Warren Consolidated Schools
Fillmore Educational Center
(Temporary Location)
8655 Irving Rd.
Sterling Heights, MI 48312
888-4WCSKIDS

PRESCHOOL REGISTRATION CHECKLIST 2021-2022

Check when complete	REQUIRED DOCUMENTS FOR REGISTRATION
☐	Completed Student Registration Information Card
☐	Original Birth Certificate
☐	Immunization Records
☐	Completed Health Appraisal (Must be completed & signed by both the parent and Doctor/Physician)
☐	Current Mortgage OR Lease Agreement OR Property Tax Statement *If you are NOT the homeowner/leaseholder you will need a notarized letter from the homeowner/leaseholder stating that you reside with them or in their home. In addition, you are required to provide documentation of the Mortgage OR Lease OR Property Tax Statement for the person with whom you reside.*
☐	Current Bill (e.g. Utility, Cellular Telephone, Doctor, Insurance Bill, etc.). Bill must have homeowner's/parent's name and address on it. *Shut off notices will not be accepted.*
☐	Special Education IEP or 504 Plan, if applicable.
☐	Medical issue Documentation, if applicable.

Warren Consolidated Schools
31300 Anita
Warren, Michigan 48093
888-4WCSKIDS

STUDENT REGISTRATION INFORMATION CARD

Last Name | First Name | Middle Name

Address | Apt. | City | Zip Code + 4 digit

Birth Date | Place of Birth – City, State or Country | Parent Email Address

Home Telephone Number | Cellular Telephone Number | Grade | Gender

Residency: Indicate in which type of residence the student lives.

☐ Fixed residence (parent/guardian owns, mortgages, or rents a house, apartment, or trailer).

☐ Transitional residence (motel, hotel, camp ground, shelter, car, or public space; sharing the housing of others due to housing loss; foster placement).

Racial Ethnic Survey – Two part question required by the Federal Government

Part One: Is Student Hispanic/Latino? ***(Choose only one)***: ☐ No, not Hispanic/Latino ☐ Yes, Hispanic/Latino
(A person of Cuban, Mexican, Puerto Rican, South or Central American, or other Spanish culture or origin, regardless of race.)

Part Two: Racial/Ethnic ***(Check all that apply)***: ☐ Alaskan or American Indian ☐ Asian ☐ African American ☐ Hawaiian or Pacific Islander ☐ Caucasian

List ALL Schools Attended ***(Include Name of School, City, State, and Phone Number)***:_____

_____

Home Language Survey ***(To be filled out for ALL students)***

Primary Language:

1. Is your ***child's native language*** a language other than English? Y or N What is the language? _____
   Note: The child's native tongue/language is the **primary** language most often spoken by the student.

Home Language:

2. Is the ***primary language used in your child's home*** a language other than English? Y or N
   What is the language? _____
   Note: The primary language is the dominant language used at home regardless of the language spoken by the student.

If the student was born outside the U.S.A., when did the student arrive in the U.S.A.?_____

If the student was born outside the U.S.A., record the date the student first attended school in the U.S.A._____

Has the student been identified or have they received Bilingual/ESL services in another district?
If yes, what district?_____

Special Education / 504 ***(If yes, parents must provide the most recent IEP or 504 plan at the time of registration)***

Does your child: Receive Special Education services? ☐ Yes ☐ No Parent Initials_____

Have a 504 Plan? ☐ Yes ☐ No Parent Initials_____

Please indicate any health problems which you believe school personnel should be aware of: _____

_____

DA Code:_____ Street Code:_____ ES#_____ MS#_____ HS#_____

Parent/Guardian Information: With whom does the child reside? *(Please check appropriate status):*

☐ Both Parents ☐ Father Only ☐ Father/Stepmother ☐ Mother Only ☐ Mother/Stepfather

☐ Legal Guardian ☐ Court Placed ☐ Relative ☐ Foster Home ☐ Divorced, joint custody

Is either Parent/Guardian an active military member? ☐ Yes ☐ No

Are there any custody issues the school should be aware of? ☐ Yes ☐ No

Do you have guardianship, custody papers, court or foster care placement letters? ☐ Yes ☐ No

_____

(If yes, please explain and provide supporting documentation)

Male Parent/Guardian:_____ Area Code & Alternate Number:_____

Email: _____

Place of Employment:_____ Area Code & Work Number:_____

Female Parent/Guardian:_____ Area Code & Alternative Number:_____

Email: _____

Place of Employment:_____ Area Code & Work Number:_____

Parent living elsewhere:_____

_____

Address Apt City/State Zip code + 4 digit

_____

Area Code and Home Number Area Code and Work Number Area Code and Alternate Number

Emergency Contact Information: The individuals listed below have authorization to pick up my child and can be reached during school hours at the number listed.

