Dooley Center
16170 Canberra
Roseville MI 48066
586-439-7600 • Fax 586-439-7601
Melissa Laseck – Director

Registration for All Tuition Based Programs

Step 1. Schedule an appointment to turn in registration paperwork. The link to schedule an appointment can be found on our website. http://dooley.fraser.k12.mi.us

You may pick up the forms at the Dooley Center, you may complete them online and print them to bring with you or you may download the completed forms and email them to Melissa.laseck@fraserk12.org

- **Required Student Enrollment Documents**
  - Completed Student Data Form
  - Medical/Allergy Questionnaire
  - Completed Health Appraisal with physician's signature
  - Up to date Immunization Record
  - Concussion Awareness
  - Statement of Varicella Disease (Chickenpox) if applicable
  - Little Learners Program Policies
  - Pesticide advisory
  - Child Information Sheet
  - Your child's **Original Birth Certificate (we will make a copy)**
    - If you do not have your child's birth certificate please use one of the resources below to obtain an original certificate
      - Order online at www.vitalcheck.com
      - Contact State of Michigan Vital Records at michigan.gov/mdhhs/doing-business/vitalrecords or by phone at (517) 335-8656
      - Go to courthouse of the county where the child was born

ALL FORMS ARE NEEDED FOR A CHILD TO ATTEND

Step 2. Register with the Little Learners Dooley Center bookkeeping department in the link that will be emailed to you after step 1 is complete. You may also complete this step at the Dooley Center during the registration appointment.

- If you have any problems registering online, please call:
  - Bookkeeper (586) 439-7038
  - Dooley Office (586) 439-7600
  - Or email Melissa.laseck@fraserk12.org

ALL REGISTRATIONS WILL BE PENDING UNTIL BOTH STEPS 1 & 2 ARE COMPLETE

Step 3. Review our Little Learners Handbook

- The handbook can be found online or is available in our office to view.
  - http://dooley.fraser.k12.mi.us
    - "Information" link on left of page

Fraser Public Schools
Student Data Form
2023-2024

Please complete and return this enrollment form.

Student Information

Student's Full Legal Name Last Name First Name Middle Name			Gender ■ M ☐ F	Grade
Home Street Address (with apt/suite)	**Home City & Zip**		**Primary Phone**	
Mailing Address	**Mailing City & Zip**		**Secondary Phone**	
Resident School District	**Race (Please choose one from list below, regardless of Ethnicity)** 1.☐Alaskan Native/American Indian 2.☐Asian American 3.☐Black or African American 4.☐Native Hawaiian/Other Pacific Islander 5.☐White 6.☐Hispanic or Latino 7.☐Multi-Racial – If Multi-Racial, please list two:			
Ethnicity (Please choose one) Hispanic/Latino ☐ Not Hispanic or Latino ☐				
Student's Date of Birth	**Student Order of Birth (if multiple)** Please circle: ☐01☐02☐03☐04☐05☐06☐07☐08		**Birth City/State (if born in US)**	

Fill in Section Below for Students not Born in US

U.S. Citizen Yes No	Date Entered US (month & year)	First Attended School in US (month & year)	Country of Birth

Fill in Sections Below for All Students

Primary Language	Language Spoken in Home

Former School

Attended School in this District Before? ☐Yes ☐No		If Yes, School Attended
Former District		**Former School**
Former School Address	**Former School City, State & Zip**	**Suspended/Expelled from Former School?** ☐Yes ☐No

Services Received at Former School

☐IEP 504	☐ Title I	☐ ELL	☐ Social Work	☐ Other Services

Please Describe Other Services ***Please provide copies related to any of the above checked boxes***

Forms Submitted

☐Birth Certificate	☐ Proof of Residency	☐ Immunization	☐ Hearing & Vision	☐ Concussion Awareness

Health-Fill Out the Medical Forms Packet for any Boxes Checked

Preferred Hospital	Names & Schedule for Medications
Emergency Medical Alerts, Allergies or Problems	**Physical Limitations (Explain)**

■ Asthma	■ Diabetes	■ Vision Problem	■ Hearing Problem	■ Peanut Allergy	Cystic Fibrosis Other

Physician Name	Physician Phone

Contact 1 (Parent/Guardian)

First & Last Name	Relationship to Student	Contact Emergency Priority
Street Address, City, State & Zip	**Home Phone**	**Cell Phone**
Cell Phone 2/Pager	**Email Address**	**Resides with Student?** ■ Yes ■ No
Employer	**Work Phone (with extension)**	**Receives Letter Mailings?** ■ Yes ■ No

