



**Office Use**  
 Date Received \_\_\_\_\_  
 \_\_\_\_\_  
 Amount Paid \_\_\_\_\_ Method of payment \_\_\_\_\_  
 Renweb \_\_\_\_\_ Constant Contact \_\_\_\_\_  
 Health Appraisal \_\_\_\_\_ FERPA \_\_\_\_\_  
 Birth Certificate \_\_\_\_\_ Child Info Card \_\_\_\_\_

## PRESCHOOL ENROLLMENT FORM 2020-2021

Child's Name \_\_\_\_\_  

Last
First
Middle
Goes by
Gender

Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_  
 ->3-year-old preschool must be 3 by September 1, 2020  
 ->4-year-old preschool must be 4 by September 1, 2020

Primary Phone Number \_\_\_\_\_ Primary Email \_\_\_\_\_

Secondary Phone Number \_\_\_\_\_ Secondary Email \_\_\_\_\_

Parents \_\_\_\_\_  

Last
Father
Mother

Address \_\_\_\_\_  

Street
City
Zip

Church your family attends \_\_\_\_\_

Preschool Options (Please use box to rank your options #1,2,3)

- Nature-based 4yr/3-day T, Th, F (8:35-11:20am) \$1,495
- Nature-based 4yr/2-day T, Th (12:35-3:05pm) \$985

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- Preschool 4yr/3-day M,W,F (8:35-11:20) \$1,375
- Preschool 4yr/2-day M,W (8:35-11:20) \$980

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- Preschool 3yr/2day T,Th (8:35-11:05) \$895
- Preschool 3yr/2-day M,W (12:35-3:05) \$895
- Preschool 3yr – Add a 3<sup>rd</sup> day option! (Friday 12:35-3:05pm) \$440

Class options are subject to change based on enrollment.

Items needed to return to ACS office:  
 Birth Certificate, Health Appraisal Form, Disclosure of Immunization Form and Child Information Form

**Enrollment Information**

**Enrollment Process/Tuition**

At time of enrollment, a \$50 non-refundable enrollment fee is due. This will be deducted from your child's tuition. Tuition due dates are September 15, November 15, January 15, and March 15.

**Semesters**

The preschool program offered at Allendale Christian School is a 34-week program, which is divided into two semesters.

**Immunizations**

Preschool students must be up to date on their immunizations by the start of school. Any student who fails to meet the immunization requirements or have a valid waiver will not be allowed to start preschool until the information is turned into the school office. The Health Appraisal form is due July 15.

**Allergies**

If your child has allergies that will affect the classroom atmosphere, please speak with the preschool teacher before final enrollment. In addition, we ask for something in writing from your child's Physician in regards to our child's specific allergy/allergies.

**Nut Free Policy**

We have a policy that all peanuts, peanut products, or products containing traces of peanuts or tree nuts may not be brought into our school.

**Potty Training**

All children must be fully potty-trained in order to attend ACS preschool. Children must be able to independently take care of their bathroom needs. Pull-ups are NOT an option.

I understand that enrollment is accepted first from current ACS families and then others on a first-come basis.

We promise to pay our tuition as stated unless other arrangements have been agreed upon.

I agree to be as active in my child's preschool experience as I am able.

Parent's Signature \_\_\_\_\_ Date \_\_\_\_\_

11050 64<sup>th</sup> Ave. | Allendale | MI 49401  
Phone: 616-895-5108  
Fax: 616-895-5109  
[www.allendalechristian.org](http://www.allendalechristian.org)

Michigan Department of Community Health  
**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: \_\_\_\_/\_\_\_\_/\_\_\_\_

Address: \_\_\_\_\_ Number & Street \_\_\_\_\_ City \_\_\_\_\_ MI \_\_\_\_\_ ZIP Code \_\_\_\_\_ Today's Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

Parent/  
Guardian: \_\_\_\_\_ Last \_\_\_\_\_ First \_\_\_\_\_ Middle \_\_\_\_\_ Telephone: (\_\_\_\_) \_\_\_\_\_ Home \_\_\_\_\_

Address: \_\_\_\_\_ Number & Street \_\_\_\_\_ City \_\_\_\_\_ MI \_\_\_\_\_ ZIP Code \_\_\_\_\_ Telephone: (\_\_\_\_) \_\_\_\_\_ Work \_\_\_\_\_

**SECTION I – HEALTH HISTORY**

Yes	No	Resolved	#	Is your child having any of the problems listed below?	Birth History:
<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"/>	2	Hay Fever, Asthma, or Wheezing:	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	3	Eczema or Frequent Skin Rashes	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	4	Convulsions/Seizures	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	5	Heart Trouble	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	6	Diabetes	
<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"/>	8	Trouble with Passing Urine or Bowel Movements	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	9	Shortness of Breath	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	10	Speech Problems	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	11	Menstrual Problems	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	12	Dental Programs: Date of Last Exam: ____/____/____	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Other (please describe): _____		
<input type="checkbox"/>	<input type="checkbox"/>		Does your child take any medication(s) regularly?		Are there any current or past diagnosis(es): <input type="checkbox"/> Yes <input type="checkbox"/> No
Reason for medication: _____				→	If yes, list medications: _____
_____ / ____/____				Parent/Guardian Signature	Date
				Was the health history reviewed by a health professional?	<input type="checkbox"/> Yes <input type="checkbox"/> 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	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: _____ Negative: <input type="checkbox"/>			
<input type="checkbox"/>	<input type="checkbox"/>	BLOOD LEAD LEVEL Date: ____/____/____	Level: _____ µg/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	DATE ADMINISTERED MM/DD/YYYY		VACCINES	DATE ADMINISTERED MM/DD/YYYY	
Hepatitis B (Hep B)	1	3	Hepatitis A (Hep A)	1	2
	2		Influenza TIV/LAIV	1	3
DTa / DTP / DT Td / Tdap (circle type)	1	5		2	4
	2	6	Meningococcal MCV4 / MPSV4	1	2
	3	7	Human Papillomavirus (HPV)	1	3
	4	8		2	4
Haemophilus Influenza type b (HIB)	1	3	OTHER Vaccines: Specify Date & Type	Type of Vaccine(s)	Date of Vaccine(s)
	2	4		1	
Polio – IPV / OPV (circle type)	1	3		2	
	2	4	3		
Pneumococcal Conjugate (PCV7)	1	3	<i>Indicate and attach physician diagnosis or laboratory evidence of immunity as applicable.</i>		
	2	4	*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 child's school or local health department.		
Rotavirus (Rota)	1	3	Parent/Guardian refused immunizations: <input type="checkbox"/>		
	2				
Measles, Mumps, Reubella (MMR)	1	2			
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

