Building Name: _____ **GSRP** **Age** _____

REGISTRATION FORM **OAK PARK SCHOOL DISTRICT** **(248)336-7708 or (248)336-7707**

Please return to the Board of Education Office at 13900 Granzon, Oak Park, Michigan 48237-2674

Today's Date _____

Student Name: _____
First Middle Last

Does your child have a current IEP for Special Education?
_____ Yes _____ No

Entering Grade: _____ **Gender:** _____ Male
_____ Female

Ethnicity: (Choose one) _____ Hispanic or Latino
_____ Not Hispanic or Latino

Race: *(choose one or more regardless of ethnicity)*
_____ Black or African American
_____ Asian
_____ White
_____ American Indian or Alaskan Native
_____ Native Hawaiian or Other Pacific Islander

Birthdate: _____
Month/Day/Year

Birth Place: _____
Hospital: _____

English is my child's native tongue: ____ **Yes** ____**No**
English is the primary language spoken in home: ____ **Yes** ____**No**
If NO what language _____
Date the Student entered the USA_____

District of Residence: _____

Hm Address: _____
Number/Street Name Apt

_____
City State Zip

Primary Email: _____

Primary Phone #: _____ **Cell Phone: Y**_____ **N**_____

FOR OFFICE USE ONLY:

Entry Date: _____

ID: _____

Birth Certificate: _____ **Yes** _____ **No**
_____**30 Day Aff, Expires**_____
_____**Perm Aff with supporting documents**

Immunization Records: _____**Yes** _____**No**
Health (KNDG & GSRP): ____**Yes** ____**No**

Lunch Survey: _____ **Yes** _____ **No**
Sent To FS: _____ **Yes** _____ **No**

Attached:
Copy of Parent DL _____
RES - Copy of Own/Lease _____
RES - Copy of 2 Bills_____
Affidavit (if living with someone) _____
NON-RES - Copy of 2 PC Mail _____
NON-RES - School of Choice Form _____

Behavior Report Rcvd_____
Last Report Card _____
Transcript(s)_____

GSRP - Income Verification _____
FPL%_____

IEP attached _____
Copied for Specialized Services_____

Court Document_____

PRIMARY CONTACTS

Parent/Guardian #1: _____

Work Phone #: _____ **Cell #:** _____

Lives with Student: Yes____ **No**_____ **Relationship to Student:** _____ **Active Military?**_____

Parent/Guardian #2 : _____

Work Phone #: _____ **Cell #:** _____

Lives with Student: Yes____ **No**_____ **Relationship to Student:** _____ **Active Military?**_____

Secondary Email: _____

Parent/Guardian Signature **Date** **Rev 04/18**

Has your child *ever received* any Special Education? Yes ___No ____ If yes please check all that apply.

Received special education services:

_____ Speech _____ HI - Hearing Impaired ____LD - Learning Disabled

_____ Social Worker _____ VI - Visually Impaired ____EI - Emotionally Impaired

_____ EMI - Educable Mentally Impaired _____ Other_____

Other services:

_____ Title 1 _____ Section 504 Plan _____ Migrant Education Services

_____ Bilingual Services/Limited English Proficient Services

_____ Gifted/Talented Program (school sponsored); Type (ex. Music, Art, Math, Science) _____

_____ Alternative Education; Type_____

Emergency Medical Conditions/Problems: Check ALL that apply

____ Nothing known (1)
____ Medical waiver (2)
____ Rheumatic (3)
____ Cardiac (4)
____ Hemophiliac (5)
____ Diabetic (6)
____ Aspirin allergy (7)
____ Penicillin allergy (8)
____ Iodine allergy (9)
____ Mult. Allergy (10)
____ Epileptic (11)
____ Contact lenses (12)
____ Special blood condition (13)
____ Sulpha allergy (14)
____ Muscle weakness (15)
____ Headaches (16)
____ Wears glasses (17)
____ Bee sting (18)
____ Asthma (19)
____ Nose bleeds (20)
____ No medication, religious (21)
____ Check health card (22)
____ Attention deficit disorder (23)
____ Hearing Problems (24)
____ Takes medication regularly at school (25)

