



GSRP Preschool Application 2025-2026

BHSJ YMCA of Greater Michiana

Child's Name _____

Please check classroom preference: Please mark 1st and 2nd choice

- Monday – Thursday ½ day 8:45am – 12:30pm**
**Class option pending enrollment.*
- Monday – Thursday full day 8:45am – 3:15pm**
- Monday – Friday full day 8:45am – 3:15pm**
**This class option is reserved for full-time working families or full-time students. Proof of full-time status must be submitted with application.*

Does your child turn 4 before September 1, 2025? Yes | No

Do both parents work or attend school full-time? Yes | No

The following items must be submitted with the application packet:

- Proof of Age:** Such as a Birth Certificate, passport, immigration record or baptismal certificate. Your child must be 4 by September 1st. (Consideration for children who turn 4 from September 2nd - December 1st of the year will take place after September 1st)
- 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 must be completed by your child's doctor's office.

****While income is not an eligibility criterion, it is used to prioritize enrollment, based on the chart below
 If you qualify for Head Start, you must apply there first - Please contact Flowers Early Learning at
flowersearlylearning.org or 1-800-792-0366**

2025-2026	Head Start	Head Start	GSRP	GSRP	GSRP	GSRP	GSRP	GSRP	GSRP
Household Size	0-50%	51-100%	101-150%	151-200%	201-250%	251-300%	301-350%	351-400%	401% and above
1	0 - 7,825	7,826 - 15,650	15,651 - 23,475	23,476 - 31,300	31,301 - 39,125	39,126 - 46,950	46,951 - 54,775	54,776 - 62,600	62,601 +
2	0 - 10,575	10,576 - 21,150	21,151 - 31,725	31,726 - 42,300	42,301 - 52,875	52,876 - 63,450	63,451 - 74,025	74,026 - 84,600	84,601 +
3	0 - 13,325	13,326 - 26,650	26,651 - 39,975	39,976 - 53,300	53,301 - 66,625	66,626 - 79,950	79,951 - 93,275	93,276 - 106,600	106,601 +
4	0 - 16,075	16,076 - 32,150	32,151 - 48,225	48,226 - 64,300	64,301 - 80,375	80,376 - 96,450	96,451 - 112,525	112,526 - 128,600	128,601 +
5	0 - 18,825	18,826 - 37,650	37,651 - 56,475	56,476 - 75,300	75,301 - 94,125	94,126 - 112,950	112,951 - 131,775	131,776 - 150,600	150,601 +
6	0 - 21,575	21,576 - 43,150	43,151 - 64,725	64,726 - 86,300	86,301 - 107,875	107,876 - 129,450	129,451 - 151,025	151,026 - 172,600	172,601 +
7	0 - 24,325	24,326 - 48,650	48,651 - 72,975	72,976 - 97,300	97,301 - 121,625	121,626 - 145,950	145,951 - 170,275	170,276 - 194,600	194,601 +
8	0 - 27,075	27,076 - 54,150	54,151 - 81,225	81,226 - 108,300	108,301 - 135,375	135,376 - 162,450	162,451 - 189,525	189,526 - 216,600	216,601 +
For each additional family member add	2,750	5,500	8,250	11,000	13,750	16,500	19,250	22,000	24,750 +

School Districts

<p>Benton Harbor Area Schools Discovery Enrichment Center 465 S. McCord Street - Benton Harbor Phone - (269) 605-1601 Email - Sandra.tyler@bhas.org Website - dec.bhas.org/o/dec Full Day Program, Monday-Thursday Transportation provided within District</p>	<p>Benton Harbor Charter School Academy 455 Riverview Drive, Suite 1 - Benton Harbor Phone - (269) 769-6439 Email - moniquecadet@choiceschools.com Website - www.bentonharborcharter.com Half Day Program, Monday-Thursday Full Day Program, Monday-Thursday Transportation provided within District</p>	<p>Berrien Springs Public Schools One Sylvester Ave. - Berrien Springs Phone - (269) 473-0703 Email - jwallace@shamrocks.us Half Day Program, Monday-Thursday Full Day Program, Monday-Thursday Transportation provided within District</p>
<p>Brandywine Community Schools 1620 LaSalle Ave. - Niles Phone - (269) 684-6511 Email - mhigh@brandywinebobcats.org Website - www.brandywinebobcats.org Full Day Program, Monday-Thursday</p>	<p>Buchanan Community Schools 109 Ottawa St. - Buchanan Phone - (269) 695-8409 Email - ejohnson@buchananschools.com Website - www.buchananschools.com Full Day Program, Monday-Thursday Transportation provided within District</p>	<p>Coloma Community Schools 262 S. West Street - Coloma Phone - (269) 468-2424 Email - rpounders@ccs.coloma.org Website - ces.coloma.org Extended Week Program, Monday-Friday Transportation provided within District</p>
<p>Countryside Academy 4800 Meadowbrook Road - Benton Harbor Phone - (269) 944-3319 ext. 106 Email - hfurney@countrysideacademy.org Website - www.countrysideacademy.org Full Day Program, Monday-Thursday Transportation provided within District</p>	<p>Eau Claire Public Schools 6238 West Main Street - Eau Claire Phone - (269) 461-6191 Email - jrumsey@eauclaireps.com Website - eauclaireps.com Full Day Program, Monday-Thursday Transportation provided within District</p>	<p>Watervliet Public Schools 287 Baldwin Ave. - Watervliet Phone - (269) 463-0820 Email - twilliams@watervlietps.org Website - www.watervlietps.org Full Day Program, Monday-Thursday</p>

