Allendale Christian School

Academically Prepared Called to Service Spiritually Equipped

Allendale Christian School

Preschool 2023-2024

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
- Family Educational rights and Privacy Act (FERPA)
- Concussion Awareness Acknowledgement Form
- 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 2023-2024

Child's Name: _____ _____
Last First Middle
Gender(M/F)
Date of Birth: _____
->3-year-old preschooler must be 3 by September 1, 2023
->4-year-old preschooler must be 4 by September 1, 2023

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
(Class options are subject to change based on enrollment)

_____ Nature-based 4yr/3-day T, Th, F (8:25-11:10am)……$1,570
_____ Nature-based 4yr/2-day T, Th (12:25-2:55pm)……..$1,060

_____ Preschool 4yr/3-day M,W,F (8:25-11:10am)……..$1,490
_____ Preschool 4yr/2-day T, TH (12:15-2:55pm)……$1,085

_____ Preschool 3yr/2day M, W (8:25-10:55am)……..$965
_____ Preschool 3yr/2-day T, Th (8:25-10:55am)……..$965
_____ Nature-rich Preschool 3yr/2-day M, W (12:25-2:55pm)…$985

Office Use
Date Received _____ Amount Paid _____ Method of payment _____
Renweb ___ Tuition Posted _____ Constant Contact ___ Health Appraisal ___ FERPA ___
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 enrollment**

- $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.

1. I understand that enrollment is accepted first from current ACS families and then from the general public.
2. We promise to pay our tuition as stated unless other arrangements have been agreed upon.
3. I agree to be as active in my child's preschool experience as I am able.
4. I/We understand that ACS does not carry any medical/liability insurance for students in case of an accident or injury of any sort.
5. 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

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.

Name of Child (Last, First, Middle Initial)			Male or Female		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
Main Email Address			Secondary 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.)					

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 Allendale Christian School, licensed by the Department of Licensing and Regulatory Affairs to secure emergency medical 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 _____

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, 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 student's 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.

Please Print Student's Name: _____

Date of Birth: ___/___/____

Please select one of the options below.

_____Yes, I authorize Allendale Christian School to release my child's immunization record to the Michigan Department of Health and Human Services and the Ottawa County Department of Public Health. This includes any immunization information and limited personally identifiable information (listed above) from the school. 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.

_____No, I do not want my child's immunization record released to the Michigan Department of Health and Human Services or to the Ottawa County Department of Public Health.

Date _____

Parent Signature _____

Printed Name _____

Some common symptoms

- Headache
- Pressure in the head
- Nausea/ vomiting
- Dizziness
- Balance problems
- Double vision
- Blurry vision
- Sensitivity to light
- Sensitivity to noise
- Sluggishness
- Haziness
- Fogginess
- Grogginess
- Poor concentration
- Memory problems
- Confusion
- "Feeling down"
- Not "feeling right"
- Feeling irritable
- Slow reaction time
- Sleep problems
- Appears dazed and stunned
- Disoriented or confused
- Forgets an instruction

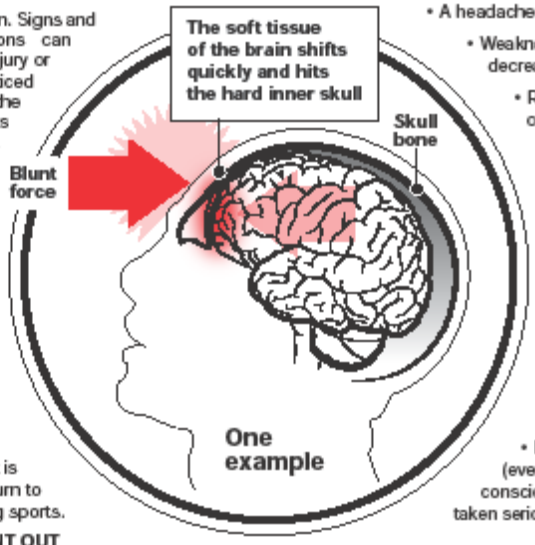
UNDERSTANDING Information for parents and students (Content meets MDCH requirements)

CONCUSSION

What is a concussion?

A concussion is a type of traumatic brain injury that changes the way the brain normally works. A concussion is caused by a bump, blow, or jolt to the head or body that causes the head and brain to move quickly back and forth. It can also be caused by the shaking or spinning of the head or body. Even a "ding,""getting your bell rung," or what seems to be a mild bump or blow to the head can be serious.

You can't see a concussion. Signs and symptoms of concussions can show up right after the injury or may not appear or be noticed until days or weeks after the injury. If the student reports any symptoms of a concussion, or if you notice symptoms yourself, seek medical attention right away.



If you suspect a concussion

1. SEEK MEDICAL ATTENTION RIGHT AWAY A health care professional will be able to decide how serious the concussion is and when it is safe for the student to return to regular activities, including sports.

2. KEEP YOUR STUDENT OUT OF PLAY

Concussions take time to heal. Don't let the student return to play the day of the injury and until a health care professional says it's OK. Students who return to play too soon-while the brain is still healing-risk a greater chance of having a second concussion. Repeat or second concussions can be very serious. They can cause permanent brain damage, affecting the student for a lifetime.

3. TELL THE SCHOOL ABOUT ANY PREVIOUS CONCUSSION

Schools should know if a student had a previous concussion. A students school may not know about a concussion received in another sport or activity unless you notify them.

Concussion danger signs

In rare cases, a dangerous blood clot may form on the brain in a person with a concussion and crowd the brain against the skull. A student should receive immediate medical attention if after a bump, blow, or jolt to the head or body s/he exhibits any of the following danger signs:

- One pupil larger than the other
- Is drowsy or cannot be awakened
- A headache that gets worse
- Weakness, numbness, or decreased coordination
- Repeated vomiting or nausea
- Slurred speech
- Convulsions or seizures
- Cannot recognize people or places
- Becomes increasingly confused, restless, or agitated
- Has unusual behavior
- Loses consciousness (even a brief loss of consciousness should be taken seriously)

How to respond to a report of a concussion

If a student reports one or more symptoms of a concussion after a bump, blow, or jolt to the head or body, s/he should be kept out of athletic play the day of the injury. The student should only return to play with permission from a health care professional experienced in evaluating for concussion.

During recovery, exercising or activities that involve a lot of concentration (such as studying, working on the computer, or playing video games) may cause concussion symptoms to reappear or get worse.

Sources: Michigan Department of Community Health and the National Operating Committee on Standards for Athletic Equipment (NOCSAE)

!!! WHEN IN DOUBT...SIT OUT !!!

ACS
Allendale Christian School
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CONCUSSION AWARENESS

EDUCATIONAL MATERIAL ACKNOWLEDGEMENT

By my name and signature below, I acknowledge in accordance with Public Acts 342 and 343 of 2012 that I have received and reviewed the Concussion Fact Sheet for Parents and Students provided by Allendale Christian School.

_____
Students Name/Grade

_____
Students Name/Grade

_____
Students Name/Grade

_____
Students Name/Grade

_____
Parent or Guardian Name Printed

_____
Parent or Guardian Signature

_____
Date

Return this signed form to the ACS office. The school must keep this on file for the duration of enrollment/participation and until age 25.

Students and parents should review and keep the educational materials available for future reference.

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	Parental Review	# 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 (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.