Marysville Public Schools

"Every student will excel, both personally and for the benefit of humanity."

495 East Huron BLVD • Marysville, MI 48040 • OFFICE: 810.364.7731 • FAX: 810.364.3150

Kindergarten Document Checklist

Please complete and return the following forms to the school office. All forms must be completed and returned for enrollment.

- ☐ Enrollment Form
- ☐ Home Language Survey
- ☐ Student Residency Questionnaire
- ☐ Elementary Record Release (If applicable)
- ☐ Permission to Place (Only if the child has received special services)
- ☐ School Bus Transportation Form – (Even if the child will not be riding the bus daily)
- ☐ Concussion Awareness Form
- ☐ Health Appraisal - Please make sure the form is complete and signed and dated by the parent (Section 1), by the Physician (Sections III and V (part 2))
- ☐ Kindergarten Oral Health Assessment - The Dental Examination is a new REQUIREMENT for 2024-25
- ☐ Immunization Records and/or Waiver (If your child is not up to date and you are foregoing additional immunizations, you must have a waiver for what you will not be completing). If your child's immunizations are behind, you must also submit a copy of the catch-up immunization record with the plan to make these up
- ☐ Consent for Disclosure of Immunization Information
- ☐ Prior Care Form

In addition, please provide the following:

- ☐ Original Birth Certificate (A copy will be made at the school)
- ☐ Driver's License
- ☐ Utility Bill, purchase/lease agreement or County School of Choice letter to show residence
- ☐ Hearing and Vision Screening (Can be done through the school, please call the office to schedule)

Thank you for taking the time to complete these requirements **prior** to the start of the academic year. We look forward to having your child attend Marysville Public Schools. Great futures begin here!

MARYSVILLE PUBLIC SCHOOLS ENROLLMENT FORM

School:_____ **Enrollment Date:**_____

Student Information

Student's Full Legal Name (Last, First, Middle)	Gender	Grade
	M ☐ F ☐	

Student's Date of Birth	Student Order of Birth (if multiple)	Birth City/State (or Country if not in US)
	Please circle 1 2 3 4	

Home Street Address	Apt/Suite	City & Zip	State	Home Phone
				( ) -

Mailing Address (if different from Home)	Apt/Suite	City & Zip	State	Cell Phone
				( ) -

Student lives with:(circle one)

Mother/Father Mother only Father only Joint Custody Mother/Stepfather Father/Stepmother Guardian

Race & Ethnicity

Please Note: Both Part A & Part MUST BE answered!

Part A : Is this 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

The above part of the question is about ethnicity, not race. No matter what you selected above, please continue to answer the boxes to indicate what you consider your student's race to be.

If unanswered, the US Department of Education REQUIRES the District to supply an answer on your behalf.

Part B: What is the student's race? (Choose one or more)

☐ **American Indian or Alaskan Native** (A person having origins in any of the original peoples of North & South America, including Central America).

☐ **Asian** (A person having origins in any of the original peoples of the Far East, Southeast Asia, or the Indian subcontinent including, for example, Cambodia, China, India, Japan, Korea, Malaysia, Pakistan, the Philippine Islands, Thailand & Vietnam).

☐ **Black or African American** (A person having origins in any of the black racial groups of Africa).

☐ **Native Hawaiian or Other Pacific Islander** (A person having origins in any of the original people of Hawaii, Guam, Samoa or other Pacific Islands).

☐ **White** (A person having origins in any of the original peoples of Europe, the Middle East or North Africa).

Home Language Survey:

1. What languages are spoken in your child's home? _____

2. Which language did your child first learn to speak? (Most often spoken by your child). _____

Services Received at Former School

☐	Speech/Language	☐	504/IEP
☐	Social Work	☐	Other Services _____

Contact 1 Parent/Guardian ONLY

First & Last Name	Relationship to Student	Home Phone
		( ) -

Street Address	City, State & Zip	Cell Phone
		( ) -

Email	Employer	Work Phone
		( ) -

Preferred method for School Messenger Notifications (circle all that apply)

Phone Call Text Message Email

Contact 2 Parent/Guardian ONLY

First & Last Name	Relationship to Student	Home Phone
		( ) -

Street Address	City, State & Zip	Cell Phone
		( ) -

Email	Employer	Work Phone
		( ) -

Emergency Contacts other than Parents/Guardian		
Name	**Relationship**	**Phone**
		( ) -
		( ) -
		( ) -

Guardianship

**** Does proof of guardianship exist? ___ Yes ___ No If not, you must have proof of guardianship before enrollment can take place.***

A Copy of guardianship must be placed in the student's file.

