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 ⇨

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 (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

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

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	

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 _____ (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.

****

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.

ST. MARY PRESCHOOL
FAMILY REGISTRATION/TUITION CONTRACT 2021-2022

FAMILY LAST NAME _____

ADDRESS _____ CITY _____ ZIP _____

EMAIL ADDRESS (MOM) _____ (DAD) _____

Tuition is the main source of educational program funding at St. Mary School.
Check the appropriate tuition payment details below.

Monthly Tuition Payment Due Dates: 1st_____ -or- 15th_____ of the month

Payment Options: One (1) payment: June _____ Two (2) payments: June & December _____
Four (4) payments: June, Sept., Dec. ,March_____ Twelve (12) monthly payments: June – May _____

Program choice: please CIRCLE the appropriate boxes below

AM PRESCHOOL	AM PRESCHOOL	AM PRESCHOOL	AM PRESCHOOL	AM PRESCHOOL
MONDAY	TUESDAY	WEDNESDAY	THURSDAY	FRIDAY

FULL DAY PRESCHOOL	FULL DAY PRESCHOOL	FULL DAY PRESCHOOL	FULL DAY PRESCHOOL	FULL DAY PRESCHOOL
MONDAY	TUESDAY	WEDNESDAY	THURSDAY	FRIDAY

FULL DAY PRESCHOOL AM/PM LATCHKEY	FULL DAY PRESCHOOL AM/PM LATCHKEY	FULL DAY PRESCHOOL AM/PM LATCHKEY	FULL DAY PRESCHOOL AM/PM LATCHKEY	FULL DAY PRESCHOOL AM/PM LATCHKEY
MONDAY	TUESDAY	WEDNESDAY	THURSDAY	FRIDAY

Registration Deposit: $100.00 per child (non-refundable)

1. The tuition has been calculated considering a school calendar year. Days off due to vacation days, sick days, and any "Act of God" days do not change the monthly payment. If you remove your child after a quarter begins (4 quarters in school year) you are responsible for payment through that quarter.

2. All preschool paperwork including child's birth certificate, physical form and current immunization record MUST be turned into the school office for the registration to be completed.

3. CHILD MUST BE FULLY TOILET TRAINED (out of diapers or pull-ups) and independent to use the bathroom.

Parent /Guardian Signature_____ Date _____

I agree to accept the policies, rules and regulations of St. Mary School as well as all terms contained in this contract and the payment schedule set forth herein.

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
	( )		( )
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 Sid

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.

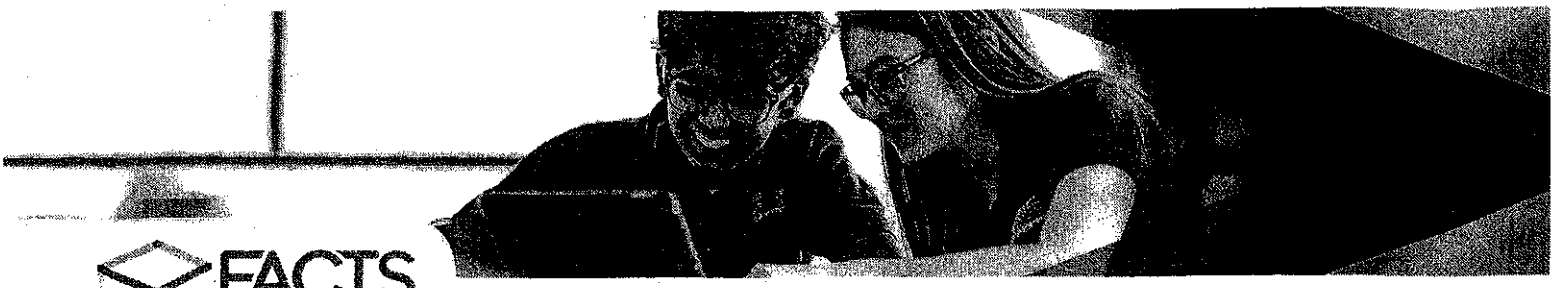
Signature of Parent or Guardian — Date Signed

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 Lega Guardian Initial

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.



FACTS

Tuition Management

https://online.factsmgt.com/signin/3YJ8Z

FACTS provides flexible payment plan options to families at private and faith-based schools. Families can budget their tuition, making private school more accessible and affordable. Our process is simple, convenient, and secure.

