PRINT
(Use white paper only)

Wayne County Early Childhood Program
Referral/Release Form 2017-2018

Sections 1 and 2 **MUST** be typed. Handwritten forms will not be processed.

*The Great Start Readiness Program **(GSRP)** representative should **only** complete Sections 1 and 2.*

Section 1: Demographics

Child's Name: _____ Parent/Guardian's Name: _____

Birth Date: _____ Phone Number: _____

Street Address: _____ Alternate Number: _____

City: _____ Zip Code: _____ Email: _____

Household Income: $_____ (before taxes) Interval: _____ Number in Household: ____ Source: _____

Are you in a homeless situation? ☐ Yes ☐ No Is this child in the foster care system? ☐ Yes ☐ No

Primary Language: _____ Is an interpreter needed? ☐ Yes ☐ No

Special needs / Circumstances: _____

_____

Does this child have an IEP? ☐ Yes ☐ No

Section 2: Great Start Readiness Program

I understand a representative from Head Start will contact me within, ***72 hours*** **(3 business days)** of the GSRP submission to discuss further options. GSRP meets the needs of our family, due to the following reason(s): (check all that apply)

☐ Transportation / Distance
☐ Schedule (i.e. parent working / in school)
☐ Hours of operation
☐ Sibling was in program
☐ Sibling attends same school
☐ Other _____

By signing, I agree this information may be shared with appropriate early childhood agencies.

Parent/Guardian Signature: _____ Date: _____

Printed Name: _____

GSRP Program: _____ Phone # / Ext: _____

Completed By: _____ Date: _____

GSRP Authorized Signature: _____ E-mail: _____

Section 3: Head Start

This child is: ☐ Released ☐ **NOT** Released

Reason(s): ☐ Head Start is full ☐ Head Start **is not** full ☐ Family prefers Head Start ☐ Family prefers GSRP

Head Start Authorized Signature: _____ Date: _____

Comments: _____

_____

_____

GSRP Authorized Signature: _____ Date Received: _____

Printed Name: _____

Scan and email completed forms to echild@resa.net

Revised for 2017-2018

WAYNE RESA
Leading... Learning for All

SERVICE
LEADERSHIP
COLLABORATION
EXCELLENCE

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

GSRP CHILD APPLICATION FORM

For office use only

Program/Location: _____

Teacher: _____

Student UIC#: _____

Date of Enrollment: _____ ***Date Dropped:*** _____

Program Year:

20____ - 20____

PARENTS/GUARDIANS COMPLETE THIS SECTION

CHILD'S NAME: _____ **BIRTHDATE:** _____ **SEX: F** ☐ **M** ☐

CHILD'S ADDRESS: _____ **CITY:** _____ **ZIP:** _____

HOME TELEPHONE: _____ **ALTERNATE TELEPHONE:** _____

BIRTH CERTIFICATE#: _____ **BIRTHPLACE (city, state or nation):** _____

Special Needs: _____ Diagnosed: ☐ Yes ☐ No

Does the child have an IEP? _____ Date of IEP: _____ Inclusive Classroom specified? ☐ Yes ☐ No

Parent/Guardian Name: _____ Relationship to Child: _____

Age at 1st Pregnancy: _____ (Father) / _____ (Mother) Marital Status: ☐ Single ☐ Married ☐ Separated ☐ Divorced

Race: _____ (see chart below) Child Ethnicity: Hispanic ☐ Yes ☐ No

American Indian or Alaska Native; Asian; White; Black/African-American; Native Hawaiian or Pacific Islander

List *ALL* household members for which you are financially responsible

NAME	BIRTHDATE	NAME	BIRTHDATE

Type of MEDICAID Insurance: _____ **Case #:** _____ **Child's Recipient ID#:** _____

OTHER Medical Insurance: (Type): _____ **Policy Number:** _____

☐ **NO health insurance**

Revised 5/22/2017

PARENTS/GUARDIANS COMPLETE THIS SECTION

IF NOT PARENT, PROOF OF GUARDIANSHIP CASE#: _____

	FATHER	MOTHER	Foster Parent(s)/Stepparent(s) or Guardian(s)/Relationship
Name:			
Home Address:			
Home Phone:			
Cell Phone:			
Birthdate:			
Home Language:			
Highest Grade or Degree completed:			
Occupation:			
Employer:			
Business Phone:			
Work/School Schedule: ***(Days & Times)***			

The above information is true and correct to the best of my knowledge. I understand that if any of this information changes, or is found to be incorrect, I am obligated to immediately notify this program. I understand that the above information and all information contained in the child's folder will remain **CONFIDENTIAL.** I hereby make application for my child to be enrolled in a Wayne County Great Start Readiness Program based on all the information on the Child's Application Form.