1. What is the reasoning behind having guardianship arranged in order for this student to qualify as a Marysville School District resident?

Check one or more if appropriate: ____ Court Placed ____ Better Educational Opportunities ____ Other_____

2. If problems in previous home was selected, please be more specific:_____

_____

3. If problems in previous school was selected, please be more specific:_____

_____

Please list all other children living in the Household		
Last Name	**First Name**	**DOB**

Previous School Information			
School Name	**School District**	**School Phone**	**School Fax**
		( ) -	( ) -
Last Grade completed			

Is child under long-term suspension or expulsion from his/her previous school? ____ Yes ____ No , if Yes please explain_____

For Kindergarten ONLY: Did your child attend a pre-K program? ____ Yes at:_____ _____ No

Additional Information

Please list any health conditions (handicaps, allergies, etc.) :_____

_____

_____

I attest that the information contained herein is correct to the best of my knowledge. A birth certificate and immunization record must also accompany this profile.

Signature of Parent/Guardian_____ Date_____

MICHIGAN STATE BOARD OF EDUCATION APPROVED
HOME LANGUAGE SURVEY

The **Marysville Public Schools District** is collecting information regarding the language background of each of its students. This information will be used by the district to determine the number of children who should be provided bilingual instruction according to Sections 380.1152-380.1157 of the School Code of 1995, Michigan's Bilingual Education Law. Thank you for your cooperation.

Name of Student _____ Grade _____ Age_____

School _____

1. Is your child's native tongue ***(language first learned)*** a language **other than English?**

   ☐ No ☐ Yes If yes, what is the language? _____

2. Is the primary language ***(language frequently used for speaking)*** in your child's home or environment a language **other than English?**

   ☐ No ☐ Yes If yes, what is the language? _____

_____ _____
Parent/Guardian Signature Address

Date:_____

Marysville Public Schools
Student Residency Questionnaire—Confidential

Date:_____ School:_____

Name of Student:_____

Birth Date:____/____/____ Age:_____ Male □ Female □
Month/Day/Year

Name of Parent(s)/Legal Guardian(s):_____

Address:_____ State:_____ Zip:_____

Primary Contact Phone:_____ Secondary Contact Phone:_____

This questionnaire is intended to address the McKinney-Vento Act 42 U.S.C. 11435. The answers to this residency information help determine the services the student may be eligible to receive.

1. Is the current address a temporary living arrangement? □ Yes □ No
2. Is this temporary living arrangement due to loss of housing or economic hardship? □ Yes □ No

If you answered YES to the above questions, please complete the remainder of this form.

If you answered NO, you may stop here, and sign below*.

Where is the student presently living?

□ With his/her parent/guardian in a house or apartment with another family due to economic hardship

□ With friends or adults(s) other than parent/guardian, or alone without an adult

□ In a motel/hotel

□ In a shelter or temporary foster care placement

□ In a place not designed for ordinary sleeping accommodations such as a car, campsite or park

□ In temporary housing in order to accompany or join a parent or guardian engaged in temporary or seasonal work in agriculture or fishing. (A migrant child/youth is not automatically considered homeless. They must be living in one of the housing arrangements listed above.)

For School Use Only:

□ Doubled-Up

□ Doubled-Up/Unaccompanied Youth

□ Hotel/Motel

□ Sheltered

□ Unsheltered

□ Migrant

Do you have preschool aged children presently living in the same location? □ Yes □ No

School districts have the right to ask new enrolees to prove residency. By signing this affidavit, you are affirming that the address/information given on all enrollment forms and the information stated above accurately reflects you/your child's present and/or anticipated residency status.

