Niles Community Schools
Northside Child Development Center

Great Start Readiness Program
Michigan's Nationally Recognized Pre-K Program

Montessori-Primary, ECSE,
Kinder Connections, ASD & GSRP-PreK

Dear Families,

I want to thank you for your patience during this time as we try to navigate our registration process without having personal contact.

How this will work...

Please complete the enclosed forms. These forms along with income verification are required to determine eligibility into the program. Along with these forms and income verification you will need to send in a proof of residency, birth certificate, immunization record and a completed physical form. If you have these items handy but do not have access to a copier, you can send in the originals. I will make copies and seal the originals in an envelope and get them back to you. If you do not have these items please work on getting them once our communities are open back for business.

Income verification is required to determine eligibility into the program. Please make sure to include all household income along with child support or any other income you may have. If you are not able to print out your income you may take a picture of it and send it to me via email at michelle.skalla@nilesschools.org. Please make sure to include your child's name in the email.

Please return your completed registration packets and income verification to Northside on Wednesday, Thursday or Fridays from 10 am – 12 pm. The drop off box is located next to the main doors, past the playground.

There will also be a box with new packets so please spread the word to anyone that you know with a child who will be 4 by Dec 1st 2020.

Please do not hesitate to email me with any questions or concerns.

I appreciate your patience and understanding and look forward to working with you.

Michelle Skalla
Preschool Coordinator
michelle.skalla@nilesschools.org
Phone 683-1982 Ext 11609
Fax 684-9542

These materials were developed under a grant awarded by the Michigan Department of Education

Great Start Readiness Program
Michigan's Nationally Recognized Pre-K Program

BERRIEN RESA
Early Childhood Education

GSRP Preschool Application 2020-2021

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Qualifications for GSRP:

- ❑ Your child must be 4 by September 1st of the school year (Consideration for children who turn 4 from September 2nd-December 1st of the year will take place after September 1st)
- ❑ You must live in Berrien County (Cross-County families will need to complete a Cross County Prior Approval form: Consideration for Cross-County will take place after September 1st and RESA will seek approval)
- ❑ You must meet the income guidelines for your family size stated below within the GSRP columns **OR**
    - If you qualify for Head Start: Please contact Tri-County Head Start at 1-800-792-0366 or www.tricountyhs.org
    - If you qualify for tuition your application will be reviewed on/after September 1st if there are still openings in the GSRP classroom

2020-2021	Head Start	Head Start	GSRP	GSRP	GSRP	Tuition enroll on/after Sept. 1
Household Size	0-50%	51-100%	101-150%	151-200%	201-250%	251-300%
1	0-6,380	6,381-12,760	12,761-19,140	19,141-25,520	25,521-31,900	31,901-38,280
2	0-8,620	8,621-17,240	17,241-25,860	25,861-34,480	34,481-43,100	43,101-51,720
3	0-10,860	10,861-21,720	21,721-32,580	32,581-43,440	43,441-54,300	54,301-65,160
4	0-13,100	13,101-26,200	26,201-39,300	39,301-52,400	52,401-65,500	65,501-78,600
5	0-15,340	15,341-30,680	30,681-46,020	46,021-61,360	61,361-76,700	76,701-92,040
6	0-17,580	17,581-35,160	35,161-52,740	52,741-70,320	70,321-87,900	87,901-105,480
7	0-19,820	19,821-39,640	39,641-59,460	59,461-79,280	79,281-99,100	99,101-118,920
8	0-22,060	22,061-44,120	44,121-66,180	66,181-88,240	88,241-110,300	110,301-132,360
For each additional family member add	2,240	4,480	6,720	8,960	11,200	13,440

What you need to provide:

If you qualify for GSRP, you'll need to provide the following documents to be considered for enrollment. Enrollment doesn't happen on a first come first serve. Enrollment looks at income and risk factors to place children into the classrooms per State of Michigan requirements for GSRP and pending state approved GSRP budget per year.

Turn in the following items with your application packet:

- ❑ **Proof of Age:** Such as a Birth Certificate, passport, immigration record or baptismal certificate
- ❑ **Proof of Income:** Such as work earnings (W-2, tax return, or check stubs), child support, unemployment, SSI, cash assistance and any other proof of income
- ❑ **Proof of Residency:** Such as driver's license, rent receipt, utility bill, letter from shelter or host if between homes
- ❑ **If your child has an IEP** (Individual Education Plan) please include a copy
- ❑ **Completed copy of the Health and Immunization form** (included in this packet): **To be completed prior to your child starting GSRP.** This document will be completed from your child's doctor's office or your county health department where your child was immunized / vaccinated.