Other _____

Please List other children who reside in the home:

Name	Birthdate	Grade	School

Please Describe the student's current living situation (MUST check one):

_____ **Shelter**
_____ **Runaway**
_____ **Foster Care**
_____ **Temporarily doubled up with relatives or friends**
_____ **Hotel/Motel**
_____ **Street, car, abandoned building, campground**
_____ **Unaccompanied Minor**
_____ NONE of the above

Parent/Guardian **Date**

Head Start Waiver Form

The family referenced below applied for admission to our Great Start Readiness Program (GSRP) and was determined to be Head Start Eligible. After reading and signing the Head Start information sheet they indicated they were interested in placement in GSRP.

Date Form is Completed	
Referring Program Information	
District/PSA/Agency	
Contact Person	
Telephone	
Fax	
Email	
Family Contact Information	
Parent Name(s)	
Child Name	
Child Date of Birth	
Mailing Address	
Telephone	
Email	

My Signature indicates I would like my child to attend GSRP. I have read and signed the Head Start information sheet.

Parent Signature _____ Date _____

Please send or email this form to:

Connie Sidor (North Oakland)
Phone: 248-409-1642
Fax: 248-724-2042
conniesidor@gmail.com

Kelly Isrow (South Oakland)
248-409-1659 or 586-864-4836
248-724-2042
kellyi@olhsa.org

CHILD INFORMATION RECORD

State of Michigan Department of Human Services - Bureau of Children and Adult 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
Father/Legal Guardian's Name	Home Phone ( )	Mother/Legal Guardian's Name		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 (optional)		
Employer Name	Work Phone ( )	Employer Name		Work Phone ( )
Name of Child's Physician or Health Clinic		Physician's or Health Clinic's Phone Number ( )		
Hospital Preferred for Emergency Treatment (optional)				
Allergies, Special Needs and Special Instructions (Attach additional sheets, if necessary)				

BCAL-3731 (Rev. 7-12) Previous editions 9-09, 3-08, 10-07, & 1-06 may be used until 12/31/13.

See Reverse Side

Emergency Contact & Release of Child: List all individuals including parents/legal guardians, in order of preference, to be contacted in an emergency. If possible, include at least one person other than the parents/legal guardians to be contacted in an emergency and to whom the child can be released. The second phone number column can be left blank. (If more individuals, attach additional sheets.)

1.	( )	( )
2.	( )	( )
3.	( )	( )

Release of Child Only: List all individuals, other than the parents/legal guardians, to whom the child may be released. (If more individuals, attach additional sheets.)

1.	( )	2.	( )
3.	( )	4.	( )

I give permission to _____ , licensed by the Department of Human Services
(Provider's Name)

to secure emergency medical and/or emergency surgical treatment for the above named minor child while in care.

Signature of Parent or Guardian	Date Signed

Date Card Reviewed	Parent or Legal Guardian Initials	Date Card Reviewed	Parent or Legal Guardian Initials	Date Card Reviewed	Parent or Legal Guardian Initials	Date Card Reviewed	Parent or Legal Guardian Initials

Department of Human Services (DHS) will not discriminate against any individual or group because of race, religion, age, national origin, color, height, weight, marital status, sex, sexual orientation, gender identity or expression, political beliefs or disability. If you need help with reading, writing, hearing, etc., under the Americans with Disabilities Act, you are invited to make your needs known to a DHS office in your area.

AUTHORITY: 1973 PA 116
COMPLETION: Required
PENALTY: Rule Violation Citation

BCAL-3731 (Rev. 7-12) Previous editions 9-09,3-08, 10-07, & 1-06 may be used until 12/31/13.