To set up your FACTS agreement, visit your school's website and locate the FACTS link, or go to https://online.factsmgt.com

FACTS CONFIRMATION NOTICE

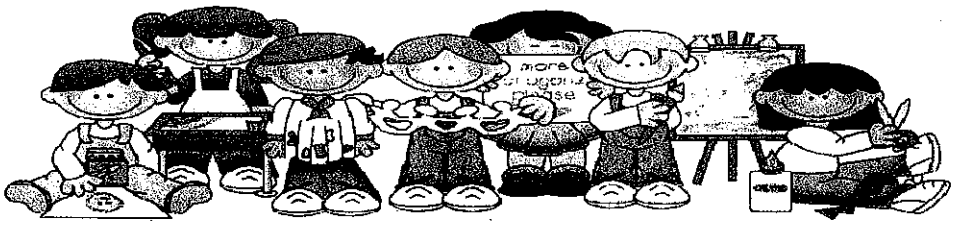
Once your information is received and processed by FACTS, you will receive a confirmation notice. This notice will confirm your payment plan information. Please check this information for accuracy, and contact your school or FACTS with any discrepancies.

Frequently Asked Questions

- **Is my information secure?**
  Yes. Your personal information, including payment information, is protected with the highest security standards in the industry. For more information on security, visit FACTSmgt.com/Security-Compliance.
- **When will my payments be due?**
  Your payment schedule is set by your school, and your financial institution will decide the time of day your payments are processed.
- **What happens when my payment falls on a weekend or a holiday?**
  Your payment will be processed on the next business day.
- **What happens if a payment is returned?**
  Returned payments may be subject to a FACTS returned payment fee. Watch for a returned payment notice for additional information.
- **How do I make changes once my agreement is on the FACTS system?**
  Changes to your address, phone number, email address, or banking information can be made at Online.FACTSmgt.com or by contacting your school or FACTS. Any changes to payment dates or amounts need to be approved by the school and the school will then need to notify FACTS. **All changes must be received by FACTS at least two business days prior to the automatic payment date in order to affect the upcoming payment.**
- **What is the cost to set up a payment plan?**
  If an enrollment fee is due, the amount of the fee is indicated when setting up your agreement. If applicable, the nonrefundable FACTS enrollment fee will be automatically processed within 14 days of the agreement being posted to the FACTS system.

FACTS CUSTOMER SERVICE

We are committed to doing all we can to provide you with the highest quality customer service in the industry. Whether you want to view your account online or speak with one of our highly trained customer service representatives, FACTS is dedicated to serving you. **To view your payment plan details, log in to your FACTS account at Online.FACTSmgt.com. Customer Care Representatives are also available to assist you 24/7.**



ST. MARY PRESCHOOL
TUITION RATES
2021 - 2022

Morning Friends Ages 3 & 4

8:25 AM – 11:15 AM

$1205.00	$1580.00	$2040.00	$2500.00
2 Days	3 Days	4 Days	5 Days

School Day Friends

8:25 AM – 3:15 PM

$2320.00	$3430.00	$4540.00	$5100.00
2 Days	3 Days	4 Days	5 Days

All Day Friends
With AM/PM Latchkey

6:45 AM – 6:00 PM

$3060.00	$4540.00	$6025.00	$6765.00
2 Days	3 Days	4 Days	5 Days

1. **$100.00 Non-Refundable deposit is due at registration.**
2. **All preschool paperwork including child's birth certificate, physical form and current immunization record MUST be turned into the school office for the registration to be completed.**
3. **CHILD MUST BE FULLY TOILET TRAINED (out of diapers or pull-ups) and independent to use the bathroom.**

St. Mary Preschool

Annual Permission for Topical, Non-Prescription Medications

2021-2022

I hereby give my permission for the caregivers of St. Mary Preschool to apply topical, non- prescription medications, as needed, to my child.

Topical nonprescription medication includes, but is not limited to: sunscreen, insect repellent, antibiotic ointment, rubbing alcohol, peroxide, and essential oils

* Caregivers will only apply topical, non-prescription medications that the parent has provided.

Name of student:_____

Signature of Parent/Guardian:_____

Abuse/Neglect Mandated Reporting Statement

The Michigan Child Protection Law, 1975 PA 238, MCL 722.623 et. Seq., requires the reporting of child abuse and neglect by certain persons (called mandated reporters) and permits the reporting of child abuse and neglect by all persons.

Mandated reporters include school administrators, school teachers, and regulated child care providers.