Contact 2

First & Last Name	Relationship to Student	Contact Emergency Priority
Street Address, City, State & Zip	**Home Phone**	**Cell Phone**
Cell Phone 2/Pager	**Email Address**	**Resides with Student?** ■ Yes ■ No
Employer	**Work Phone (with extension)**	**Receives Letter Mailings?** ■ Yes ■ No

Contact 3

First & Last Name	Relationship to Student	Contact Emergency Priority
Street Address, City, State & Zip	**Home Phone**	**Cell Phone**
Cell Phone 2/Pager	**Email Address**	**Resides with Student?** ■ Yes ■ No
Employer	**Work Phone (with extension)**	**Receives Letter Mailings?** ■ Yes ■ No

Contact 4		
First & Last Name	**Relationship to Student**	**Contact Emergency Priority**
Street Address, City, State & Zip	**Home Phone**	**Cell Phone**
Cell Phone 2/Pager	**Email Address**	**Resides with Student?** ■Yes ■ No
Employer	**Work Phone (with extension)**	**Receives Letter Mailings?** ■Yes ■ No

Siblings		
Name	**Date of Birth**	**School Attended**
Name	**Date of Birth**	**School Attended**
Name	**Date of Birth**	**School Attended**
Name	**Date of Birth**	**School Attended**

INTERNET ACCEPTABLE USE POLICY PRESS / VIDEO RELEASE

Fraser Public Schools has my permission to use photographs and/or videos of my child to show school activities to the public. I understand that the personally identifiable information may be used at the discretion of the media, involving no financial compensation to Fraser Public Schools, the student, or family of the student.

Press/Video Release ■ Yes ■ No

I understand that I have the right to deny consent to the release of photographs, information and/or Internet accessibility specified above by notifying the principal of my child's school.

Parent/Guardian Signature   Date

If permission is denied, please write "DENIED" on the signature line.

INTERNET USE

All students are able to use the Internet in accordance with Fraser Public Schools Internet acceptable use policy, available at each school. If you do not want your child to use the Internet, please contact his/her school principal.

MEDICAL ASSISTANCE

In the event that my child is injured or may need medical assistance and I cannot be reached, school personnel of this district are hereby authorized to take whatever action that is necessary to provide medical emergency care for my child. I agree to assume all expenses.

I certify that the information on this form is true and correct to the best of my knowledge.

Parent/Guardian Signature   Date

Dooley Center
16170 Canberra
Roseville MI 48066
586-439-7600
Fax 586-439-7601

Melissa Laseck – Director

MEDICAL / ALLERGY QUESTIONAIRE

Student's name ____ Class ____________________

Date of birth ______/_______/______ Doctor ________________________ Phone (_____) _____-___________

Does your child have any medical conditions ? (Diabetes, seizures, heart conditions, etc) _____Yes _____No

If so, please list:

- ☐ ____
- ☐ ____
- ☐ ____

Does your child have asthma? _____Yes _____No If so, please list any medications they use.

NAME AMOUNT FREQUENCY

- ☐ ____
- ☐ ____
- ☐ ____

Does you child have any allergies?

☐ **My child has <u>NO CURRENT ALLERGIES</u>** (Skip to Parent Permission)

☐ **My child has allergies.** Please answer the questions below.

****

Has your child been diagnosed by a doctor for his/her allergies? _____Yes _____No

When/How was your child diagnosed with allergies? ____

When was the last time your child had an allergic reaction? ____

How many times has your child been treated in the ER or hospitalized for an allergic reaction? ___________

FOOD ALLERGIES: Check all that apply. Name the specific food causing the reaction.