Great Start Readiness Program (GSRP)
INCOME ELIGIBILITY GUIDELINES
For Fiscal Year 2018-2019

Effective July 1, 2018 to June 30, 2019															
Household Size	Federal Poverty Level* 1-50%			Federal Poverty Level** 51-100%			Federal Poverty Level 101-150%			Federal Poverty Level 151-200%			Federal Poverty Level 201-250%		
	ANNUAL	MONTH	WEEK	ANNUAL	MONTH	WEEK	ANNUAL	MONTH	WEEK	ANNUAL	MONTH	WEEK	ANNUAL	MONTH	WEEK
48 CONTIGUOUS UNITED STATES, DISTRICT OF COLOMBIA, GUAM AND TERRITORIES															
1	6,070	506	117	12,140	1,012	233	18,210	1,518	350	24,280	2,023	467	30,350	2,529	584
2	8,230	686	157	16,460	1,372	317	24,690	2,058	475	32,920	2,743	633	41,150	3,429	791
3	10,390	866	197	20,780	1,732	400	31,170	2,598	599	41,560	3,463	799	51,950	4,329	999
4	12,550	1,046	241	25,100	2,092	483	37,650	3,138	724	50,200	4,183	965	62,750	5,229	1,207
5	14,710	1,226	283	29,420	2,452	566	44,130	3,678	849	58,840	4,903	1,132	73,550	6,129	1,414
6	16,870	1,406	324	33,740	2,812	649	50,610	4,218	973	67,480	5,623	1,298	84,350	7,029	1,622
7	19,030	1,586	358	38,060	3,172	732	57,090	4,758	1,098	76,120	6,343	1,464	95,150	7,929	1,830
8	21,190	1,766	398	42,380	3,532	815	63,570	5,298	1,223	84,760	7,063	1,630	105,950	8,829	2,038
For each additional family member add	2,160	180	42	4,320	360	83	6,480	540	125	8,640	720	166	10,800	900	208

*Families at or below 100% of poverty must be referred to Head Start. Enrollment in GSRP is deferred until the referral process is complete.

**Head Start grantees that demonstrate all children at 100% are being served may receive approval to serve up to 35% of their enrolled children from families with incomes up to 130% of the federal poverty level.

Family Information

(This information is necessary to determine child's eligibility and will be kept confidential.)

# of persons in the household _____ (verification documentation required)

1 Family Income Verification Documentation Required / Attach Income Eligibility Form

For office use only: FPL 50% _____ FPL 100% _____ FPL 150%_____
FPL 200% _____ FPL 250% _____ FPL above 250%_____

2 _____ Child has a diagnosed disability or identified developmental delay (has current IEP)
(Copy of IEP must be submitted for verification and to best plan for and support child.)

3 _____ Child has severe or challenging behaviors

4 _____ Child's primary home language is something other than English
My child can speak the following languages: _____

5 _____ Highest Education level Completed (Indicate Mother and/or Father)
_____less than 12th grade
_____GED Received
_____High School Graduate
_____Technical Training
_____College Courses
_____College Graduate

6 Abuse and/or Neglect of Child or Parent
_____ Someone in our home was a victim of physical, sexual or emotional abuse or neglect.
_____ There is a history of substance abuse in our family (alcohol, drugs, prescription drugs)

7 Environmental Factors (Documentation required if any of the below are checked.)
_____ Parental loss due to death, divorce, incarceration, military service, or absence.
_____ Child's situation is negatively affected by issues related to a sibling (chronic illness, disability, death).
_____ Teenage parent at birth of any of the children in the family.
_____ Family is without stable housing (homeless, living in a shelter, living with another family has frequent changes of address).
_____ Prenatal or postnatal exposure to toxic substances known to cause developmental delays.

_____ I certify that the information given on this application is true and accurate to the best of my knowledge.
(parent initial)

Parent / Guardian Signature: _____ Date:_____

Parental Medical Self Certification

I certify that my child, _____is in good health with no known activities restrictions noted. I also state that my child's immunization is current and up to date and on file with the school in which this center is housed.

If my child is exempt from having immunization shots that the waiver is on file at the school.

This information is true to the best of my knowledge and that any restrictions are listed below.

Please list any known restrictions below:

1._____

2._____

3._____

4._____

5._____

_____Parent Signature

This information in being requested in order for our center to be in compliance with the State of Michigan Child Care rules R 400.8143(8 a-c), effective Jan. 2, 2014.