As part of our licensing requirements, you are being provided a copy of the Mandated Reporter's Guide. Additional copies of this guide are available in the Preschool Licensing Handbook found in the school office. Please read this document and retain it for future references should the need arise. After reading the document, please sign below and return to the preschool director for our licensing files.

I understand that I am obligated by Michigan Child Protection Law to report all suspected cases of child abuse and neglect for the children that are in my care. I have reviewed the State of Michigan's Mandated Reporter's Guide prior to signing this form.

_____ _____

Signature Date

PHOTO RELEASE

_____ Yes, I hereby grant St. Mary Catholic School, their legal representative, or those for whom they are acting, the absolute right and permission to copyright and use photographic portraits or pictures of my child for display during the school year. Photos may be used for marketing purposes such as in the church bulletin, displays, diocesan or school websites, FAITH magazine, etc.

I hereby waive any right I may have to inspect or approve the finished product or products.

I hereby release St. Mary Catholic School, their representative, or those for whom they are acting, from any liability for any violation of any personal or proprietary right I may have in connection with the use of the above stated images.

I state further that I have the above authorization, release and agreement and that I am fully familiar with its contents.

_____ No, I decline to have my child's photograph displayed; however, I do allow my child to be in unidentified group pictures with no names mentioned, such as pictures displayed for Catholic Schools Week.

Printed Name of Child: _____ Grade _____

Printed Name of Parent or Guardian: _____

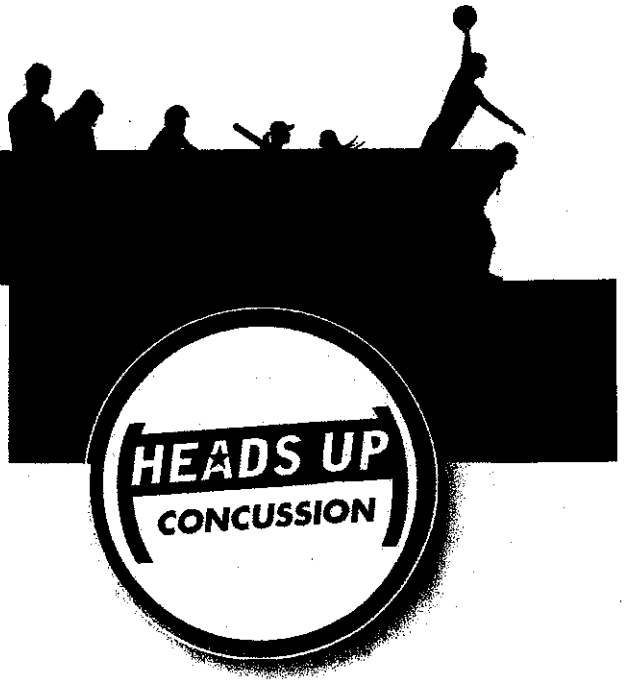
Street Address: _____

City: _____ State _____ Zip Code: _____

Phone: _____

Signature of Parent or Guardian: _____ Date: _____

PARENT & ATHLETE CONCUSSION INFORMATION SHEET



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. Even a "ding,""getting your bell rung," or what seems to be a mild bump or blow to the head can be serious.

WHAT ARE THE SIGNS AND SYMPTOMS OF CONCUSSION?

Signs and symptoms of concussion can show up right after the injury or may not appear or be noticed until days or weeks after the injury.

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

DID YOU KNOW?

- Most concussions occur without loss of consciousness.
- Athletes who have, at any point in their lives, had a concussion have an increased risk for another concussion.
- Young children and teens are more likely to get a concussion and take longer to recover than adults.

SYMPTOMS REPORTED BY ATHLETE:

- Headache or "pressure" in head
- Nausea or vomiting
- Balance problems or dizziness
- Double or blurry vision
- Sensitivity to light
- Sensitivity to noise
- Feeling sluggish, hazy, foggy, or groggy
- Concentration or memory problems
- Confusion
- Just not "feeling right" or is "feeling down"

SIGNS OBSERVED BY COACHING STAFF:

- Appears dazed or stunned
- Is confused about assignment or position
- Forgets an instruction
- Is unsure of game, score, or opponent
- Moves clumsily
- Answers questions slowly
- Loses consciousness (even briefly)
- Shows mood, behavior, or personality changes
- Can't recall events prior to hit or fall
- Can't recall events after hit or fall

MDHHS
Michigan Department of Health & Human Services
RICK SNYDER, GOVERNOR · NICK LYON, DIRECTOR

"IT'S BETTER TO MISS ONE GAME THAN THE WHOLE SEASON"

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. An athlete 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)

WHAT SHOULD YOU DO IF YOU THINK YOUR ATHLETE HAS A CONCUSSION?