Community Based Organizations

<p>The Blessed Noah's Ark Day Care 1844 Cofax Ave. - Benton Harbor Phone - (269) 252-5112 Email - tynishamurphy22@gmail.com Full Day Program, Monday-Thursday Transportation provided</p>	<p>The Children's Center - Niles 210 Main Street - Niles Phone - (269) 683-0405 Email - kelsey@weloveourfamilies.com Website - www.thechildrenscenterinc.com/preschool2.html Full Day Program, Monday-Thursday</p>	<p>The Children's Center - Peace Boulevard 219 Peace Blvd - St. Joseph Phone - (269) 683-0405 Email - kelsey@weloveourfamilies.com Website - www.thechildrenscenterinc.com/preschool2.html Full Day Program, Monday-Thursday</p>
<p>Immanuel EC Development Center 9650 Church Street - Bridgman Phone - (269) 465-6131 ext. 114 Email - barba@immanuelbridgman.org Full Day Program, Monday-Thursday</p>	<p>Lylabugs & Buttons 1924 Territorial Road - Benton Harbor Phone - (269) 925-7167 Email - Lylabuttons@yahoo.com Full Day Program, Monday-Thursday Transportation provided</p>	<p>Montessori Children's Center 1000 Miners Road - St. Joseph Phone - (269) 256-4456 Email - kelsey@weloveourfamilies.com Website - montessorichildrenscenter.com/ Extended Week Program, Monday-Friday</p>
<p>Trinity Lutheran 9123 George Avenue - Berrien Springs Phone - (269) 473-1811 Email - school@trinityberrien.org Full Day Program, Monday-Thursday</p>	<p>YMCA of Greater Michiana - BH/SJ YMCA 3655 Hollywood Rd - St. Joseph Phone - (269) 428-9622 Email - kfreyer@ymcagm.org Website - www.ymcagm.org/GSRP Half Day Program, Monday-Thursday Full Day Program, Monday-Thursday Extended Week Program, Monday-Friday</p>	<p>YMCA of Greater Michiana - Northside Child Development Center 2020 N. Fifth Street - Niles Phone - (269) 683-1982 Email - mskalla@ymcagm.org Website - www.ymcagm.org/GSRP Half Day Program, Monday-Thursday Full Day Program, Monday-Thursday Extended Week Program, Monday-Friday Transportation provided</p>

These materials were developed under a grant awarded by MiLEAP



BERRIEN COUNTY GSRP APPLICATION 2025-2026

Completing an application 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

- | | | |
|--|--|---|
| <input type="checkbox"/> Benton Harbor Area Schools | <input type="checkbox"/> Benton Harbor Charter School | <input type="checkbox"/> Berrien Springs Public Schools |
| <input type="checkbox"/> The Blessed Noah's Ark | <input type="checkbox"/> Brandywine Community Schools | <input type="checkbox"/> Buchanan Community Schools |
| <input type="checkbox"/> The Children's Center - Niles | <input type="checkbox"/> The Children's Center - Peace | <input type="checkbox"/> Coloma Community Schools |
| <input type="checkbox"/> Countryside Academy | <input type="checkbox"/> Eau Claire Public Schools | <input type="checkbox"/> Immanuel EC Development Center |
| <input type="checkbox"/> Lylabugs & Buttons | <input type="checkbox"/> Montessori Children's Center | <input type="checkbox"/> Trinity Lutheran |
| <input type="checkbox"/> Watervliet Public Schools | <input type="checkbox"/> YMCA - Northside | <input type="checkbox"/> YMCA - BH/SJ YMCA |