Great Start Readiness Program
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BERRIEN COUNTY GSRP APPLICATION 2020-2021

By completing an application this doesn't automatically enroll you into GRSP. All applications/enrollments are pending per review of qualifications and the state GSRP budget. All final notifications will come from teachers/sites prior to the fall start.

PROGRAM PREFERENCE

☐BH Charter ☐BH Discovery Enrichment Center ☐Berrien Springs ☐Brandywine
☐Buchanan ☐Coloma ☐Eau Claire ☐Niles ☐Watervliet ☐Immanuel Lutheran/Bridgman
☐The Children's Center/Niles ☐The Children's Center/Saint Joseph

CHILD INFORMATION

Child's Legal Name: _____ _____ _____ Date of Birth: ___/___/____
First Name Middle Name Last Name mm dd yyyy

Gender: ☐Male ☐Female

Ethnicity: Hispanic or Latino ☐Yes ☐No

Race: American ☐African American or Black ☐Indian or Alaska Native ☐Asian ☐Hispanic
☐Native Hawaiian or Pacific Islander ☐Caucasian or White ☐Two or more races_____

Address_____ City _____ Zip_____ County_____

Phone Number: _____ School District of Residence:_____

FAMILY INFORMATION

Child lives with: ☐Both Parents ☐Mother ☐Father ☐Joint Custody (If joint, Physical or Legal, Explain) _____
☐Legal Guardian ☐Grandparents ☐Foster Care ☐Other: Explain _____

Parent/guardian Name 1:_____
Parent/guardian date of birth:_____
Address: (if different from above):_____
Current Employer:_____
Employers Address:_____
Primary Phone#:_____
Alternative Phone#:_____
Email: _____

Parent/guardian Name 2:_____
Parent/guardian date of birth:_____
Address: (if different from above):_____
Current Employer:_____
Employers Address:_____
Primary Phone#:_____
Alternative Phone#:_____
Email: _____

EMERGENCY CONTACTS other than parent/guardian

1. _____ _____ _____ ____ _____ _____
Name Street Address City State Phone Number Relationship to child
2. _____ _____ _____ ____ _____ _____
Name Street Address City State Phone Number Relationship to child

How many family members are in your household? _____

RISK FACTORS (Please mark all that apply)

01: Income: Annual Gross Income: $_____

02: Diagnosed disability or identified developmental delay
- ☐My Child has been referred or diagnosed with a disability/delay by a provider
- ☐My Child has an IEP (IEP will need to be provided with application)

03: Severe or challenging behavior
- ☐My child has been excluded/expelled from other preschool/child care programs
- ☐My child has social services or medical referrals for behavior
- ☐Other:

04: Primary and/or home language other than English
- ☐Primary and/or home language is other than English _____

05: Parent/Guardian with low educational attainment
- ☐One or both parents have no High School diploma or GED Certificate

06: Abuse/Neglect of the child or parent
- ☐There has been abuse/neglect for the child or parent

07: Environmental risk
- ☐There has been parental loss due to death, divorce, incarceration, military service or absence
- ☐There has been sibling issues that have impacted my child
- ☐I was under 20 when my first child was born
- ☐Family is homeless (please mark all that apply below)
  - ☐Doubled up: Sharing housing with others due to loss of housing, economic hardship, etc.
  - ☐Lack of adequate accommodations: Living in a motel, hotel, car, park, campground (public or private place not designed for regular sleeping) or accommodations are inadequate (water, heat, space, etc)
  - ☐Transitional Housing: Living in emergency transitional shelters/housing
  - ☐Foster Care: awaiting placement (for 6 months from the date of placement)
  - ☐Migrant: Migratory children living in any circumstances listed above
    - ☐By marking any of the above homeless situations I understand I qualify for McKinney Vento Services and will be referred onto the District Homeless Liaison

08: None
- ☐My child has none of the risk factors listed above

Parent/Guardian Signature_____ **Date**_____

FOR OFFICE USE ONLY FOR POWERSCHOOL STAFF: Teachers/Staff must complete this section
Teacher:_____**Start Date:** _____**End Date:**_____**Child's Name:**_____

% FPL: Quintile:
- ❑ 01 0-50%
- ❑ 02 51-100%
- ❑ 03 101-150%
- ❑ 04 151-200%
- ❑ 05 201-250%
- ❑ 06 251-300%(These families must pay for GSRP Tuition and considered after September 1st)
- ❑ 07 301-and above% (These families **do not qualify for GSRP)**