1. If you suspect that an athlete has a concussion, remove the athlete from play and seek medical attention. Do not try to judge the severity of the injury yourself. Keep the athlete out of play the day of the injury and until a health care professional, experienced in evaluating for concussion, says s/he is symptom-free and it's OK to return to play.
2. Rest is key to helping an athlete recover from a concussion. Exercising or activities that involve a lot of concentration, such as studying, working on the computer, and playing video games, may cause concussion symptoms to reappear or get worse. After a concussion, returning to sports and school is a gradual process that should be carefully managed and monitored by a health care professional.
3. Remember: Concussions affect people differently. While most athletes with a concussion recover quickly and fully, some will have symptoms that last for days, or even weeks. A more serious concussion can last for months or longer.

WHY SHOULD AN ATHLETE REPORT THEIR SYMPTOMS?

If an athlete has a concussion, his/her brain needs time to heal. While an athlete's brain is still healing, s/he is much more likely to have another concussion. Repeat concussions can increase the time it takes to recover. In rare cases, repeat concussions in young athletes can result in brain swelling or permanent damage to their brain. They can even be fatal.

_____

STUDENT-ATHLETE NAME PRINTED

_____

STUDENT-ATHLETE NAME SIGNED

_____

DATE

_____

PARENT OR GUARDIAN NAME PRINTED

_____

PARENT OR GUARDIAN NAME SIGNED

_____

DATE

JOIN THE CONVERSATION www.facebook.com/CDCHeadsUp

HEADS UP

TO LEARN MORE GO TO

Content Source: CDC's Heads Up Program. Created through a grant to the CDC Foundation from the National Operating Committee on Standards for Athletic Equipment (NOCSAE).

St. Mary Catholic School
1-05-21

VOLUNTEER BACKGROUND CHECK

Acknowledgment Form

Nonemployment Background Checks Only

Service to provide: ST. MARY SCHOOL Date to Provide Service: **2021-2022**

In order to ensure the protection of children in the care of St. Mary Catholic School, school policy requires, prior to any and all persons providing a volunteer service at the school or for any function conducted by the school; all potential volunteers complete a State of Michigan ICHAT background check. ICHAT, the background check is a name check only, through the State of Michigan ICHAT system, and is based on individual identifiers. Any applicant declining to complete a "Volunteer Background Check" acknowledgment form will not be considered.

POTENTIAL VOLUNTEER INFORMATION

Full Printed Name: _____

Maiden name or other name(s) previously used: _____

DOB: _____ Sex: _____ Eye Color: _____ Hair Color: _____ Height: _____
[mm/dd/yyyy]

HISTORY INFORMATION

1) Have you volunteered at St. Mary Cathloic School before? ☐ Yes ☐ No

2) Have you ever pled guilty, or been convicted of a felony in a state or federal court?
☐ Yes ☐ No
Date and state offense/conviction occurred: _____

If yes, provide a detailed description of the conviction: _____

_____

3) Have you ever pled guilty, or been convicted of a misdemeanor in a state or federal court?
☐ Yes ☐ No
Date and state offense/misdemeanor occurred: _____

If yes, provide a detailed description of the conviction: _____

_____

4) Are you the subject of a current criminal investigation or have pending charges against you?
☐ Yes ☐ No
Date and state the investigation is ongoing: _____

If yes, provide a detailed descripition of the investigation or pending charges: _____

_____

St. Mary Catholic School
1-05-21

St. Mary Cathloic School reserves the right to "approve" or "deny" any volunteer service upon review of the background check returned. The determination will be based upon the individual's fitness to have responsibility for the safety and wellbeing of children. Providing false information, or information contradicting to the background check information, is grounds for immediate volunteer denial.

By affixing your signature to this form you acknowledge your statements are to be true and give full consent to complete the requested background check.

Signature: _____

Date Signed: _____

Please return completed form to St. Mary Catholic School/Veronica Kinsey. Questions or concerns, please contact Veronica Kinsey- Principal: mrskinsey@stmarypinckney.org.

OFFICE USE ONLY

Approved ☐ Denied ☐ Date Approved/Denied _____ Determining Staff Member (initials) _____