- ☐ Peanuts
- ☐ Tree Nuts Specifically: ____
- ☐ Fish Specifically: ____
- ☐ Fruit Specifically: ____
- ☐ Dairy Products Specifically: ____

REACTION can occur by (check all that apply) ______Ingestion _____Contact ______Inhalation

SYMPTOMS of child's food allergy reaction/intolerance include:

- ☐ Nausea and vomiting
- ☐ Cramping and/or abdominal pain
- ☐ Facial swelling, itching, welts or hives
- ☐ Swelling of the lips, nose, tongue or throat.
- ☐ Respiratory changes difficulty breathing, wheezing or continuous coughing.
- ☐ Inability to speak or swallow.
- ☐ Flushed face
- ☐ Drooling
- ☐ Complains that the throat feels tight, scratchy, or different in some way.
- ☐ OTHER – DESCRIBE: ____

FOR PEANUT ALLERGY:

Reading food labels all the time is important. If a label indicates the food item is made in a facility that also processes peanuts, my child may consume. _____Yes _____No

Does your child have an Epinepherine Auto-injector prescribed? _____Yes _____No

MEDICATIONS: If your child takes for these symptoms please inquire about additional required forms

- ☐ Non-Prescription Medication
- ☐ Prescription Medication
- ☐ Allergy & Anaphylaxis Emergency Care Plan

OTHER ALLERGIES: Please list any other allergies you child has.

- ☐ ____
- ☐ ____
- ☐ ____
- ☐ ____
- ☐ ____
- ☐ ____

Does your child wear a Medic Alert to identify him/her as having allergies? _____Yes _____No

****

PARENT PERMISSION

I verify that the above information is correct. I give my permission to share this information with staff on a need to know basis. The information is **valid for ONE SCHOOL YEAR**. Annual parent signature is required.

Does your child ever ride the school bus to or from school? _____Yes _____No

Parent/guardian signature ____ Date ______/______/_____

Mother ____ Phone (________) ________-___________

Father ____Phone (________) ________-___________

HEALTH APPRAISAL

Michigan Department of Health and Human Services

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, dentist, dental therapist, and dental hygienist.
(**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/Cell Phone Number
Address (Number, Street, City, Zip Code)	Work Phone Number

SECTION I – HEALTH HISTORY

Yes	No	Resolved	#	Is your child having any of the problems listed below?	Birth History
☐	☐	☐	1	Allergies or Reactions (for example, food, medication or other)	
☐	☐	☐	2	Anaphylaxis	
☐	☐	☐	3	Does your child take any medication(s) regularly?	If yes, list medications
☐	☐	☐	4	Hay Fever, Asthma, or Wheezing	
☐	☐	☐	5	Eczema or Frequent Skin Rashes	
☐	☐	☐	6	Convulsions/Seizures	
☐	☐	☐	7	Heart Trouble	
☐	☐	☐	8	Diabetes	
☐	☐	☐	9	Frequent Colds, Sore Throats, Earaches (4 or more per year)	Are there any current or past diagnosis(es) ☐ Yes ☐ No
☐	☐	☐	10	Trouble with Passing Urine or Bowel Movements	If yes, please describe
☐	☐	☐	11	Shortness of Breath	
☐	☐	☐	12	Speech Problems	
☐	☐	☐	13	Menstrual Problems	
☐	☐	☐	14	Dental Problems Date of Last Exam _____ **OR** Date of Last Assessment _____	
☐	☐	☐		Other (please describe) _____	

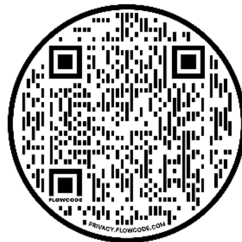
Reason for Medication		
Concussion History		
Parent/Guardian Signature	Date	Was the health history reviewed by a health professional? ☐ Yes ☐ No **Examiner's Initials** _____

SECTION II – PHYSICAL EXAMINATION, INSPECTION, TESTS AND MEASUREMENTS

Required for Child Care and Head Start / Early Head Start

Test and Measurements						
Yes	No	Was child tested for	Tests and results	Normal	Referred	Under care
☐	☐	Vision Date _____	Visual Acuity			
			Muscle Imbalance			
			Other			
☐	☐	Hearing Date _____	☐ Audiometer (R= Right, L=Left)	R/L	R/L	
			☐ OAE (R= Right, L=Left)	R/L	R/L	
			☐ Other (R= Right, L=Left)	R/L	R/L	
☐	☐	Urinalysis	Sugar			
			Albumin			
			Microscopic			
☐	☐	Blood Lead Level Date _____	Level _____ ug/dl			
Note: All children in Medicaid need to be tested at 1 and 2 years of age, or once between 3 and 6 years of age if not previously tested. All children, regardless of Medicaid status, should be tested at those same ages if they live in an area where lead risk is high.						
☐	☐	Height & Weight	Height			
			Weight			
		Other _____	Other _____			
☐	☐	Hemoglobin/Hematocrit	⇨			
☐	☐	Blood Pressure	Reading _____			

Complete pediatric tuberculosis risk assessment available at: https://www.michigan.gov/documents/mdhhs/4._MI_Pediatric_TB_Risk_Assessment_661537_7.pdf **OR** feel free to use the attached QR code instead of the full link text.