Eligibility Factors:
- ❑ 02 Diagnosed disability or identified developmental delay
- ❑ 03 Severe or challenging behavior
- ❑ 04 Primary and/or home language other than English
- ❑ 05 Parent/Guardian with low educational attainment
- ❑ 06 Abuse/Neglect of the child or parent
- ❑ 07 Environmental risk
- ❑ 08 None

Qualifying factors
- ❑ A Homeless (these families are Quintile 01: 0-50%)
- ❑ B Foster Care (these families are Quintile 01: 0-50%)
- ❑ C Qualifying IEP (these families are Quintile 01: 0-50%)
- ❑ D None

Application Prioritization Rank#____
Quintile:____ #of Risk Factors:____

____Family qualifies for HS: approved to be served in GSRP

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PERMISSION FORM FOR OUTSIDE SCREENING/SERVICES

Child's Name_____ School/Site_____

I _____(parent/guardian name) give permission for _____ (child's name) to receive the following services outside of the GSRP classroom.

The following screening/services may be provided:

- Speech screening and/or services
- OT screening and/or services
- PT screening and/or services
- Vision screening and/or services
- Hearing screening and/or services
- Kindergarten screening
- Other_____

I am aware that all school staff and volunteers receive a background check and understand it is not the same comprehensive check as the GSRP teachers. I understand that my child will be screened or provided services outside of the GSRP classroom.

Please check on of the responses listed below and sign and date the form in the space provided:

___Yes, I give permission for the screening (s) and/or service (s)

___No, I do not give permission for the screening (s) and/or service (s)

_____

Parent/Guardian Signature **Date**

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BERRIEN RESA
Early Childhood Education

Photo Release Form for GSRP Students

☐I **give permission** for my son/daughter photo/image to be used. Please complete the form below

☐I **do not give permission** for my son/ daughter photo/image to be used. However, please complete the Guardian's name and Minor's name sections as well as sign and date the form.

I, _____, give the GSRP school/site, Berrien RESA and its affiliated programs permission to use the photo/image/video of the minor named below and grant the GSRP school/site and Berrien RESA all rights to use these photo/image/video in any medium for educational, promotional, advertising or other purposes that support the mission of the District. I agree that all rights to the photo/image/video belong to GSRP/Berrien RESA.

Guardian's Name:_____

Minor's Name:_____

Parent/Guardian's Signature:_____

Date:_____

Address:_____

Phone:_____

Email:_____

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CHILD INFORMATION RECORD

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

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	Home Phone ( )	Parent/Legal Guardian's Name (Optional)	Home Phone ( )
Home Address (if not child's address)	Cell Phone ( )	Home Address (if not child's address)	Cell Phone ( )
City / State / Zip Code		City / State / Zip Code	
Email Address (optional)		Email Address	
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 Special Instructions (Attach additional sheets, if necessary.)	

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 _____, 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.

First Student

STUDENT INFORMATION FORM FOR **NORTHSIDE SCHOOL ONLY**

PH: 269-684-1420 FAX: 269-684-9536

DATE FORM COMPLETED: _____ FORM COMPLETED BY: _____

STUDENT NAME: _____

HOME ADDRESS: _____

HOME PHONE: _____ OTHER PHONE: _____

PARENT/GAURDIAN NAME: _____

AM ADDRESS: _____

PM ADDRESS: _____

CHILD CARE PROVIDER NAME: _____ PHONE: _____

EMERGENCY CONTACT: _____ PHONE: _____

EMERGENCY CONTACT: _____ PHONE: _____

SIGNATURE OF PERSON COMPLETING FORM: _____

PLEASE NOTE: Once you turn this form into your child's school, please allow 2-3 business days for completion.

Transportation & School office use only

New or Existing Student (Circle one) Student ID: _____ Program: _____

Gen or ECSC (Circle one) AM PM FULL (Circle one) MON-THURS or MON-FRI (Circle one)

AM Route: _____ PM Route: _____ Stop Location: _____

AM Time: _____ PM Time: _____ Processed by: _____

Driver Notified: _____ Parent Notified: _____ School Notified: _____ Date to Start: _____

HEALTH APPRAISAL

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

PERSONAL

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

SECTION I - HEALTH HISTORY

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

Birth History:

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

If yes, please describe:

If yes, list medications:

_____ / / Was the health history reviewed by a health professional?

Parent/Guardian Signature Date ☐ Yes ☐ No ***Examiner's Initials:*** _____

SECTION II - PHYSICAL EXAMINATION, INSPECTION, TESTS AND MEASUREMENTS

Required for Child Care and Head Start / Early Head Start

Tests and Measurements

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

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