NORTH CENTRAL AREA SCHOOLS

REGISTRATION FOR 2022/2023

BY APPOINTMENT ONLY

KINDERGARTEN SCREENING & PRESCHOOL SIGNUPS (AGES 3-5)

WEDNESDAY, APRIL 27TH, 2022

AT NORTH CENTRAL ELEMENTARY FROM 8:00 A.M. - 5:00 P.M.

PLEASE BRING THE FOLLOWING ITEMS:

1) ***A STATE CERTIFIED BIRTH CERTIFICATE***
2) ***PROOF OF RESIDENCY (DRIVERS LIC; COPY OF BILL, TAXES, ETC.)***
3) ***IMMUNIZATION RECORDS***

PLEASE CALL THE ELEMENTARY OFFICE AT 906-498-7737 TO SCHEDULE AN APPOINTMENT.

CHILDREN MUST BY FIVE YEARS OLD ON OR BEFORE SEPTEMBER 1, 2022, UNLESS A PARENT CHOOSES TO USE THE AGE WAIVER FOR THE CHILDREN WHO TURN FIVE ON OR BEFORE DEEMBER 1, 2022.

IT'S A GREAT DAY TO BE A JET!

North Central Area Schools

P. O. Box 159 W5465 East Third Street Hermansville, MI 49847
Phone: 906-498-7737 Fax: 906-498-2235
Jennifer Eichmeier, Superintendent/Elementary Principal

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

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

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

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

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

Student's Name: ________________________________ Date of Birth: ___/___/___

Signature of Parent/Guardian
or Eligible Student: ________________________________ Date: ___/___/___

Printed Parent/Guardian Name: ________________________________

NORTH CENTRAL AREA SCHOOLS

HEALTH APPRAISAL

Dear Parent or Guardian: The following information is requested so that the school can work with the parent to meet the physical, intellectual and emotional needs of the child. Fill out the information requested in Section I. Section III may be certified by the transcription of information from the certificate of immunization. The remaining sections are to be completed by a doctor, nurse and dentist. **(BE SURE TO BRING YOUR CHILD'S IMMUNIZATION RECORDS TO THE EXAMINATION.)**

PERSONAL

CHILD'S NAME (Last, First, Middle)			DATE OF BIRTH (mm/dd/yy) / /
ADDRESS (Number & Street)	(City)	(ZIP Code) MI	TODAY'S DATE (mm/dd/yy) / /
PARENT/GUARDIAN (Last, First, Middle)			HOME TELEPHONE NUMBER ( )
ADDRESS (Number & Street)	(City)	(ZIP Code) MI	WORK TELEPHONE NUMBER ( )

SECTION I - HEALTH HISTORY

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

☐ ☐ Does your child take any medication(s) regularly?

Reason for Medication

______________ / / ______________
Parent/Guardian Signature Date

Birth History:

Are there any current or past diagnosis(es) ☐ Yes ☐ No

If yes, please describe:

If yes, list **medications:**

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

SECTION II - PHYSICAL EXAMINATION, INSPECTION, TESTS AND MEASUREMENTS

Required for Child Care and Head Start / Early Head Start

Tests and Measurements

No	Yes	Was child tested for:	Test results:	Normal	Referred	Under Care
☐	☐	VISION Date: / /	Visual Acuity			
			Muscle Imbalance			
			Other:			
☐	☐	HEARING Date: / /	Audiometer			
			Other:			
☐	☐	URINALYSIS Date: / /	Sugar			
			Albumin			
			Microscopic			
☐	☐	BLOOD LEAD LEVEL Date: / /	Level ______ ug/dl ⇨			

No	Yes	Was child tested for:	Test results:	Normal	Referred	Under Care
☐	☐	HEIGHT & WEIGHT	Height			
			Weight			
☐	☐	Other: ______	Other			
☐	☐	HEMOGLOBIN / HEMATOCRIT	⇨			
☐	☐	BLOOD PRESSURE	Reading: ______			
☐	☐	TUBERCULIN Date: / /	Type: ______ Neg.: ☐ Pos.: ☐ ______ mm			

NOTE: Blood lead level required for all children enrolled in Medicaid must be tested at one and two years of age, or once between three and six years of age if not previously tested. All children under age six living in high-risk areas should be tested at the same intervals as listed above.