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 based on this information.*

Vaccines (Circle Type)	Date Administered mm/dd/yy		Vaccines (Circle Type)	Date Administered mm/dd/yy	
Hepatitis B (HepB)	1	3	Hepatitis A (HepA)	1	3
	2	4		2	
DTaP/DTP/DT/Td	1	4	Influenza (IIV/LAIV)	1	3
	2	5		2	4
	3	6	Meningococcal MenACWY (MCV4)	1	3
				2	
Tdap	1		Meningococcal B (Bexsero, Trumenba)	1	3
				2	
Haemophilus Influenzae type b (HIB)	1	3	Human Papillomavirus (9vHPV, 4vHPV, 2vHPV)	1	3
				2	
	2	4	Additional Vaccines Specify Date & Type	Type of Vaccine(s)	Date of Vaccine(s)
Polio (IPV/OPV)	1	4		1	
	2	5		2	
	3			3	
Pneumococcal Conjugate (PCV7/PCV13)	1	3	Indicate and attach physician diagnosis or laboratory evidence of immunity as applicable.		
	2	4			
Rotavirus (RV1/RV5)	1	3	***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.		
	2				
Measles, Mumps, Rubella (MMR/MMRV)	1	3			
	2				
Varicella (Chickenpox), (Var, MMRV)	1	2			
History of Chickenpox Disease? ☐ Yes ☐ No If yes, date _____			Parent/Guardian refused recommended immunizations at visit: ☐		
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)

Yes	No	
☐	☐	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 EXAM OR ASSESSMENT RECOMMENDATIONS (OPTIONAL)

Child's Name	Has received ☐ Dental Exam ☐ Dental Assessment
Findings and Recommendation (Check all that apply) ☐ No Urgent Needs ☐ Routine Care Needed ☐ Treated Decay ☐ Restorative/Urgent Needs for Dental Care ☐ Untreated Decay ☐ Further Referral for Specialist	
Signature	Date
Check One ☐ Dentist ☐ Dental Therapist ☐ Dental Hygienist	

PHYSICIAN'S SIGNATURE

Examiner's Signature	Date		Examiner's Name (Print)	Degree or License
Number & Street	City	MI	Zip Code	Telephone Number

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 preventative and primary health care, including medical, dental, and mental health. The schedule must incorporate the well-childcare 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.

The Michigan Department of Health and Human Services will not exclude from participation in, deny benefits of, or discriminate against any individual or group because of race, sex, religion, age, national origin, color, height, weight, marital status, partisan considerations, or a disability or genetic information that is unrelated to the person’s eligibility.

Dear Parent/Guardian:

Key Points Related to Claiming a Nonmedical Immunization Waiver for Children Attending Michigan Schools and Licensed Childcare Programs

In early 2015, Michigan instituted an administrative rule change on nonmedical waivers for childhood immunizations. Parents/guardians seeking to obtain a nonmedical immunization waiver for their child/children who are enrolled in school or licensed childcare programs are required to attend an educational session, where they are provided with information about vaccine-preventable diseases and vaccinations.

- Michigan has one of the highest immunization waiver rates in the country, with select counties reporting waiver rates over 10% (that is 1 out of 10 school-aged students that have not received all vaccinations required for school)[1]. In addition, individual school buildings have reported even higher waiver rates.

Key Points

- The rule applies to parents/guardians seeking a nonmedical immunization waiver for their child/children enrolled in public or private:
  - Licensed childcare, preschool, and Head Start programs
  - Kindergarten, 7th grade, and any newly enrolled student into the school district
- This rule preserves your ability to obtain a nonmedical waiver.
- Nonmedical waivers (religious or philosophical/other objections) are available at your county health department and cannot be found at schools/childcare programs or physician offices.
- Parents/guardians are required to follow these steps when seeking a nonmedical waiver:
  1. Contact your county health department for an appointment to speak with a health educator.
  2. During the visit, immunization-related questions and concerns of the parents/guardians can be brought up for discussion. The staff will present evidence-based information regarding the risks of vaccine-preventable diseases and the benefits/potential risks (risks consisting mostly moderate side effects) of vaccination.
  3. Schools/childcare programs will only accept the current, un-altered, official State of Michigan form (Any new waivers issued should have the revision date of January 1, 2019.)
     - A county health department will not issue a waiver without both signatures as it would be considered an incomplete and invalid waiver.
     - Forms cannot be altered in any way (this includes crossing information out).
  4. Take the current, certified waiver form to your child's school or childcare program.
- If your child has a medical reason (that is, a true medical contraindication or precaution) for not receiving a vaccine, a physician (MD/DO) must sign the State of Michigan Medical Contraindication Form.
- Based on the public health code, a child without an up-to-date immunization record, a certified nonmedical waiver form, **or** a physician (MD/DO)-signed medical waiver shall be excluded from school/childcare.