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: _____

Did the child participate in Strong Beginnings in the 2024/2025 school year? Yes No

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 Name 2: _____

Parent/guardian date of birth: _____

Parent/guardian date of birth: _____

Address: (if different from above): _____

Address: (if different from above): _____

Current Employer: _____

Current Employer: _____

Employers Address: _____

Employers Address: _____

Primary Phone#: _____

Primary Phone#: _____

Alternative Phone#: _____

Alternative Phone#: _____

Email: _____

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

RISK FACTORS (Please mark all that apply)

01: Income: Annual Gross Income: \$ _____ # in your household _____

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 (lack of 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 enrollment prioritization and PowerSchool documentation

Teachers/Staff must complete this section

Teacher: _____ Start Date: _____ End Date: _____ Child's Name: _____

% FPL Bracket:

- 01 0-50%
- 02 51-100%
- 03 101-150%
- 04 151-200%
- 05 201-250%
- 06 251-300%
- 07 301% and above

Qualifying Factors:

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

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

Application Prioritization Rank# _____

FPL Bracket: _____ #of Risk Factors: _____

_____ Family qualifies for HS: approved to be served in GSRP



2025-2026 Income/Age/Resident/IEP Verification Form

Berrien County GSRP Program

Child's Name: _____ Parent(s) Name: _____

Income Source Verification Documentation provided	Amount Received			
	Annually	Monthly	Weekly	Biweekly
Income tax Form 1040				
W-2				
TANF documentation				
Pay Stub or Pay Envelopes				
Unemployment				
Written statement from employer(s)				
Foster Care Reimbursement				
SSI documentation				
Child Support				
Alimony				
Pension(s)				
Other				
Documentation of no income				

Total of Income Documented Above: \$ _____ Number in Household: _____

I verify that I have provided true and accurate documentation as indicated above.

Parent/Guardian Signature

Date of Verification

FOR OFFICE USE ONLY

I verify that I have reviewed the following documentation with the families:

- 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 a child has an IEP** (Individual Education Plan) copy has been reviewed

GSRP Staff Signature

Date of Verification



GSRP Underage Consideration

******Only complete if your child will turn 4 after September 1 - December 1******

GSRP Underage Eligibility Consideration-Special Circumstances for Children turning 4 **after** September 1st - December 1st.

I understand that a child who turns 4 years old **after** September 1st - December 1st can be considered for enrollment in the Free Preschool in Berrien County by requesting this Special Consideration.

I also understand that the intention of the Great Start Readiness Preschool program is to be provided the year before a child enters kindergarten, therefore I am requesting that eligibility for enrollment into a Great Start Readiness Preschool program be considered for my child because I plan to request early entry into kindergarten the following year.

_____ and _____
Child's full name Date of Birth

I understand that this does not guarantee my child a classroom placement in GSRP for the school year and that I will be notified of the enrollment status after **September 1**.

Parent Signature

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				
Parent/Legal Guardian's Name		Home Phone ()	Parent/Legal Guardian's Name (Optional)	
Date of Birth		Cell Phone ()	Home Phone ()	
City		State	Zip Code	
Email Address		City		
Employer Name		Work Phone ()	State	
Name of Child's Physician or Health Clinic		Zip Code		
Hospital Preferred for Emergency Treatment (optional)		Email Address		
Allergies, Special Needs and Special Instructions (Attach additional sheets, if necessary.)		Employer Name		
		Work Phone ()		
		Physician's or Health Clinic's Phone Number ()		

BCAL-3731 (Rev. 7-18) Previous edition 6-17 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 Initials:

_____ I give permission to YMCA of Greater Michiana, 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.

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

<table style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 10%; text-align: center;">Yes</td> <td style="width: 10%; text-align: center;">No</td> <td style="width: 10%; text-align: center;">Resolved</td> <td style="width: 10%;"></td> <td style="width: 50%;"># Is your child having any of the problems listed below?</td> </tr> <tr> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> <td>1 Allergies or Reactions (for example, food, medication or other)</td> </tr> <tr> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> <td>2 Hay Fever, Asthma, or Wheezing</td> </tr> <tr> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> <td>3 Eczema or Frequent Skin Rashes</td> </tr> <tr> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> <td>4 Convulsions/Seizures</td> </tr> <tr> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> <td>5 Heart Trouble</td> </tr> <tr> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> <td>6 Diabetes</td> </tr> <tr> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> <td>7 Frequent Colds, Sore Throats, Earaches (4 or more per year)</td> </tr> <tr> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> <td>8 Trouble with Passing Urine or Bowel Movements</td> </tr> <tr> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> <td>9 Shortness of Breath</td> </tr> <tr> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> <td>10 Speech Problems</td> </tr> <tr> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> <td>11 Menstrual Problems</td> </tr> <tr> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> <td>12 Dental Problems: Date of Last Exam / /</td> </tr> <tr> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> <td>Other (please describe): _____</td> </tr> <tr> <td colspan="5" style="padding-top: 10px;"> <input type="checkbox"/> Does your child take any medication(s) regularly? Reason for Medication _____ </td> </tr> </table>	Yes	No	Resolved		# Is your child having any of the problems listed below?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	1 Allergies or Reactions (for example, food, medication or other)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	2 Hay Fever, Asthma, or Wheezing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	3 Eczema or Frequent Skin Rashes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	4 Convulsions/Seizures	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	5 Heart Trouble	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	6 Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	7 Frequent Colds, Sore Throats, Earaches (4 or more per year)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	8 Trouble with Passing Urine or Bowel Movements	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	9 Shortness of Breath	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	10 Speech Problems	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	11 Menstrual Problems	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	12 Dental Problems: Date of Last Exam / /	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Other (please describe): _____	<input type="checkbox"/> Does your child take any medication(s) regularly? Reason for Medication _____					<p>Birth History:</p> <p>Are there any current or past diagnosis(es) <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>If yes, please describe:</p> <p>If yes, list medications:</p> <p>Was the health history reviewed by a health professional? <input type="checkbox"/> Yes <input type="checkbox"/> No Examiner's Initials: _____</p>
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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	No	Yes	Was child tested for:	Test results:	Normal	Referred	Under Care
<input type="checkbox"/>	<input type="checkbox"/>	VISION Date: / /	Visual Acuity Muscle Imbalance Other: _____				<input type="checkbox"/>	<input type="checkbox"/>	HEIGHT & WEIGHT Other: _____	Height Weight Other: _____			
<input type="checkbox"/>	<input type="checkbox"/>	HEARING Date: / /	Audiometer Other: _____				<input type="checkbox"/>	<input type="checkbox"/>	HEMOGLOBIN / HEMATOCRIT BLOOD PRESSURE	→ Reading: _____			
<input type="checkbox"/>	<input type="checkbox"/>	URINALYSIS Date: / /	Sugar Albumin Microscopic				<input type="checkbox"/>	<input type="checkbox"/>	TUBERCULIN Date: / /	Type: _____ Neg.: <input type="checkbox"/> Pos.: <input type="checkbox"/> _____ mm			
<input type="checkbox"/>	<input type="checkbox"/>	BLOOD LEAD LEVEL Date: / /	Level _____ ug/dl				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		VACCINES (Circle Type)	DATE ADMINISTERED MM/DD/YYYY	
Hepatitis B (HepB)	1	3	Hepatitis A (HepA)	1	2
	2			2	3
DTaP/DTP/DT/Td	1	4	Influenza (IV/LAV)	1	3
	2	5		2	4
	3	6	Meningococcal (MCV4 / MPSV4)	1	2
Tdap	1		Human Papillomavirus (HPV9/HPV4/HPV2)	1	3
Haemophilus Influenzae type b (HIB)	1	3	OTHER Vaccines Specify Date & Type	Type of Vaccine(s)	Date of Vaccine(s)
	2	4		1	
Polio (IPV/OPV)	1	3		2	
Pneumococcal Conjugate (PCV7/PCV13)	1	3	3		
	2	4	Indicate and attach physician diagnosis or laboratory evidence of immunity as applicable		
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)	1	2	Parent/Guardian refused immunizations: <input type="checkbox"/>		
Varicella (Chickenpox)	1	2			
History of Chickenpox Disease? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, date: _____					
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		
<input type="checkbox"/>	<input type="checkbox"/>	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:	

<input type="checkbox"/>	<input type="checkbox"/>	Should the child's activity be restricted because of any physical defect or illness? If yes, check and explain degree of restriction(s): <input type="checkbox"/> Classroom <input type="checkbox"/> Playground <input type="checkbox"/> Gymnasium <input type="checkbox"/> Swimming Pool <input type="checkbox"/> Competitive Sports <input type="checkbox"/> 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.