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

Registration for All Tuition Based Programs

Step 1. Come to our office to pick the days/times and teacher to reserve a spot in preschool. We must have the following forms to complete the registration process. You may pick up the forms at the Dooley Center or they may be found on the Dooley Center web page.

- Required Student Enrollment Documents
  - Completed Student Data Form
  - Little Learners Program Policies
  - Parent Notification of Licensing Notebook
  - Child Information Sheet
- Your child's **Original Birth Certificate**
  - Can be ordered online at www.vitalcheck.com
  - Can be obtained from the courthouse of the county where the child was born
  - Can contact State of Michigan Vital Records by phone at (517) 335-8656
- Completed Health Appraisal
- Up to date Immunization Record

ALL FORMS ARE NEEDED FOR A CHILD TO ATTEND

Step 2. Complete the Dooley Center's online registration to sign up with our bookkeeping department.

- Online registration is required but does not guarantee enrollment.
- http://weblink.donorperfect.com/register_fraser_dooley_odd

Step 3. Review our Little Learners Handbook

- Little Learners Handbook can be found online here or is available in our office to view.

If you have any problems registering online please email or call

Kathy Grout – Bookkeeper
Kathryn.grout@fraserk12.org
(586) 439-7038

Fraser Public Schools
Student Data Form
2019-2020

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

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.

****

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.

Dooley Center
16170 Canberra
Roseville MI 48066
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Kathy Moroney – 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 NO CURRENT ALLERGIES** (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: ________________________________

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 (________) ________-___________

Mark A. Hackel
County Executive

MACOMB COUNTY HEALTH DEPARTMENT

Mount Clemens Health Center
43525 Elizabeth Road ♦ Mount Clemens, Michigan 48043
PHONE: 586-469-5235 FAX: 586-469-5885
www.macombgov.org/publichealth

William J. Ridella, M.P.H., M.B.A.
Director/Health Officer

Kevin P. Lokar, M.D.
Medical Director

Dear Parent or Guardian:

Since 1978, the State of Michigan has required children to be age-appropriately vaccinated to enroll in school or childcare programs. Vaccination exemptions or waivers have been permitted for valid medical reasons (medical waivers) and for religious or philosophical beliefs (nonmedical waivers).

In December 2014, Michigan modified the administrative rules that outline vaccination requirements. The new rules now require parents/guardians seeking a nonmedical waiver for their child to go to a local health department for education and waiver certification. Nonmedical waiver forms are no longer available at individual schools and childcare programs.

The Macomb County Health Department will provide one-on-one education with a public health nurse and waiver certification for Macomb County residents and for out-of-county residents who have a child attending a Macomb County school or childcare program. Appointments are required and will last approximately 15-20 minutes. The benefits of vaccination and the risks of vaccine-preventable diseases will be discussed so that parents/guardians can make an informed decision.

If you are considering a nonmedical waiver for your child, we encourage you to make an appointment as soon as possible. Appointments will be scheduled on a first-come, first-serve basis, and will become limited as the new school year approaches. If you have questions or would like to make an appointment, please contact the Macomb County Health Department School Immunization Program at (586) 466-6840.

Sincerely,

William J. Ridella, M.P.H., M.B.A
Director/Health Officer

Kevin P. Lokar, M.D., M.P.H.
Medical Director

03/19/2015

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

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.

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

Little Learners Program Policies

_____ I understand that the tuition is due on the:
- -Traditional Preschool: 10th of the month
- -FLEX Preschool: 15th&30th of the month
- -Early Childhood Care: Billed every 2 weeks. Due by due date stated.

***** 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 $10.00 late fee for every 15 minutes I am late. This fee will be added to my invoice.

_____ I understand that tuition is not prorated due to snow days or other building closures.

_____ I understand that I will make my child's teacher 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 have made my child's teacher aware of any allergies, medications and special needs that my child may have.

_____ 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 this notebook will be available for parents to review during regular business hours.

_____ I understand that all employees of the Little Learners at Fraser Public Schools have been cleared through D.H.S. Central Registry and through the Michigan State Police Criminal Clearance Program.

_____ I understand that Little Learners Preschool classrooms are all 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 ______/______/_____

Revised September 2018

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

Kathy Moroney – Director

Parents/Guardians,

As required by the State of Michigan, Little Learners at Fraser Public Schools maintains a licensing notebook that is available for your review.

- The center maintains a licensing notebook of all licensing inspection reports, special investigation reports and all related corrective action plans.
- The notebook will be available to parents for review during regular business hours.
- Licensing inspection and special investigation reports from the past two years are available on the Bureau of Children and Adult Licensing website.
    - www.michigan.gov/michildcare.

Please sign below to indicate that you have been informed of the availability of our licensing notebook and that you understand that you may request it at any time during our normal business hours.

