GSRP Preschool Application 2025-2026

YMCA at Northside Child Development Center

Child's Name _____

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

- ❑ **Monday – Thursday ½ day** 8:20am – 12:00pm
  **Class option pending enrollment.*
- ❑ **Monday – Thursday full day** 8:20am – 3:20pm
- ❑ **Monday – Friday full day** 8:20am – 3:20pm
  **This class option is reserved for full-time working families or full-time students. Proof of full-time status must be submitted with application.*

Do you reside within the Niles Community Schools District? Yes | No

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.
- ❑ **Transportation form:** Residence must be within the Niles Community School District to be eligible for transportation. *Transportation forms must be submitted by August 7th to ensure busing on the first day of school.*

These materials were developed under a grant awarded by MiLEAP

School Districts

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

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

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

Brandywine Community Schools
1620 LaSalle Ave. - Niles
Phone - (269) 684-6511
Email - mhigh@brandywinebobcats.org
Website - www.brandywinebobcats.org
Full Day Program, Monday-Thursday

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

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

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

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

Watervliet Public Schools
287 Baldwin Ave. - Watervliet
Phone - (269) 463-0820
Email - twilliams@watervlietps.org
Website - www.watervlietps.org
Full Day Program, Monday-Thursday

Community Based Organizations

The Blessed Noah's Ark Day Care
1844 Colfax Ave. - Benton Harbor
Phone - (269) 252-5112
Email - tynishamurphy22@gmail.com
Full Day Program, Monday-Thursday
Transportation provided

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

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

Immanuel EC Development Center
9650 Church Street - Bridgman
Phone - (269) 465-6131 ext. 114
Email - barba@immanuelbridgman.org
Full Day Program, Monday-Thursday

Lylabugs & Buttons
1924 Territorial Road - Benton Harbor
Phone - (269) 925-7167
Email - Lylabuttons@yahoo.com
Full Day Program, Monday-Thursday
Transportation provided

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

Trinity Lutheran
9123 George Avenue - Berrien Springs
Phone - (269) 473-1811
Email - school@trinityberrien.org
Full Day Program, Monday-Thursday

YMCA of Greater Michiana - BH/SJ YMCA
3655 Hollywood Rd - St. Joseph
Phone - (269) 428-9622
Email - kfreye@ymcagm.org
Website - www.ymcagm.org/GSRP
Half Day Program, Monday-Thursday
Full Day Program, Monday-Thursday
Extended Week Program, Monday-Friday

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

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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

☐Benton Harbor Area Schools
☐Benton Harbor Charter School
☐Berrien Springs Public Schools
☐The Blessed Noah's Ark
☐Brandywine Community Schools
☐Buchanan Community Schools
☐The Children's Center - Niles
☐The Children's Center - Peace
☐Coloma Community Schools
☐Countryside Academy
☐Eau Claire Public Schools
☐Immanuel EC Development Center
☐Lylabugs & Buttons
☐Montessori Children's Center
☐Trinity Lutheran
☐Watervliet Public Schools
☐YMCA - Northside
☐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 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

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

These materials were developed under a grant awarded by MiLEAP

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

Berrien County GSRP Program

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

Income Source Verification	Amount Received			
Documentation provided	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

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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

These materials were developed under a grant awarded MiLEAP

Teacher: _____

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 ( )
Date of Birth	Cell Phone ( )	Date of Birth	Cell Phone ( )
City / State / Zip Code		City / State / Zip Code	
Email Address		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.)	

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.

BCAL-3731 (Rev. 7-18) Previous edition 6-17may be used.

First Student

NORTHSIDE SCHOOL ONLY STUDENT TRANSPORTATION INFORMATION FORM

Transportation is available for families who live within the Niles Community School district ONLY.

DATE FORM COMPLETED: _____ COMPLETED BY (PRINT) _____

STUDENT NAME: _____

HOME ADDRESS: _____

HOME: PHONE: _____

PARENT/GAURDIAN NAME: _____

AM ADDRESS: _____

PM ADDRESS: _____

CHILD CARE PROVIDER NAME: _____ PHONE: _____

EMERGENCY CONTACT: _____ PHONE: _____

EMERGENCY CONTACT: _____ PHONE: _____

SIGNATURE OF PERSON COMPLETING FORM: _____

*A parent or guardian must meet the student at the bus stop during drop-off. If no one is present, the student will be returned to school and must be picked up by a parent or guardian.

PLEASE NOTE: Once you turn this form into your child's school, busing is not guaranteed to start the following day.

TRANSPORTATION & SCHOOL OFFICE USE ONLY

STUDENT ID: _____ PROGRAM: YMCA - GSRP

(Circle One)
1/2 day Full day

(Circle One)
Monday-Thursday Monday-Friday

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

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

Driver Notified: _____ Parent Notified: _____ School Notified: _____ Start 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	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

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	
	Type of Vaccine(s)	Date of Vaccine(s)
OTHER Vaccines Specify Date & Type	1	
	2	
	3	

History of Chickenpox Disease? ☐ Yes ☐ No If yes, date:

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 _____ 's teeth. As a result of this examination, my recommendation for treatment is: _____

child's name

_____ ___/___/___

Dentist's Signature | Date

PHYSICIAN'S SIGNATURE

_____ ___/___/___ _____ _____

Examiner's Signature | Date | ***Examiner's Name (Print or Type)*** | Degree or License

_____ _____ MI _____ (_____) _____

Number & Street | City | 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.