For more information, please visit www.michigan.gov/immunize > click on *Local Health Departments* > click on *Immunization Waiver Information.* This website will provide you with a link to all the county health departments, along with their addresses and phone numbers.

[1] MDHHS unpublished data

*County Health Department includes the City of Detroit

January 3, 2019

Educational Material for Parents and Students (Content Meets MDCH Requirements)

Sources: Michigan Department of Community Health. CDC and the National Operating Committee on Standards for Athletic Equipment (NOCSAE)

UNDERSTANDING CONCUSSION

Some Common Symptoms

Headache	**Balance Problems**	**Sensitive to Noise**	**Poor Concentration**	**Not "Feeling Right"**
Pressure in the Head	**Double Vision**	**Sluggishness**	**Memory Problems**	**Feeling Irritable**
Nausea/Vomiting	**Blurry Vision**	**Haziness**	**Confusion**	**Slow Reaction Time**
Dizziness	**Sensitive to Light**	**Fogginess**	**"Feeling Down"**	**Sleep Problems**
		Grogginess		

WHAT IS A CONCUSSION?

A concussion is a type of traumatic brain injury that changes the way the brain normally works. A concussion is caused by a fall, bump, blow, or jolt to the head or body that causes the head and brain to move quickly back and forth. A concussion can be caused by a shaking, spinning or a sudden stopping and starting of the head. Even a "ding," "getting your bell rung," or what seems to be a mild bump or blow to the head can be serious. A concussion can happen even if you haven't been knocked out.

You can't see a concussion. Signs and symptoms of concussions can show up right after the injury or may not appear or be noticed until days or weeks after the injury. If the student reports any symptoms of a concussion, or if you notice symptoms yourself, seek medical attention right away. A student who may have had a concussion should not return to play on the day of the injury and until a health care professional says they are okay to return to play.

IF YOU SUSPECT A CONCUSSION:

1. **SEEK MEDICAL ATTENTION RIGHT AWAY –** A health care professional will be able to decide how serious the concussion is and when it is safe for the student to return to regular activities, including sports. Don't hide it, report it. Ignoring symptoms and trying to "tough it out" often makes it worse.

2. **KEEP YOUR STUDENT OUT OF PLAY –** Concussions take time to heal. Don't let the student return to play the day of injury and until a heath care professional says it's okay. A student who returns to play too soon, while the brain is still healing, risks a greater chance of having a second concussion. Young children and teens are more likely to get a concussion and take longer to recover than adults. Repeat or second concussions increase the time it takes to recover and can be very serious. They can cause permanent brain damage, affecting the student for a lifetime. They can be fatal. It is better to miss one game than the whole season.

3. **TELL THE SCHOOL ABOUT ANY PREVIOUS CONCUSSION –** Schools should know if a student had a previous concussion. A student's school may not know about a concussion received in another sport or activity unless you notify them.

SIGNS OBSERVED BY PARENTS:

- Appears dazed or stunned
- Is confused about assignment or position
- Forgets an instruction
- Can't recall events prior to or after a hit or fall
- Is unsure of game, score, or opponent
- Moves clumsily
- Answers questions slowly
- Loses consciousness (even briefly)
- Shows mood, behavior, or personality changes

CONCUSSION DANGER SIGNS:

In rare cases, a dangerous blood clot may form on the brain in a person with a concussion and crowd the brain against the skull. A student should receive immediate medical attention if after a bump, blow, or jolt to the head or body s/he exhibits any of the following danger signs:

- One pupil larger than the other
- Is drowsy or cannot be awakened
- A headache that gets worse
- Weakness, numbness, or decreased coordination
- Repeated vomiting or nausea
- Slurred speech
- Convulsions or seizures
- Cannot recognize people/places
- Becomes increasingly confused, restless or agitated
- Has unusual behavior
- Loses consciousness (even a brief loss of consciousness should be taken seriously.)