_____ _____

Parent's Name (print) **Parent's Signature** **Date**

STAFF COMPLETE THIS SECTION

At the time of registration, was proof provided of:

Birth Certificate (date received:_____)

Letters of Guardianship (date received:_____)

Income (date received:_____)

Immunization (date received:_____)

Health Appraisal (date received:_____)

Parent has been informed of Head Start Eligibility? ☐ Yes ☐ Not Applicable

Head Start Referral Release Form completed? ☐ Yes (please attach) ☐ Not Applicable

Date child entered the United States (if birth documents are from a foreign country): _____

RISK FACTORS: *STAFF COMPLETE THIS SECTION*

	CHECK ALL THAT APPLY:	***TYPE OF DOCUMENTATION*** *(i.e., parent report, pay stub, IEP, etc.)*
☐	**1. Low family income: Quintile # ___**	
☐	**2. Diagnosed disability**	
☐	**3. Severe or challenging behavior**	
☐	**4. Primary home language other than English**	
☐	**5. Parent/guardian with low educational attainment**	
☐	**6. Abuse/neglect of child or parent**	
☐	**7. Environmental risk**	

_____ _____

Staff Signature **Date** **Signature of ECS Reviewing Form** **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			

Birth History:

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

If yes, please describe:

If yes, list medications:

_____ / / _____

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

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.

PARENT NOTIFICATION OF THE LICENSING NOTEBOOK

Child Care Organizations Act, 1973 Public Act 116

Michigan Department of Licensing and Regulatory Affairs

All child care centers must maintain a licensing notebook which includes all licensing inspection reports, special investigation reports and all related corrective action plans (CAP). The notebook must include all reports issued and CAPs developed on and after May 27, 2010 until the license is closed.

- This 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 at least the past two years are available on the Bureau of Community and Health Systems website at **www.michigan.gov/michildcare**.

I have read the above statement issued by _____.
Name of Child Care Center

Child(ren)'s Name(s) _____

_____

Parent Name _____

Parent Signature _____ Date _____

LARA is an equal opportunity employer/program.

WAYNE RESA Leading... Learning for All | SERVICE LEADERSHIP COLLABORATION EXCELLENCE

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

Income Statement

Program Name: _____

Parent/Guardian Name: _____

Child's Name: _____

☐ I am a student.

☐ I affirm that I do not receive income from any source.

☐ I am supported by family members.

☐ Other: _____

_____

Parent/Guardian Print Name

_____ _____

Parent/Guardian Signature *Date*

_____

GSRP Staff Print Name

_____ _____

GSRP Staff Signature (Witness) *Date*

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
Father/Legal Guardian's Name	Home Phone ( )	Mother/Legal Guardian's Name		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 (optional)		
Employer Name	Work Phone ( )	Employer Name		Work Phone ( )
Name of Child's Physician or Health Clinic		Physician's or Health Clinic's Phone Number ( )		
Hospital Preferred for Emergency Treatment (optional)				
Allergies, Special Needs and Special Instructions (Attach additional sheets, if necessary.)				

BCAL-3731 (Rev. 4-16) Previous edition 6-15 & 7-12 only may be used.

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 must initial one of the following:

_____I give permission to _____, licensed by the Department of Licensing and Regulatory Affairs to secure emergency medical and/or emergency surgical treatment for the above named minor child while in care.

_____I do not give permission to _____, licensed by the Department of Licensing and Regulatory Affairs to secure emergency medical and/or emergency surgical treatment for the above named minor child while in care. I understand I assume responsibility for all emerency medical care.

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.

BCAL-3731 (Rev. 4-16- Previous edition 6-15 and 7-12 only may be used.