as required in Part 2 of these rules.]**

### **R 400.5205 Formula; milk; foods**

Rule 205. (1) The requirements of R 400.5110 apply to infant formula and feeding in addition to the requirements of subrules (2) to (11) and (13) of this rule.

- (2) When a center provides formula for the child who is on the infant formula, commercially prepared, pre-bottled, ready-to-feed formula shall be provided. A center shall keep a list of formulas it offers and the number of calories per ounce that each formula provides.
- (3) A formula shall be iron-fortified for a child who is less than 6 months of age, unless otherwise recommended by the parent or a licensed physician for the individual child. Iron-fortified cereal if not already provided the recommended by the parent or licensed physician for the individual child.
- (4) Formula left in a bottle at the end of a feeding shall be discarded with the bottle.
- (5) Special formula required for an individual child by the center in commercially prepared, pre-bottled, ready-to-feed units, unless provided by the parent as specified in subrule (12) of this rule.



- (6) When formula is discontinued, all of the following provisions shall apply:
- (a) A center provide and use whole homogenized vitamin D-fortified cow's milk, unless otherwise directed by the parent or a licensed physician.
  - (b) Milk shall be poured into clean cups or bottles and have sanitized nipples. Excess milk left in a bottle or cup shall be discarded.
  - (c) Nipples shall be thoroughly cleaned and sanitized after each feeding and before being used again. This sterilization shall be by boiling the nipples for not less than 5 minutes.
- (7) This rule does not preclude a mother from visiting the center in order to breast-feed her child or from sending to the center expressed milk for the child.
- (8) A child too young to sit in a highchair or at a feeding table shall be held in a semi-sitting position or placed in an infant seat while being fed.
- (9) A child who is unable to hold his or her bottle shall be held when the bottle is given.
- (10) Solid foods shall be introduced to the individual child according to the parent's or a licensed physician's instructions.
- (11) Commercial baby food containers that are opened, and foods prepared in the center which are stored, shall be covered, dated, and labeled as to the contents and refrigerated. The contents shall be used or discarded within a 36 hour period. A child shall not be fed directly from baby food containers if the contents are to be fed to the child at more than 1 sitting or more than 1 child.
- (12) When a parent chooses to provide formula or food in accordance with R 400.5110(1)(b), the center shall assure that the food, formula, bottles, nipples, and containers comply with all of the following provisions:
- (a) Formula shall be prepared at the child's home and placed in an assembled bottle unit before being brought to the center.
  - (b) Formula, milk, and perishable foods needing refrigeration shall be refrigerated. Formula shall not be stored longer than 24 hours after opening. Foods shall be covered and labeled as to the contents, date of opening, and the specific child for whom its use is intended. Foods other than formula shall be used or discarded within a 36 hour period after opening.
  - (c) Each bottle and nipple supplied by a parent shall be used for a single feeding only and then returned to the parent.
  - (d) Formula and milk left in a bottle at the end of a feeding shall be discarded.
- (13) An exception to subrules (2) and (3) of this rule may be made when a center which provides formula is located in an area where commercially prepared, pre-bottled, ready-to-feed formula is not available for center use and the center is in compliance with all of the following provisions:
- (a) All formula shall be commercially prepared ready-to-feed formula
  - (b) All formula shall be poured directly from the opened can of formula into clean bottles with disposable liners.
  - (c) All nipples shall comply with either of the following provisions:
    - (I) Be disposable nipples, each of which shall be for a single use only by an individual child (II) and shall be discarded after use.
    - (II) Be reusable nipples, each of which is cleaned after each single use with hot detergent water and rinsed thoroughly. Each reusable nipple shall then be sterilized by boiling fully for not less than 5 minutes in water before reuse.
  - (d) Each liner shall be for a single use only by an individual child and shall be discarded after use along with any remaining formula.
  - (e) All liner, nipples, formula and other equipment used in bottle preparation shall be prepared, handled, and stored in a sanitary and sterile manner as required to safeguard children.
  - (f) Prepared bottles and opened cans of formula shall be refrigerated until used by the child.
  - (g) All opened formula which has not been used within the manufacturer's stated use time after opening shall be discarded. All bottles filled with formula and all opened cans of formula shall be dated to show the date and time of the opening of the commercially prepared formula and the manufacturer's stated use time of the formula. An individual formula for an individual child shall be labeled identifying the individual child for whom its use is intended. Bottles liners and disposable nipples of the unused bottles shall be discarded with the formula. Reusable nipples shall be cleaned and sterilized as required in subdivision (c) of this subrule before being used by a child.

**Rule 400.5209 Diapering; toilet training plan.**

Rule 209. (1) Diapers shall be disposable or from a commercial diaper service. If a child's health condition necessitates that disposable diapers or diapers from a commercial service cannot be used, then an alternative arrangement may be made according to the parent's or a licensed physician's instructions.

- (2) Diapering shall be done in the child's own crib or in a designated diapering area.
- (3) A center shall maintain a diapering area, and all supplies and equipment shall be maintained in a safe and sanitary manner.
- (4) The caregiver shall thoroughly wash his or her hands after each diapering, and after cleaning up bodily fluids, using soap and running water.
- (5) A washcloth or towel, or both used in diapering shall not be used subsequently on another part of the body or for any other purpose until laundered.
- (6) Toilet training shall be planned cooperatively between the child's primary caregiver and the parent so that the toilet routine established is consistent between the center and the child's home, and at a minimum, shall include washing hands after toilet use. The center shall empty and sanitize all training devices immediately after each use.
- (7) The caregiver shall change diapers when soiled or wet.