Examinations and/or Inspections

Essential Findings Deviating from Normal:

Exam Date: / /

SECTION III - IMMUNIZATIONS

Statements such as "UP-TO-DATE" or "COMPLETE" will not be accepted. Admission to school may be denied on the basis of this information.*

VACCINES (Circle Type)	DATE ADMINISTERED MM/DD/YYYY	
Hepatitis B (HepB)	1	3
	2	
DTaP/DTP/DT/Td	1	4
	2	5
	3	6
Tdap	1	
Haemophilus Influenzae type b (HIB)	1	3
	2	4
Polio (IPV/OPV)	1	3
	2	4
Pneumococcal Conjugate (PCV7/PCV13)	1	3
	2	4
Rotavirus (RV1/RV5)	1	3
	2	
Measles,Mumps, Rubella (MMR)	1	2
Varicella (Chickenpox)	1	2

History of Chickenpox Disease? ☐ Yes ☐ No If yes, date:

VACCINES (Circle Type)	DATE ADMINISTERED MM/DD/YYYY	
Hepatitis A (HepA)	1	2
Influenza (IIV/LAIV)	1	3
	2	4
Meningococcal (MCV4 / MPSV4)	1	2
Human Papillomavirus (HPV9/HPV4/HPV2)	1	3
	2	
OTHER Vaccines Specify Date & Type	Type of Vaccine(s)	Date of Vaccine(s)
	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 _______________ (child's name) 's teeth. As a result of this examination, my recommendation for treatment is: _______________

_______________ *Dentist's Signature* ___/___/___ Date

PHYSICIAN'S SIGNATURE

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

_______________ Number & Street _______________ City MI _______________ ZIP Code (_____)_______________ Telephone

Information required for:

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

Child Care Licensing - Physical Exam, 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.

NORTH CENTRAL AREA SCHOOLS STUDENT RESIDENCY FORM

This questionnaire is in compliance with the McKinney-Vento Act, U.S.C. 42 § 11431 et seq. Your answers will help determine if the student meets eligibility requirements for services under the McKinney-Vento Act.

Student ______________________________ Parent/Guardian _________________________________

School __________________________ Phone ____

Age _____ Grade ________ D.O.B. __________________

Address _______________________________________ City

____

Zip Code ______________ Is this address **Temporary** or **Permanent?** (circle one)

Please choose which of the following situations the student currently resides in (you can choose more than one):

_____ House or apartment with parent or guardian
_____ Motel, car, or campsite
_____ Shelter or other temporary or transitional housing
_____ With friends or family members (without parent/guardian)
_____ With friends or family members (in addition with parent/guardian)
_____ In housing that lacks adequate heat, running water or electricity

If the student is living in <u>shared housing</u>, please check all of the following reasons that apply:

_____ Loss of housing
_____ Economic situation
_____ Temporarily waiting for house or apartment
_____ Providing care for a family member
_____ Living with boyfriend/girlfriend
_____ Loss of employment
_____ Parent/Guardian is deployed
_____ Parent/Guardian is incarcerated
_____Other Family Hardship____
_____Other (Please explain)____

Is the student under the age of 18 and living apart from parents or guardians? Yes No
If yes, who is the student's primary caregiver? ____________________________Relationship______________

Residency and Educational Rights

Students without fixed, regular, and adequate living situations have the following rights:

1) Immediate enrollment in the school they last attended or the local school where they are currently staying even if they do not have all of the documents normally required at the time of enrollment without fear of being separated or treated differently due to their housing situations;
2) Transportation to the school of origin for the regular school day;
3) Access to free meals, Title I and other educational programs, and transportation to extracurricular activities to the same extent that it is offered to other students.

Any questions about these rights can be directed to the local McKinney-Vento Liaison at or the State Coordinator at <u>517-</u>488-9161

By signing below, I acknowledge that I have received and understand the above rights.