Child's Name ____

Parent's Name ____

Parent's Signature ______________________________Date ______/______/______

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

Kathy Moroney – 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
enviromental@fraserk12.org

Child's Name ____

Parent's Signature ____________________________________ Date ______/______/______

Revised September 2018

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

Kathy Moroney - Director

FLEX-TIME PRESCHOOL USE CONTRACT

My child ____ will use the Flex-Time preschool program for the ________________ school year.

He/She will attend the preschool on the following days for the following hours:

(Please check each day you will use and circle Full Day* or Half Day**)

Monday __________	Full Day / Half Day
Tuesday __________	Full Day / Half Day
Wednesday ________	Full Day / Half Day
Thursday _________	Full Day / Half Day
Friday ___________	Full Day / Half Day

I understand that I will be billed each month for the school days that correspond to my child's schedule as marked above. I will pay this monthly fee, whether or not my child is in attendance for all of the days. I understand that this fee will not be prorated due to illness or vacation. Should my child attend any extra days in a month, an additional charge for those days will be added to my monthly bill the following month. Additional days are only allowed if the number of students enrolled does not exceed our state imposed class limits.

Parent Signature ___________________________________ Date_____/_____/_____

*Full Day = 5 to 9.5 hours @ $35 per day

**Half Day = up to 5 hours @ $20 per day

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Kathy Moroney – Director

Little Learners
at
Fraser Public Schools
EARLY CHILDHOOD CARE

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.

The Department of Agriculture requires that licensed Child Care Centers provide notices to parents or guardians of their right to be notified about pesticide applications prior to application. A form is provided on the back of this sheet. If you would like to be notified prior to application of pesticide, please complete the form and notify the caregivers at your program.

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/Teacher-in-Charge will be held to decide what is in the best interest of the child.

Child's Name ____

Parent/Guardian's Signature _____________________________________ Date ______/______/_____

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Roseville MI 48066
586-439-7600
Fax 586-439-7601

Kathy Moroney – Director

Dear Early Childhood Care Parents:

In order for us to plan our staffing, could you please give us an approximate number of how many days and what hours you will use our childcare program.

Thank you in advance for your cooperation.

Child's name ____

Days/Hours Needed:

Monday ______________________

Tuesday ______________________

Wednesday ______________________

Thursday ______________________

Friday ______________________

Additional comments ____

____

____

Other class your child attends (Preschool, DK, Headstart)? When?

____

Revised September 2018

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.

As required by State of Michigan law, you will receive advance notice regarding the non-emergency application of a pesticide such as an insecticide, fungicide or herbicide, other than a bait or gel formulation, that is made to the school or day care grounds or buildings during this school year. Please note that notification is not given for the use of sanitizers, germicides, disinfectants or anti-microbial cleaners. In certain emergencies, such as an infestation of stinging insects, pesticides may be applied without prior notice to prevent injury to students, but you will be notified following any such application.

Advance notification of pesticide applications, other than a bait or gel formulation, will be given by at least 2 methods. The first method will be by posting at the main entrance to the school. The second method will be by the method(s) checked below:

- ☐ Posting in a public, common area of the school, other than an entrance. We will post in the main office.
- ☐ E-mail.
- ☐ A telephone call by which direct contact is made with a parent or guardian of a student of the school or a message is recorded on an answering machine.
- ☐ Providing the students of the school with a written notice to be delivered to their parents or guardians.
- ☐ Posting information on the school's web site.

Please be advised that parents or guardians of children attending the school are entitled to receive the advance notice of a pesticide application, other than a bait or gel formulation, by first class United States mail postmarked at least 3 days before the pesticide application, if they so request. If you prefer to receive the notification by first class mail, please complete the attached form and return it to our office.

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 school's pest management procedures, please contact:
Mary Anne Santarossa
586-439-7114
Maryanne.santarossa@fraserk12.org

REQUEST FOR ADVANCE NOTIFICAITON BY FIRST CLASS MAIL

Dear Parent / Guardian:

Complete this form **ONLY** if you are requesting advance notification of a pesticide application by United States Postal Service first-class mail.

Please be advised that you WILL receive notice via the methods identified in the annual advisory notice and should only complete this form if you are also requesting notification by first-class mail.

If you are requesting prior notification of pesticide treatments conducted at this school, other than a bait or gel formulation, and you would like the notice to be delivered by United States Postal Service first-class mail, postmarked at least 3 days prior to the planned treatment, please complete the information on the following form and submit it to:

Fraser Public Schools, Operations and Maintenance, 33499 Klein Road, Fraser, MI 48026

****

I wish to receive a prior notice of any pesticide application to the school by first-class mail.

PARENT NAME: ____

STUDENT NAME: ____

STREET ADDRESS: ____

CITY, ZIP ____

DAY PHONE # ____

EVENING PHONE # ____

Please Check One:

- ❑ I wish to be notified prior to a scheduled pesticide application inside of the school building.
- ❑ I wish to be notified prior to a scheduled pesticide application on the outside grounds of the school building.
- ❑ Both of the above.

____ ______________________

Signature Date