***Signature of Parent/Legal Guardian:**_____ **Date:**_____

School Use Only:

Address verified by: □ Rent/Mortgage Receipts □Utility Bill □ Driver's License □ Property Tax Bill □ Purchase Agreement □ Other

The above address is within the Marysville Public Schools residency area □ Yes □ No

If the parent/guardian has answered YES to any of the questions above, the MPS McKinney-Vento Reporting form must be completed and submitted to the District Homeless Liaison immediately.

DateMcKinney-Vento Form faxed to District Liaison:_____
Date Free/Reduced Meal Application indicating Homeless submitted to Food Service Coordinator:_____

MARYSVILLE PUBLIC SCHOOLS DISTRICT
Elementary Records Release

Date of Request: _____

Previous School: _____ Phone: _____

Street Address: _____ Fax: _____

City, State. ZC: _____

Permission to Release: I hereby authorize the above named school to release any and all records, General Education and/or Special Education, including psychological evaluations and health information.

Enrollment Date: _____

Student(s) Name	Grade	DOB
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

_____ _____
Parent Signature Date

Please release student(s) General Education Records to:

◯ Gardens Elementary
1076 Sixth St.
Marysville, MI 48040
(810-364-7141
Fax: 810-364-2987

◯ Morton Elementary
920 Lynwood St.
Marysville, MI 48040
(810) 364-2990
Fax: 810-364-5983

◯ Washington Elementary
905 16th St.
Marysville, MI 48040
(810) 364-7101
Fax: 810-364-2986

SPECIAL EDUCATION RECORDS ARE TO BE SENT TO:

Marysville Public Schools Special Education
495 East Huron Blvd.
Marysville, MI 48040
(810) 455-6035
Fax: 810-364-3150

please include the MET, REED and any health and testing information with the IEP, as available.

This request is being sent in accordance with Section 1135 of the Michigan Revised School Code which requires a transfer of student's previous school to forward the student's school record to the enrolling district; and the final regulations of Family Educational Right and Privacy Act, (FERPA), which permits the disclosure of students records to another school where a student is in attendance or seeks to enroll without written consent, provided appropriate notice is given.

Internal: Request sent _____, _____, __mail __fax __ email

Marysville Public Schools
OFFICE OF SPECIAL EDUCATION & STATE / FEDERAL PROGRAMS
KARRIE SMITH – EXECUTIVE DIRECTOR
495 East Huron Blvd. • Marysville, MI 48040 • 810.455.6035 • FAX: 810.364.3150

SPECIAL EDUCATION PERMISSION TO PLACE FORM

(Complete if your child was receiving Special Education programs or services at prior school)

TO BE COMPLETED BY PARENT FIRST DAY TO ATTEND: _____

STUDENT NAME _____ DOB_____

HOME ADDRESS _____

ATTENDING BUILDING _____ GRADE _____

PARENT/GUARDIAN NAME _____ PHONE NO. _____

PRIOR DISTRICT _____ PRIOR SCHOOL _____

CIRCLE ANY PRIOR SCHOOL CLASSROOM PROGRAM PLACEMENT:

RR - Resource Room
CI - Mild Cognitive Impairment
ECSE - Early Childhood Special Education Program
NCP - Non-classroom Early Childhood Services

AMOUNT OF **SPECIAL EDUCATION CLASSROOM TIME: _____HOURS PER WEEK**

CIRCLE ANY PRIOR SCHOOL SUPPORT SERVICE(S) RECEIVED:

SLT - Speech & Language Therapy
TC - Teacher Consultant
OT - Occupational Therapy
PT - Physical Therapy
SSW - School Social Work
WBL - Work Based Learning
HB - Homebound/Hospitalized
OTHER - _____

Specialized Transportation needed? No ____ Yes ____ Specify: _____

Please note: For out of county and state placements, a new IEP will be conducted within 30 days from the parental consent and receipt of this placement form in the Special Education Office.

*Time in Special Education may vary during these 30 days as we adjust the program/services to the student's needs.

REQUEST FOR PARENT CONSENT:

____ I GIVE PERMISSION for the immediate special education placement of my child & for the release of his/her previous Special Education records to Marysville Public Schools.