HOW TO RESPOND TO A REPORT OF A CONCUSSION:

If a student reports one or more symptoms of a concussion after a bump, blow, or jolt to the head or body, s/he should be kept out of athletic play the day of the injury. The student should only return to play with permission from a health care professional experienced in evaluating for concussion. During recovery, rest is key. Exercising or activities that involve a lot of concentration (such as studying, working on the computer, or playing video games) may cause concussion symptoms to reappear or get worse. Students who return to school after a concussion may need to spend fewer hours at school, take rests breaks, be given extra help and time, spend less time reading, writing or on a computer. After a concussion, returning to sports and school is a gradual process that should be monitored by a health care professional.

Remember: Concussion affects people differently. While most students with a concussion recover quickly and fully, some will have symptoms that last for days, or even weeks. A more serious concussion can last for months or longer.

To learn more, go to www.cdc.gov/concussion.

Parents and Students Must Sign and Return the Educational Material Acknowledgement Form

CONCUSSION AWARENESS

EDUCATIONAL MATERIAL ACKNOWLEDGEMENT FORM

By my name and signature below, I acknowledge in accordance with Public Acts 342 and 343 of 2012 that I have received and reviewed the Concussion Fact Sheet for Parents and/or the Concussion Fact Sheet for Students provided by ____

Sponsoring Organization

______________________________	______________________________
Participant Name Printed	Parent or Guardian Name Printed
______________________________	______________________________
Participant Name Signature	Parent or Guardian Name Signature
______________________________	______________________________
Date	Date

Return this signed form to the sponsoring organization that must keep on file for the duration of participation or age 18.

Participants and parents please review and keep the educational materials available for future reference.

Health Department

Statement of Varicella Disease
CHICKENPOX

The Michigan Public Health Code Act 368 of 1978 Part 92 Immunization and Macomb County Immunization Regulations require all children admitted to any public, private, parochial, special education, alternative education, adult education, career/technical education, homeschool cooperative, virtual school or charter academy, childcare center, nursery school, preschool, camp, or any other organized care or educational facility operating in Macomb County to present a certificate indicating dates of all required immunizations.

Complete the portion below **only** if your child has had varicella (chickenpox) disease. **This form must be signed and witnessed at your child's school/childcare program.**

I certify my child: ____
Last Name First Name M.I.

____
Birth Date Grade Date of School Enrollment

Has had varicella disease ______________________________________
(When did varicella occur: Age or Date?)

Signature: ____________________________ Date: ___________________
(Parent or Legal Guardian)

Witnessed by: _________________________ Date: ___________________
(School/Program Staff)

School District: ____

School/Childcare Program: ______________________________________

PLACE THIS FORM IN THE CHILD'S PERMANENT RECORD

MCHD/SIP 6/99, Revised 05/2018

Dooley Center
16170 Canberra
Roseville MI 48066
586-439-7600 • Fax 586-439-7601
Melissa Laseck – Director

Little Learners Program Policies

Please initial that you have read each of the following statements. This form can also be found in the Parent Handbook.

________I understand that the tuition for Traditional Preschool is due on the 10th of each month.

________I understand that that a schedule must be provided for Early Childhood Care

________**I understand that failure to make payments in a timely manner may result in my child being dropped from the program**

________I understand that if I am late picking up my child I may be charged a $15.00 late fee for every 15 minutes I am late. This fee will be added to my invoice.

________I understand that I will make preschool and childcare staff aware of any changes with phone numbers, addresses, e-mail address and information pertaining to my child.

________I understand I must provide local emergency contact information.

________I understand the illness policy, which includes a child being fever/diarrhea/vomit free for 24 hours without medication before returning to school.

________I understand that additional illness policies may be in place based on the current requirements from MCHD, MDHHS and Michigan Child Care Licensing.

________I will make sure staff is aware of any allergies, medications and special needs that my child may have and will have my child's immunization record on file at the school.

________I understand the parents provide transportation to and from all field trips and there are no refunds for preschool tuition if I can't attend.

________I understand the toilet-trained policy and procedure.

________I understand that my child may be photographed or videotaped during their time in the program. These photos or tapes may be used in newsletters, the FPS website or FPS TV channel.

