ACS
Allendale Christian School
Academically Prepared Called to Service Spiritually Equipped

Allendale Christian School

Preschool 2024-2025

Preschool Registration Checklist

The following forms are required to be completed/turned in to finalize your preschool registration:

- Complete Preschool Enrollment Form and turn it in along with your $50 Non-Refundable Deposit
- Child Information Record
- The Health Appraisal form – Due no later than July 15
- Please submit your Child's Birth Certificate at the time of enrollment.
- If you would like to sign up for auto debit, please go to https://www.allendalechristian.org/editoruploads/files/Links/Recurring_Payment_form_for_Renweb.pdf

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PRESCHOOL ENROLLMENT FORM 2024-2025

Child's Name: _____ _____
Last First Middle
Gender(M/F)
Date of Birth: _____
->3-year-old preschooler must be 3 by September 1, 2024
->4-year-old preschooler must be 4 by September 1, 2024

Primary Phone Number: _____ Primary Email: _____

Phone Number #2: _____ Email #2: _____

Parent: _____
(Father) Last First

Parent _____
(Mother) Last First

Address _____
Street City Zip

Church your family attends: _____

Select your class - Please rank your options #1, #2, #3
(Class options are subject to change based on enrollment)

_____ Nature-based 4yr/3-day T, Th, F (8:25-11:10am)……$1,900
_____ Nature-based 4yr/2-day T, Th (12:25-2:55pm)……..…$1,300

_____ Preschool 4yr/3-day M,W,F (8:25-11:10am)……..…$1,700
_____ Preschool 4yr/2-day T, TH (12:15-2:55pm)……$1,250

_____ Preschool 3yr/2-day M, W (8:25-10:55am)……..…..$1,200
_____ Preschool 3yr/2-day T, Th (8:25-10:55am)……..$1,200
_____ Nature-rich Preschool 3yr/2-day M, W (12:25-2:55pm)…$1,250

Office Use
Date Received _____ Amount Paid _____ Method of payment _____
Renweb ___ Tuition Posted _____ Constant Contact ___ Health Appraisal ___
Birth Certificate ___ Child Info Card ___

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.
_____**I understand the following items are needed to complete the enrollment process.**

- $50 Deposit
- Birth Certificate
- Disclosure of Immunization form
- Child Information Form
- The Health Appraisal form is due by July 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.

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 your child's specific allergy/allergies.

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.

Faith Goals and Beliefs
ACS Preschool students will be provided a well-rounded education centered on the following faith nurture goals:

- Learn more about who God is and what it means to be a child of God
- Learn about loving God and each other
- Develop their God-given gifts
- View the different themes they learn from a Christ-focused perspective
- Become more aware of what it means to live for Jesus
- Hear Bible stories, learn Bible songs, learn Bible verses, and experience prayer
- Learn within the Biblical worldview framework of Teaching for Transformation

The Core Beliefs of Allendale Christian School can be found at
https://www.allendalechristian.org/about-acs/what-we-believe.cfm

I understand that enrollment is accepted first from current ACS families and then from the general public.

1. We promise to pay our tuition as stated unless other arrangements have been agreed upon.
2. I agree to be as active in my child's preschool experience as I am able.
3. I/We understand that ACS does not carry any medical/liability insurance for students in case of an accident or injury of any sort.
4. I have read and am in full agreement with the Faith Goals of the Preschool program and Core Beliefs of Allendale Christian School.

Parent's Signature _____ **Date** _____

CHILD INFORMATION RECORD

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

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	Primary Phone ( )	Parent/Legal Guardian's Name (Optional)		Primary Phone ( )
Home Address (if not child's address)	2nd Phone (if applicable) ( )	Home Address (if not child's address)		2nd Phone (if applicable) ( )
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/or Special Instructions? Yes ☐ No ☐ If yes, explain: (Attach additional sheets, if necessary.)				

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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.

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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	Remarks	# 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	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 (Hep B)	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 (Hep A)	1	2
Influenza TIV/LAIV	1	3
	2	4
Meningococcal MCV4 / MPSV4	1	2
Human Papillomavirus (HVP4/HPV2)	1	2
	2	3
	Type of Vaccine(s)	Date of Vaccine(s)
OTHER Vaccines Specify Date & Type	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 child's school or local health department.

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 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 and regular intervals based on age.

Developed in Cooperation with the 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.