____ I REFUSE PERMISSION for the immediate special education placement of my child.

_____ _____ _____
Parent/Guardian (Printed Name) Parent/Guardian (Signature) Date

_____ _____ _____
District Representative /Receiving Consent District Representative (Signature) Date

TO BE COMPLETED BY SE OFFICE

Last IEP Date: _____ Last MET Date:_____ Last Eligibility Category: _____
Resident: Yes No

Transportation Tips!

- Pick-up and drop off times may vary during the first week of school, but they will become more consistent once routines are established. Your patience is greatly appreciated.

- Please have your student at his/her bus stop before the bus arrives. We are unable to wait for students to come down their driveways or porches. Adding 90 seconds to each bus stop, for this practice, would add an average of 50 minutes to the existing route.

- Please tune in to channel 2, 4 or 7, radio 1380, the district website or Facebook page for all cancellations and updates.

- When buses are running on main roads only, the students must come out to the nearest paved road. Main roads only will be for morning and afternoon bus routes.

- Kindergarteners are accustomed to seat belts in a passenger vehicle; so a school bus is a new experience of freedom to them. Although it is tempting to walk around and visit with friends, please discuss with your child the importance of bus safety rules. The driver must watch the roads and students are expected to follow safety rules independently. The most important rules include:

    - Stay in your seat
    - Sit on your bottom
    - Use a quiet voice at all times

- Students are permitted to bring and use their technology devices on the school bus. However, they must respect others with their volume, content of music, games, videos, etc. These items can draw a crowd around them. If the technology becomes a distraction or a safety risk, students will be asked to put the devise in their backpack.

- We will not be responsible for lost, stolen, traded or damaged items. If an item is irreplaceable or extremely important to your child, it is strongly recommended to have your child leave it in his/her backpack while riding the bus or keep is safely at home.

- If you cannot be at the bus stop when your child arrives home, please inform the driver of how your child will know you are there. Examples: the red van will always be in the driveway; the garage door will be open; I will be standing in the door, etc. If you are unable to be at home as planned, please call a neighbor or a relative to greet your child at the bus stop. Please call our office at 364-7789 if there is a delay or an emergency keeping you from being at the bus stop for your child.

- Failure to be at the bus stop on time will result in the bus returning your child to his/her elementary school. You will be responsible for picking your child up at his/her designated school building upon arrival.

- If your child requires alternate route pick-ups or drop-offs, we can only accommodate two locations and the days *must be consistent*. For example, Joey goes to daycare on Gratiot Ave Monday, Tuesday and Thursday after school, and on Wednesday and Friday he goes home. Schedules that change from week to week require ongoing communication with the school and leave opportunities for oversights.

Please call Marysville School Bus, Inc. office anytime at (810) 364-7789 for questions or concerns. We look forward to working with you and your child.

Marysville School Bus, Inc., 1421 Michigan Ave., Marysville, MI 48040

School Bus Transportation Request Form

Please choose all that apply: ◯ New Student ◯ Current Student

First day attending or effective date for this request: _____.

Health concerns and/or daily medication _____

Full name of student: _____

Home address of the student: _____
Street address City

Home telephone number: _____ Cell/other contact number: _____

Email Address: _____

School Attending: ◯ High School ◯ Middle School ◯ Washington ◯ Gardens ◯ Morton

Student will be riding the bus: ◯ to school ◯ from school ◯ extra-curricular only

Students' date of birth: _____ Grade: _____

Alternative contact person: _____ Contact number: _____

Parent/Guardian Signature: _____ Date: _____

For transportation to a location other than the student's home address, please complete this section.
These requests will not always be possible. The decision will be based on our current bus stops, routes and the number of students entitled to ride the bus your student would be added to. We will, however, grant the request where we are able too.

Address to be PICKED UP at for transportation to school: _____

Contact person and phone number at this location: _____

Address to be DROPPED OFF at after school: _____

Contact person and phone number at this location: _____

_____

This section is to be completed by the transportation department. This information will be forwarded to your student's school and the school will make you aware of the details of your student's transportation.