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 \_\_\_\_\_ MI \_\_\_\_\_ 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 schedule of well-child care 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 Departments of Human Services, Education, Community Health; 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

**Allendale Christian School**

**Consent for Disclosure of Immunization Information to Local and State Health Departments**

Immunizations are an important part of keeping our children healthy. Schools and State and Local health departments must monitor immunization levels to ensure that all communities are protected from potentially life-threatening diseases and, if necessary, respond promptly to an emerging public health threat. It is important that disease threats be minimized through the monitoring of students being immunized.

Sharing immunization and personally identifiable information including the students name, Date of Birth, gender, and address with local and state health departments will help to keep your child safe from vaccine preventable diseases. The Family Educational Rights and Privacy Act (FERPA), 20 U.S.C. § 1232g, requires written parental consent before personally identifiable information from your child's education records is disclosed to the health department. If your child is 18 or over, he or she is an "eligible student" and must provide consent for disclosures of information from his or her education records.

You may withdraw your consent to share this information in writing at any time.

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*I authorize Allendale Christian School to release my child's immunization record to the Michigan Department of Health and Human Services and Local Health Department. I understand this information will be used to improve the quality and timeliness of immunization services and to help schools comply with Michigan Law. This includes any immunization information and limited personally identifiable information from the school.*

Student's Name: \_\_\_\_\_ Date of Birth: \_\_/\_\_/\_\_

Signature of Parent/Guardian  
or Eligible Student: \_\_\_\_\_ Date: \_\_/\_\_/\_\_

Printed Parent/Guardian Name: \_\_\_\_\_

# 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.

<b>For Provider Use Only:</b>		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.)			

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 \_\_\_\_\_, 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 6-17 may be used.

## Affording Christian Education

*How can I afford Christian Education? We have heard this question many times. ACS is pleased to offer multiple opportunities to offset some of the costs of education. I am committed to working with families who desire a Christian education to make tuition as affordable as possible. If you have any questions about the opportunities below, please give me a call at (616)895-5108, and we can have a conversation about how to make an ACS education a reality for your family!*

*Did you know: For a full-time ACS student, the cost of tuition is less than \$40 per day, which is less than the average daily cost of daycare!*

### ***Tuition Reduction Incentive Program (TRIP)***

Many ACS families participate in the Tuition Reduction Incentive Program (TRIP). This is a great program that allows you to earn tuition money by doing the shopping and every day business that you would normally do. That is correct – help pay tuition by shopping, filling your gas tank, and going out to eat! There are over 370 retailers that participate by refunding a portion of their sales to Christian school parents. Please visit our TRIP page on the ACS website (<https://www.allendalechristian.org/visitors/trip.cfm>) to learn more about this program and to begin earning money toward tuition! I strongly encourage you to get signed up for the program soon, as it can help pay for any tuition from preschool through 8<sup>th</sup> grade. You can also get family and friends to participate and help you earn more for tuition!

### ***Needs-Based Financial Assistance***

ACS participates in FACTS, a grant application program. Families who wish to apply for tuition assistance will use the FACTS confidential website (<https://online.factsmgmt.com/signin/3Z45H>). The best part of the application process: it is completely FREE for your family. The required application information will be easily accessible data from your tax return, financial accounts, and other basic financial information. The FACTS organization will analyze the information of each applicant and recommend grant amounts based on the needs of your family. Please note that your information remains safe and confidential with the FACTS program. To begin the application process, please visit the FACTS Grant and Aid Assessment page. Also, please feel free to contact the ACS office at (616)895-5108 or the FACTS organization at 1-866-315-9262 should you have any questions.

### ***Multiple Student Tuition Discount Plan***

ACS is able to provide discounts to families with more than one child at the school. There is a rate for two, three, or four full-time children at ACS. The discount already kicks in with the second full-time student. If there are more than four students from the same immediate family, any student beyond the fourth attends free of charge. Additionally, if your third or fourth child is in a part-time class (Young Fives or 3-day Kindergarten), they also qualify for a discount!

### ***Local Churches***

There are a number of churches in the Allendale area that assist families in making Christian education a reality. We encourage you to check with your church to see if support is available. If you would like to know more about our supporting churches, please give us a call. We would love to share with you more information about the church families near ACS.

I invite you to give me a call at (616)895-5108, fill out the contact form on the home page, or email me at [bkoetje@allendalechristian.org](mailto:bkoetje@allendalechristian.org). I would love an opportunity for an educational consultation and tour of the ACS facilities, as well as highlight the ways we can make Christian education a reality for your family!

Serving Him,



## **Enrollment Information**

### **Enrollment Process/Tuition**

At time of enrollment, a \$50 non-refundable enrollment fee is due. This will be deducted from your child's tuition. Tuition due dates are September 15, November 15, January 15, and March 15.

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