_____

Name Relationship Area Code & Telephone Number

_____

Name Relationship Area Code & Telephone Number

_____

Name Relationship Area Code & Telephone Number

Warren Consolidated Schools has designated the following as Directory Information: student's name, address, telephone number, date and place of birth, grade, major field of study, participation in school activities, honors and awards, other similar information (alumni associations, height and weight of athletes) and information generally found in a yearbook. Directory information can be provided to any individual, other than for-profit organizations, even without the written permission of a parent. If you wish to have Directory Information totally withheld from release, please check the box below.

☐ Until further notice, withhold all Directory Information from the student listed on this form.

Warren Consolidated Schools and the local media regularly cover school events for news, public relations, cable TV or other not-for-profit purposes. This would include photographs, video and audio taping and interviews. If you wish your student to be excluded from video tapes, audio tapes, photographs or interviews in conjunction with school or school district events, performances, or activities, please check the box below.

☐ Until further notice, exclude the student shown on this form from all school, school district, or news media video and audio taping, photography or interviews.

Verification of Data: I affirm that as the parent/guardian, all information provided in this document is true and accurate, and my child and I reside at the listed address. I understand any false information provided by me may result in the immediate removal of this student from Warren Consolidated Schools.

_____ _____

Signature of Parent/Guardian 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 Date: / /	Visual Acuity			
			Muscle Imbalance			
			Other:			
☐	☐	HEARING Date: / /	Audiometer			
			Other:			
☐	☐	URINALYSIS Date: / /	Sugar			
			Albumin			
			Microscopic			
☐	☐	BLOOD LEAD LEVEL Date: / /	Level _____ ug/dl ⇨			

No	Yes	Was child tested for:	Test results:	Normal	Referred	Under Care
☐	☐	HEIGHT & WEIGHT	Height			
			Weight			
☐	☐	Other: _____	Other			
☐	☐	HEMOGLOBIN / HEMATOCRIT	⇨			
☐	☐	BLOOD PRESSURE	Reading: _____			
☐	☐	TUBERCULIN Date: / /	Type: _____ 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	
OTHER Vaccines Specify Date & Type	Type of Vaccine(s)	Date of Vaccine(s)
	1	
	2	
	3	

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

Indicate and attach physician diagnosis or laboratory evidence of immunity as applicable

Parent/Guardian refused immunizations: ☐

*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.***

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 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.

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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.

Obtaining Your Child's Birth Certificate

Your child's birth certificate may be obtained from the county in which your child was born. Macomb, Oakland and Wayne counties all have websites and contract information listed below.

Frequently Asked Questions

Who can get a copy of my child's birth certificate? Anyone listed on the birth certificate or legal guardian.

How much does it cost to get a birth certificate? Fees vary from $7.50 to $25.

What do I need to request a birth certificate? A valid driver's license or 3 pieces of identification.

Can I request a birth certificate online? Yes, many counties provide an online service.