AM	**PM**
Bus # to School: _____	**Bus # Home:** _____
Location of bus stop: _____	**Drop off bus stop:** _____
Reporting time to bus stop: _____	**Drop off bus stop time:** _____

PLC Drop Off time: _____ **Half Day Drop Off time:** _____

Educational Material for Parents and Students (Content from MDHHS Requirements)

Sources: Michigan Dept. of Health and Human Services. Created through a grant to the CDC Foundation from NOCSAE.

UNDERSTANDING CONCUSSION

Some Common Symptoms

Headache	**Balance Problems**	**Sensitive to Noise**	**Poor Concentration**	**Not "Feeling Right"**
Pressure in the Head	**Double Vision**	**Sluggishness**	**Memory Problems**	**Feeling Irritable**
Nausea/Vomiting	**Blurry Vision**	**Haziness**	**Confusion**	**Slow Reaction Time**
Dizziness	**Sensitive to Light**	**Fogginess**	**"Feeling Down"**	**Sleep Problems**
		Grogginess	**Lost Consciousness**	

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 fall, bump, blow, or jolt to the head or body that causes the head and brain to move quickly back and forth. A concussion can be caused by a shaking, spinning or a sudden stopping and starting of the head. Even a "ding," "getting your bell rung," or what seems to be a mild bump or blow to the head can be serious. A concussion can happen even if you haven't been knocked out.

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. A student who may have had a concussion should not return to play on the day of the injury and until a health care professional says they are okay to return to play.

IF YOU SUSPECT A CONCUSSION:

1. **SEEK MEDICAL ATTENTION RIGHT AWAY – DON'T HIDE IT, REPORT IT**. Playing or practicing with concussion symptoms is dangerous and can lead to a longer recovery. 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. Ignoring symptoms and trying to "tough it out" often makes it worse.

2. **KEEP YOUR STUDENT OUT OF PLAY –** Concussions take time to heal. Don't let the student return to play the day of injury and until a heath care professional says it's okay. A student, who returns to play too soon, while the brain is still healing, risks a greater chance of having a second concussion. Young children and teens are more likely to get a concussion and take longer to recover than adults. Repeat or second concussions increase the time it takes to recover and can be very serious. They can cause permanent brain damage, affecting the student for a lifetime. They can be fatal. It is better to miss one game than the whole season.

3. **TELL THE SCHOOL ABOUT ANY PREVIOUS CONCUSSION –** Schools should know if a student had a previous concussion. A student's school may not know about a concussion received in another sport or activity unless you notify them.

SIGNS OBSERVED BY PARENTS:

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

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/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 must be kept out of athletic activity the day of the injury. The student shall only return to activity (practice, scrimmage or competition) with written unconditional permission from an MD, DO, Physician's Assistant or Nurse Practitioner. During recovery, rest is key. 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. Students who return to school after a concussion may need to spend fewer hours at school, take rests breaks, be given extra help and time, spend less time reading, writing or on a computer. After a concussion, returning to sports and school is a gradual process that should be monitored by a health care professional.

Remember: Concussion affects people differently. While most students 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.

To learn more, go to www.cdc.gov/concussion.

Parent and Student Must Sign Consent & Waiver on MHSAA Physical Form Acknowledging Awareness

This portion below may be substituted for the signatures on the MHSAA Physical Form

CONCUSSION AWARENESS

EDUCATIONAL MATERIAL ACKNOWLEDGEMENT FORM

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/or the Concussion Fact Sheet for Students provided by _____
Sponsoring Organization

_____	_____
Participant Name Printed	Parent or Guardian Name Printed
_____	_____
Participant Name Signature	Parent or Guardian Name Signature
_____	_____
Date	Date

Return this signed form to the participant's MHSAA member school. The school should keep this document on file for five years following the student's high school graduation.

Participants and parents please review and keep the educational materials available for future reference.

GRADUTATION YEAR_____

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:

_____ / / Was the health history reviewed by a health professional?

Parent/Guardian Signature Date ☐ 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

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	
	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 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 _____ 's teeth. As a result of this examination, my recommendation for treatment is: _____

child's name

_____ ___/___/___

Dentist's Signature Date

PHYSICIAN'S SIGNATURE

_____ ___/___/___ _____ _____

Examiner's Signature Date ***Examiner's Name (Print or Type)*** Degree or License

_____ _____ MI _____ (___) _____

Number & Street 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 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.