________I am being made aware of a Licensing Notebook. I understand that: (i) The licensing notebook is available for parents to review during regular business hours, (ii) The licensing notebook contains all the licensing inspection reports, special investigation reports and related corrective action plans for the last 5 years, (iii) Licensing inspection reports, special investigation reports and related corrective action plans for at least the last 3 years are available on the department's child care licensing website at www.michigan.gov/michildcare.

________I understand that all child care and preschool staff have been cleared through a comprehensive background check.

________I understand that all Tuition Preschool and Early Childhood Care classrooms are peanut and tree nut free. I will not send to school items that contain peanut or tree nut products.

________I have read the Parent Handbook found on Dooley's website under information: http://dooley.fraser.k12.mi.us and I agree to the policies described within it. A copy of this handbook can also be viewed in the Dooley Center office.

Child's Name ____

Parent/Guardian's Signature ________________________________ Date ______/______/______

Dooley Center
16170 Canberra
Roseville MI 48066
586-439-7600
Fax 586-439-7601

Melissa Laseck – Director

Advisory to Parents/Guardians

Dear Parent or Guardian:

State of Michigan law requires that schools and day care centers that may apply pesticides on school or day care property must provide an annual advisory to parents or guardians of students attending the facility.

Please be advised that the Fraser Public Schools district utilizes an Integrated Pest Management (IPM) approach to control pests. IPM is a pest management system that utilizes all suitable techniques in a total pest management system with the intent of preventing pests from reaching unacceptable levels or to reduce an existing population to an acceptable level. Pest management techniques emphasize sanitation, pest exclusion, and biological controls. One of the objectives of using an IPM approach is to reduce or eliminate the need for chemical applications of pesticides. However, certain situations may require the need for pesticides to be utilized.

Please be advised that parents or guardians of children attending Fraser Public Schools may review the district's Integrated Pest Management program and records of any pesticide application upon request.

If you have questions regarding the district's pest management procedures, please contact:

Fraser Operations & Maintenance
33499 Klein Road
Fraser, MI 48026
(586) 439-7114

Child's Name ____

Parent's Signature ________________________________ Date ____/____/____

CHILD INFORMATION SHEET

Child's full name: ____

Nickname: _______________________________ Birth date: ______/_______/_______

Allergies: _______ If so, please list: ______________________________________

____

Mother's Name: __________________________ Occupation: ___________________

Father's Name: __________________________ Occupation: ___________________

Home address: ____

Home phone number: (_________) _________-_____________

With whom does your child live? ____

Name and age of siblings: ____

What languages are spoken in the home? ____

Does your child have any special needs? _______ If so, please explain: ______________

____

List your child's skills and interests (such as books, music he/she enjoys using):

____

Describe events such as death, divorce, illness and hospital trips:

____

Are there particular areas in which your child needs help?

____

Any other concerns or things that you feel we should know about?

____

Is there any other information you would like to share with the teacher?

____

____

You may describe your family's traditions and cultural heritage on the back.

Dooley Center
16170 Canberra
Roseville MI 48066
586-439-7600 • Fax 586-439-7601
Melissa Laseck – Director

EARLY CHILDHOOD CARE

at Dooley Little Learners

Dear Parents:

We are licensed by the State of Michigan. It is required by them that we have a written statement signed by the parents regarding safety, health, and discipline policies. Thank you for your cooperation.

1. I have received a copy of the Parent Handbook explaining the policies of the center.

2. I understand that my child must nap or rest quietly. I will provide the necessary linens.

3. I understand that the childcare staff will provide appropriate and reasonable guidelines for the children. Positive method of discipline shall be used. If a caregiver feels that a child should be withdrawn from the program a meeting with both parents and the Director will be held to decide what is in the best interest of the child.

Child's Name ____

Parent/Guardian's Signature ______________________________________ Date _____/_____/_____

Dooley Center
16170 Canberra
Roseville MI 48066
586-439-7600
Fax 586-439-7601

Melissa Laseck – Director

Dear Early Childhood Care Parents:

For us to plan our staffing appropriately, please tell us which days and approximately what hours you will use our childcare program. Thank you in advance for your cooperation.

Child's name ____

Name of other class/program your child attends (Preschool, Focus Four, Head Start)

________________________________ Teacher ________________

Days/Hours Needed:

- ☐ Monday ____________________
- ☐ Tuesday ____________________
- ☐ Wednesday ____________________
- ☐ Thursday ____________________
- ☐ Friday ____________________

Additional comments ____

____

____

Revised January 2023