Macomb County
40 N. Main Mt Clemens MI 48043
Macombcountymi.gov
586-469-5205

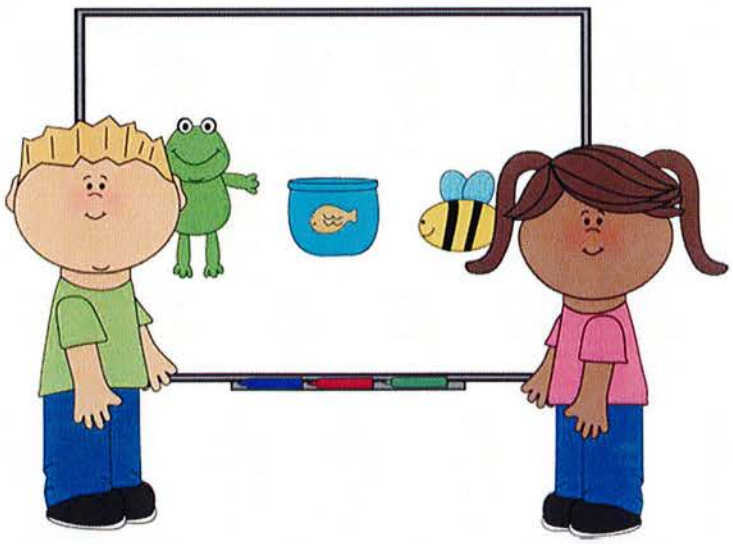
Oakland County
www.oakgov.com
248-858-0581

Wayne County
www.waynecounty.com

Child born in the city of Detroit
640 Temple St Suite 678
Detroit, MI 48201

Child born outside the city of Detroit
Office of Wayne County Clerk
C/O Birth/Death Records Division
2 Woodward Ave Room 201
Detroit, MI 48226

For additional options visit:
http://health.macombgov.org/Health-Programs-HPDC-SchoolImmunization under additional forms.



IMMUNIZATIONS ARE REQUIRED

The State of Michigan & the Macomb County Immunization Ordinance requires children to be adequately immunized to start school.

TO ENTER SCHOOL

Your child must have the following vaccines:

- 1dose of DTP/DTaP
  Diphtheria, Tetanus, Pertussis (Whooping Cough)
- 1 dose of Polio
- 1 dose of MMR – Measles, Mumps & Rubella (must be received on or after the 1st birthday) **OR** Laboratory proof of immunity
- 1 dose of Hepatitis B **OR** Laboratory proof of immunity
- 1 dose of Varicella (chickenpox) (must be received on or after the 1st birthday) **OR** Laboratory proof of varicella immunity **OR** Provide a written statement from a parent/guardian or doctor verifying the child already had chickenpox disease
- 1 dose of Pneumococcal Conjugate (PCV13)
- 1 dose of H. *influenzae* type b (Hib)

TO REMAIN IN SCHOOL

Children 4-6 Years of Age Must Have the Following Minimum Vaccines:

- 4 doses of DTP/DTaP with 1 dose on or after the 4th birthday
- 4 doses of Polio. If dose #3 was given on or after the 4th birthday, only 3 doses are needed.
- 2 doses of MMR and Varicella on or after the 1st birthday, at least 28 days apart from each other and/or the nasal flu vaccine
- 3 doses of Hepatitis B
- 4 doses of Pnemococcal Conjugate (PCV13)
- 3 doses of H. *influenzae* type b (Hib); 1 dose at or after 15 months.
- Appropriate spacing between all vaccines is essential for the development of adequate immunity. A complete date (month, day, and year) for each vaccine is required. You will be contacted if there is a concern about the spacing of your child's vaccines.

SPECIAL NOTES

- **Always bring your child's immunization record to your doctor or Health Department clinic.**
- Get immunizations on time to avoid the last minute rush.
- Keep your child's immunization record in a safe place.

DAILY SELF-SCREENING CHECKLIST FOR ALL STAFF / VOLUNTEERS:

YES	NO		
☐	☐	Have you been exposed to a person with a suspected or confirmed case of coronavirus (COVID-19) within the last 14 days?	
☐	☐	Do you have a fever (100.4 degrees or higher), cough (out of the norm), shortness of breath, sore throat, diarrhea, body aches, and / or loss of taste or smell?	
☐	☐	Have you traveled internationally in the last 14 days?	

IF YOU ANSWERED YES TO ANY OF THE ABOVE SCREENING QUESTIONS YOU WILL BE EXCLUDED:

Until you have had no fever for at least three full days without the use of medicine that reduces fevers

– AND –

At least **7** days have passed since your coronavirus symptoms first appeared.

www.cdc.gov/coronavirus/2019-ncov/if-you-are-sick/steps-when-sick.html

YOU WILL ALSO BE EXCLUDED:

10 days if you have had close contact with a diagnosed case of coronavirus.

At least 7 days following international travel.

These guidelines do not replace the judgment of a healthcare professional. If you are experiencing potential symptoms of coronavirus seek health advice immediately.