Did You Know?

Being prepared for kindergarten starts with a dental assessment. Children are now required to have one prior to starting school.

A healthy mouth is important. **Dental problems can prevent children from doing well in school.** **Children are required to have a dental assessment before starting kindergarten** so that any problems can be fixed and they start school ready to learn.

Cavities are common. Tooth decay (cavities) is the most common chronic disease in children.

Cavities can cause pain. Pain can make it hard for children to pay attention in school, prevent them from eating well, and keep them awake at night. All of this can all affect their ability to learn.

Dental problems affect attendance and grades. Children with dental problems miss more school than children with good dental health.

Facts About Kindergarten Dental Assessments

1. **It's easy to get your child screened.** Local health departments provide the assessments (screenings) at places like preschools, school enrollment events, community events, and at the health department. Check with your school or the local health department for a schedule.

2. **The assessment is free.** There is no cost to you if the local health department does the assessment. Check with the school to see if it will have a registration event and if dental staff from the health department will be there or call the health department to check when and where they will be doing assessments.

3. **A dental assessment is simple and fast.** A dental professional will look into your child's mouth and note what they see on the assessment form. No treatment is done. It's simply a quick look in the mouth. They will let you know if your child needs to see a dentist.

4. **Help is available.** The local health department can help you find a dentist if you don't have one. Your child may be able to enroll in the Michigan Healthy Kids Dental Program if they don't have insurance. For information about Healthy Kids Dental, visit: www.michigan.gov/mdhhs/assistance-programs/healthcare/childrenteens/hkdental

Common Questions

How will my child benefit from having a dental assessment?

Dental problems can cause pain and make it difficult for children pay attention in school, prevent them from eating and sleeping well, and can even affect their ability to speak and socialize. All of this can affect a child's ability to learn and do well in school. Children benefit from having a dental assessment (screening) before starting school to check for any dental problems that need to be fixed so that they start school ready to learn.

How can I get the assessment done?

The school should give you a form, or you can download it from the MDHHS Kindergarten Oral Health Assessment website. You can take this form to your dentist to get the assessment done, or you can have it done by the local health department. **There is no cost to you if the assessment is done by the local health department**. Check with the school to see if it will have a registration event and if dental staff from the health department will be there or check with the health department for their schedule.

Do my older children need a dental assessment, too?

The dental assessment requirement is only for children entering kindergarten, but it is highly recommended that all children see a dentist at least once a year.

What if I don't have a dentist or I can't afford one?

The local health department can provide you with a list of dental providers in your area. Check the Michigan Oral Health Directory for a list of low- and no-cost dental providers by county: https://www.michigan.gov/mdhhs/adult-child-serv/childrenfamilies/familyhealth/oralhealth. If your child does not have dental insurance, they may be eligible for the Michigan Healthy Kids Dental Program: www.michigan.gov/mdhhs/assistance-programs/healthcare/childrenteens/hkdental

For More Information

MDHHS-KOHA@michigan.gov

MDHHS
MICHIGAN DEPARTMENT OF HEALTH AND HUMAN SERVICES

Protecting your child's priceless smile.

Besides brushing twice a day, seeing a dentist twice a year can help keep your child's mouth healthy and their teeth cavity-free.

Kids should see a dentist when their first tooth appears, or no later than their first birthday.

The next time you call to make an appointment, tell them you have Healthy Kids Dental.

HEALTHY KIDS Dental

To find a dentist or learn more about Healthy Kids Dental, visit **HealthyKidsDental.org**.

MDHHS
Michigan Department of Health & Human Services

HEALTHY KIDS Dental

Healthy Kids Dental: the right choice for bright smiles.

What is Healthy Kids Dental?

The Healthy Kids Dental program (HKD) helps children with Medicaid have healthy, happy smiles at NO cost to you.

Is my child eligible?

HKD coverage is as wide as your child's grin. If your children have Medicaid and are under the age of 21, they have Healthy Kids Dental.

Does my dentist accept HKD?