____
Signature of Parent/Guardian/Unaccompanied Youth *Date*

____
Signature of McKinney-Vento Liaison *Date*

NORTH CENTRAL AREA SCHOOLS
W3795 Hwy US 2 & 41
Powers, Michigan 49874

STUDENT INFORMATION SHEET

FULL NAME OF CHILD: ______________________________
(First) (Middle) (Last)

FULL MAILING ADDRESS: ______________________________
(Include Street or Fire Number) City State Zip

TELEPHONE NO: (Home) ____________ COUNTY OF RESIDENCE: ____________

ETHNICITY (Race): ____________ GENDER: ____________

DATE OF BIRTH: ____________ CITY OF BIRTH: ____________

SOCIAL SECURITY NO.: ____________ FAMILY DOCTOR: ____________

DATE OF FIRST DTP/DTaP/DT/TD Shot: ____________ TELEPHONE NO: (Doctor) ____________

ALLERGIES: ____________ DISABILITIES: ____________

LIST ALL SERIOUS ILLNESSES & CHILDHOOD DISEASES YOUR CHILD HAS HAD: ____________

____

DATE OF ENROLLMENT: ____________ GRADE LEVEL: ____________

IS YOUR CHILD RECEIVING TITLE I SERVICES? (Check One) Yes ______ No ______

IF YES, FOR WHAT SUBJECT AREAS DOES YOUR CHILD RECEIVE SERVICES? ____________

DOES YOUR CHILD QUALIFY FOR FREE OR REDUCED MEALS? Free ______ Reduced ______ Neither ______

DOES YOUR CHILD RECEIVE SPECIAL EDUCATION SERVICES? Yes ______ No ______

IF YES, WHAT IS THE PRIMARY DISABILITY? ____________

WHAT IS THE SECONDARY DISABILITY IF ANY? ____________

WHAT WAS THE DATE OF THE LAST IEP? ____________

WHAT WAS THE DATE OF THE LAST MET? ____________

FAMILY DATA

	MOTHER	FATHER
NAME:	____________ (First & Maiden)	____________
PLACE OF BIRTH:	____________ (State or Country)	____________ (State or Country)
DATE OF BIRTH:	____________	____________
GRADE LEVEL OF SCHOOLING:	____________	____________
GENERAL OCCUPATION:	____________	____________

LANGUAGE SPOKEN IN HOME: ____________

IF PARENTS ARE PARTED, WITH WHOM DOES CHILD RESIDE? (Check One) MOTHER ______ FATHER ______

IS THERE A STEP-PARENT? (Check One) MOTHER ______ FATHER ______

IS THERE A GUARDIAN? ______ IF YES, PLEASE GIVE NAME: ____________

OTHER CHILDREN IN FAMILY

NAME	BIRTH DATE	NAME	BIRTH DATE

NORTH CENTRAL AREA SCHOOLS

P. O. Box 159 W5465 Third S... Hermansville, MI 49847 PHONE: 906-498-7737 FAX: 906-498-2235

Student Transportation Schedule

Student Name:______________________________ Date:___________

Over the summer, this information is used to establish bus routes for the fall of 2018. To assist us in creating our tentative bus routes, please return your student transportation/childcare information to our elementary office as soon as possible. *If you have changes over the summer, please call 497-5821 as soon as possible and leave a message if necessary.*

______No, I do not need transportation for my child. *(No further information needed)*
______Yes, I need transportation for my child. *(Continue completing form)*

My child will be bused **to** school from:
Home address:____ or
Day care address:____
On the Following days *(circle all that apply)*: M T W TH F

My child will be bused **from** school to:
Home address:____ or
Day care address:____
On the Following days *(circle all that apply)*: M T W TH F

Please complete if using district transportation services:

Students Home Phone:______________ Emergency Phone Number: ______________

Name of Child Care Provider:_________________________ Phone:____________

Hours Your Child Attends Day Care: From________________ to ________________

Scheduled Days at Day Care: Every Day _____ Certain Days _____
Please Specify Days *(circle all that apply)*: M T W TH F

Should the bus driver be aware of any health concerns or other issues for your child?

____

____

______________________________ ______________

Parent/Guardian Signature Date