Parent, Legal Guardian or Responsible Adult

**Upon signing this agreement, the parent, legal guardian or responsible adult and the child care facility agrees to abide by all of the provisions contained in the contract.**

In witness whereof, the parties hereto have executed this contract as of the specified date:

Parent, Legal Guardian or Responsible Adult

Clawson Public Schools

*Claire Prost*

Signature

Signature

Printed Name

Claire Prost

Printed Name

Relationship to Child

Clawson Preschool Director

Title

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

#	Resolved	#	Is your child having any of the problems listed below?	
<input type="checkbox"/>	<input type="checkbox"/>	1	Allergies or Reactions (for example, food, medication or other)	<b>Birth History:</b>  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 <b>Examiner's Initials:</b> _____
<input type="checkbox"/>	<input type="checkbox"/>	2	Hay Fever, Asthma, or Wheezing	
<input type="checkbox"/>	<input type="checkbox"/>	3	Eczema or Frequent Skin Rashes	
<input type="checkbox"/>	<input type="checkbox"/>	4	Convulsions/Seizures	
<input type="checkbox"/>	<input type="checkbox"/>	5	Heart Trouble	
<input type="checkbox"/>	<input type="checkbox"/>	6	Diabetes	
<input type="checkbox"/>	<input type="checkbox"/>	7	Frequent Colds, Sore Throats, Earaches (4 or more per year)	
<input type="checkbox"/>	<input type="checkbox"/>	8	Trouble with Passing Urine or Bowel Movements	
<input type="checkbox"/>	<input type="checkbox"/>	9	Shortness of Breath	
<input type="checkbox"/>	<input type="checkbox"/>	10	Speech Problems	
<input type="checkbox"/>	<input type="checkbox"/>	11	Menstrual Problems	
<input type="checkbox"/>	<input type="checkbox"/>	12	Dental Problems: Date of Last Exam / /	
<input type="checkbox"/>	<input type="checkbox"/>	Other (please describe): _____		
<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	↔			
<input type="checkbox"/>	<input type="checkbox"/>	URINALYSIS Date: / /	Sugar Albumin Microscopic				<input type="checkbox"/>	<input type="checkbox"/>	TUBERCULIN Date: / /	Reading: _____ Type: _____ Neg.: <input type="checkbox"/> Pos.: <input type="checkbox"/> _____ mm			
<input type="checkbox"/>	<input type="checkbox"/>	BLOOD LEAD LEVEL Date: / /	Level _____ ug/dl				<b>NOTE:</b> 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: / /





Child's name \_\_\_\_\_

Clawson Early Childhood Center  
IN-DISTRICT FIELD TRIP  
PERMISSION SLIP

Dear Parent/Guardian,

Throughout each school year special field trips are planned to support our curriculum. When field trips are outside of Clawson, your child's teacher will send home a specific permission slip for you to approve and sign.

Since some of our educational field trips are within the Clawson community (the Clawson Performing Arts Center, fire hall, police station, post office, park, etc.) we thought it would be helpful to have one permission slip at the beginning of each school year that you could sign for all field trips within the community of Clawson. You will be notified about trips to the post office, police station, etc., any trip that is more than a few blocks away from our building.

Please read and initial \_\_\_\_\_ 2024-2025 School Year

My child may participate in all field trips within the Clawson community sponsored by Clawson Early Childhood during the current school year.

While my child is on any field trip it is my understanding that the school district personnel in charge will take all normal precautions to ensure the safety of all students. I further understand that I have the responsibility to see that my child understands they must cooperate and obey the school district personnel in charge of any field trip to the fullest extent possible

**PARENT NOTIFICATION OF THE LICENSING NOTEBOOK**  
Child Care Organizations Act, 1973 Public Act 116  
**Michigan Department of Licensing and Regulatory Affairs**  
**Child Care Licensing Bureau**

CENTER MUST CHECK ONE

The center keeps a licensing notebook containing a summary sheet, all licensing inspections and special investigations, and related corrective action plans for the last 5 years. The licensing notebook is available to parents/guardians during regular business hours. Reports from at least the past three years are available at [www.michigan.gov/michildcare](http://www.michigan.gov/michildcare).

The center does not keep a licensing notebook, but internet is available onsite. Reports from at least the last three years are available at [www.michigan.gov/michildcare](http://www.michigan.gov/michildcare).

I have read the above statement issued by Clawson Early Childhood Center

Name of Child Care Center

Child(ren)'s Name(s):	
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Parent Name \_\_\_\_\_

Parent Signature \_\_\_\_\_ Date \_\_\_\_\_

LARA is an equal opportunity employer/program.

# CLAWSON EARLY CHILDHOOD PARENT HANDBOOK ACKNOWLEDGMENT LETTER

Child(ren)'s Name(s) (Last, First)	Center Name Clawson Early Childhood Center
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A written information packet has been provided (online) at the time of enrollment. The packet included all the following information:

- Criteria for admission and withdrawal
- Schedule of operation, denoting hours, days, and holidays during which the center is open and services are provided.
- Fee policy
- Discipline policy
- Food service policy
- Program philosophy
- Typical daily routine
- Parent notification plan for accidents, injuries, incidents, illnesses.
- Exclusion policy for child illnesses.
- Notice of the availability of the center's licensing notebook
  
- The center does not keep a licensing notebook, but the internet is available onsite. Reports from at least the last three years are available at [www.michigan.gov/michildcare](http://www.michigan.gov/michildcare).
  
- Other \_\_\_\_\_

I certify that I received all of the above items.

\_\_\_\_\_  
Parent Signature

\_\_\_\_\_  
Date

**Note: A single BCAL-4340 form may be used for all children in the same family**

LARA is an equal opportunity employer/program.  
Auxiliary aids, services and other reasonable accommodations are available upon request to individuals with disabilities.