Finding dental care is easy with HKD, because 8 out of 10 Michigan dentists accept it. So if you have HKD, make sure you use your benefit.

Healthy smile, healthy child.

Maintaining a healthy mouth is smart. Kids may miss less school, make friends more easily, speak more clearly and learn better in class when they have healthy teeth and mouths.

When children see HKD dentists, they have access to covered services like:

- Oral exams
- Teeth cleanings
- Fluoride treatments
- X-rays
- Screenings and assessments
- Fillings
- Sealants
- Stainless steel or resin crowns
- Crown buildup, including pins
- Space maintainers
- Re-cementing of crowns, bridges and space maintainers
- Root canals
- Extractions
- Complete, partial and temporary partial dentures
- Denture adjustments and repairs
- Denture rebases and relines
- Emergency treatment to reduce pain
- IV sedation (when needed)

Finding an HKD dentist is EASY.

To find a dentist near you, visit **HealthyKidsDental.org**.

To receive services at no cost to you, your child must see an HKD dentist. You may switch to another HKD dentist at any time. If you see a dentist who doesn't accept HKD, you may have to pay for provided services.

MDHHS-6067, KINDERGARTEN ORAL HEALTH ASSESSMENT

Michigan Department of Health and Human Services (MDHHS)
(New 8-23)

SECTION 1 – STUDENT INFORMATION

Child's Name (Last, First, Middle)	Date of Birth
Address (Number, Street, City, Zip Code)	Home/Cell Phone Number
Parent/Guardian Name (Last, First, Middle)	Parent/Guardian Email
School Name	

SECTION 2 – DENTAL EXAM OR ASSESSMENT RECOMMENDATIONS
(Licensed dental professional must complete this section)

Date of Service	Type of Service ☐ Dental Exam ☐ Dental Assessment
Findings (Check all that apply) ☐ No findings ☐ Treated decay ☐ Untreated decay	Recommendations (Check **one**) ☐ Routine care ☐ Referral for dental treatment ☐ Referral for urgent dental care
Provider Type (Check **one**) ☐ Dentist	☐ Dental Therapist ☐ Dental Hygienist
Provider Signature	Agency/Local Health Department
Provider Name (Print)	Phone Number
Additional Comments	

Immunizations for School Entry in Michigan

A guide for parents

Students must follow Michigan's vaccine laws in order to attend school. These laws are the minimum standard to help protect children from disease outbreaks in school settings, where crowded hallways and playgrounds increase the likelihood of exposure to illnesses.

WHAT YOUR CHILD NEEDS BEFORE KINDERGARTEN

Requirements for all kindergartners and 4–6 year old transfer students:

- **Diphtheria, Tetanus, Pertussis (DTP, DTaP, Tdap)**
- **Polio**
- **Measles, Mumps, rubella (MMR)**
- **Hepatitis B**
- **Varicella (Chickenpox)**

WHERE TO GET VACCINATED

Plan ahead. The weeks before the start of school are very busy.

Your physician's office
Vaccines can be administered at a physician's office for families with insurance covering vaccines.

St. Clair County Health Department
Clinics are available for infants, children, and adolescents, from birth through 18 years of age.

Main Office, 3415 28th Street, Port Huron, 810-987-5729
10 a.m.–6:30 p.m. Monday
8 a.m.–4:30 p.m. Tuesday through Friday
By appointment. Walk-ins are accommodated as schedule allows.
@scchdmi stclaircounty.org/pagebuilder/scchd/

HOW TO GET MORE INFORMATION

Ask your child's healthcare provider if you're unsure about what vaccines your child needs.

I Vaccinate
Scan for Information and tools to help Michigan parents protect their kids

Michigan Department of Health & Human Services
Scan for a list of vaccines required for school entry in Michigan

Centers for Disease Control
Scan for the CDC's recommended vaccination schedule for children ages 0–6

St. Clair County RESA
GREAT START COLLABORATIVE ST. CLAIR COUNTY
Help Me Grow St. Clair

Funding provided by a grant awarded by the Michigan Department of Education and the U.S. Department of Education

JAN 2022

SCHOOLS Vaccines Required for School Entry in Michigan

Whenever children are brought into group settings, there is a chance for diseases to spread. Students must follow state vaccine laws in order to attend school. These laws are the minimum standard to help prevent disease outbreaks in school settings. The best way to protect students in your care from other serious diseases is to promote the recommended vaccination schedule at www.cdc.gov/vaccines. Encourage parents to follow CDC's recommended schedule; by doing so, school requirements will be met.

	All Kindergarteners and 4-6 year old transfer students	All 7th Graders and 7-18 year old transfer students
Diphtheria, Tetanus, Pertussis (DTP, DTaP, Tdap)	4 doses DTP or DTaP 1 dose must be at or after 4 years of age	4 doses diphtheria and tetanus or 3 doses if 1st dose given at or after 1 year of age 1 dose Tdap at 11 years of age or older upon entry into 7th grade or higher
Polio	4 doses 3 doses if dose 3 was given at or after 4 years of age	
Measles, Mumps, Rubella (MMR)*	2 doses at or after 12 months of age	
Hepatitis B*	3 doses	
Meningococcal Conjugate (MenACWY)	None	1 dose at 11 years of age or older upon entry into 7th grade or higher
Varicella (Chickenpox)*	2 doses at or after 12 months of age or Current lab immunity or History of varicella disease	

During disease outbreaks, incompletely vaccinated students may be excluded from school. Parents and guardians choosing to decline vaccines must obtain a certified non-medical waiver from a local health department. Read more about waivers at www.Michigan.gov/Immunize.
*If the student has not received these vaccines, documented immunity is required.
All doses of vaccines must be valid (correct spacing and ages) for school entry purposes.

MDHHS Michigan Department of Health & Human Services

Updated December 11, 2019

Marysville Public Schools

"Every student will excel, both personally and for the benefit of humanity."

495 East Huron BLVD • Marysville, MI 48040 • OFFICE: 810.364.7731 • FAX: 810.364.3150

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 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 disease. 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 record 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 disclosure of information from his or her education records.

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

I authorize Marysville Public Schools 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: _____ DOB: _____

Signature of Parent/Guardian
or Eligible Student: _____ Date: _____

Printed Parent/Guardian Name: _____

MISSION

"Personalize learning for every student through rigor, relevance and relationships."

Marysville Public Schools

"Every student will excel, both personally and for the benefit of humanity."

495 East Huron BLVD • Marysville, MI 48040 • OFFICE: 810.364.7731 • FAX: 810.364.3150

MISSION

"Personalize learning for every student through rigor, relevance and relationships."

Marysville Public Schools

"Every student will excel, both personally and for the benefit of humanity."

Prior Care Information

Dear Parent/Guardian,

We would like to have the most complete information about the children enrolling in our kindergarten and early childhood programs. Please complete the following information about your child. Thank you!

School District and School: _____

Child's Name (first, middle, last): _____

PLEASE PRINT

Child's Date of Birth:_____

What was your child's primary form of care in the last year? (Check up to 3 relevant choices). If the child was primarily at home during the last year, please check **No Prior Care**.

- ❑ **Great Start Readiness Program (GSRP)** **(State funded program age 4 by Sept 1st)**
- ❑ **Head Start** **(Federally funded program ages 3 & 4)**
- ❑ **Early Childhood Special Education Classroom** **(School based preschool for special needs students with an IEP)**
- ❑ **Young Fives/Developmental Kindergarten** **(Plan is for child to attend regular Kindergarten next year)**
- ❑ **Child Care-Home Based** **(Operated out of a private home)**
- ❑ **Private Child Care Center** **(Commercial business that may be independent or part of a chain)**
- ❑ **Registered Family/Relative Child Care** **(Family/relative care provider receiving state assistance to provide care)**
- ❑ **Tuition-Based Preschool** **(Full or half day of instruction and learning)**
- ❑ **No Prior Care Program** **(Stay at home for care)**
- ❑ **Kindergarten** **(Child has been retained for a second year of kindergarten)**

OFFICE USE ONLY

Homeroom Teacher _____

495 East Huron BLVD • Marysville, MI 48040 • OFFICE: 810.364.7731 • FAX: 810.364.3150