Verification of Varicella (Chicken Pox) Disease (GSRP)

The Michigan Department of Community Health now requires all children enrolled in Head Start, GSRP, preschool or childcare programs to show proof of having received the varicella (chicken pox) vaccine or provide proof that the child had a case of chicken pox.

Children who have had varicella (chicken pox) do not need to receive the vaccine, however a signed statement of verification is required when the child enters Head Start, GSRP, preschool or child care.

If your child has NOT had a case of varicella (chicken pox) you do not need to complete this form. You will however need to show proof of your child's vaccination for varicella (chicken pox). This proof will appear on your child's vaccination record.

If your child HAS had a case of chicken pox, please complete the verification statement below.

I verify that my child _____ ***has had a case of varicella (chicken pox).***
(child's name)

Parent/Guardian Signature _____ **Date**_____

Oak Park School District

ADMINISTRATION BUILDING: 13900 GRANZON • OAK PARK, MICHIGAN 48237-2799
TELEPHONE: (248) 336-7708 • TELEFAX (248) 336-7738

Rebecca Luddington
Student Services Coordinator

WAIVER AND RELEASE FOR ELECTRONIC AND PRINT MEDIA

I, _____, hereby consent to the use of statements or responses made by my child if interviewed by representatives of any electronic or print journal, magazine, newspaper, and/or internet publication and any photograph taken of my child and used in any such publication for educational purposes.

I also hereby consent to the use of my child's name, recorded likeness or voice on videotape, audiotape, or any other electronic medium by the Oak Park School District, its staff, its agents, employees of the Oakland Intermediate School District, and any other authorized parties whether for live or delayed transmission for educational purposes.

I hereby irrevocably grant to authorized parties permission to speak with, interview and/or photograph, videotape or audiotape my child, transmit and/or retransmit his/her name, voice and/or appearance in a print/electronic program/production, in whole or in part, for any purpose except as a commercial advertisement, for any commercial enterprise, or for nonprofit endeavor.

Further, I hereby waive and forego any compensation for the use of material, including photographs, gained from an interview, or for my child's voice and/or appearance on the transmission or retransmission of a print/electronic program/production. I hereby release the Oak Park School District, its staff, its agents, employees of Oakland Intermediate School District, and any other authorized parties from liability arising from creation and/or use of the material created or furnished by me or others in connection with the production of the material.

Student's Name _____

Parent/Guardian Signature _____

Date _____

Oak Park Schools
13900 Granzon
Oak Park, MI 48237
Aric Weinclaw
248-336-7757

Community Eligibility Provision Survey
Free Breakfast and Lunch Program

Return survey to school office, mail, or e-mail to awiencl@oakparkschools.org

SCHOOL USE ONLY
Approved for:
1 ☐ 2 ☐

Oak Park Schools is participating in the Community Eligibility Provision (CEP) under the National School Lunch Program. Under CEP, all children in the school will receive a breakfast/lunch at no charge regardless of completion of this form. However, to determine eligibility for state and federal programs that you school building can qualify for, please complete, sign and return this application to your school building or mail to Aric Weinclaw at the above address.

If any member of your household receives Food Assistance Program (FAP), Family Independence Program(FIP), or FDPIR, provide the name and case number for the person who receives benefits. Bridge Card Numbers and Medicaid Numbers are NOT ACCEPTABLE case numbers.

Name: _____ Case Number: _____

INSTRUCTIONS: Complete survey and return to your child's school or mail to the address listed above.

These sections must be completed by the head of household or designee.

1. SIZE OF FAMILY - Indicate the total number of individuals living in your household, including all adults and children _____

2. STUDENT INFORMATION – Complete for each student Pre-K through 12th Grade

Last Name	First Name	Birth Date MM-DD-YYYY	School	Identify H if Homeless M if Migrant R if Runaway F if Foster
1.				
2.				
3.				
4.				
5.				
6.				
7.				
8.				

If you need additional lines, attach a second sheet to this survey or attach a copy of this survey clearly marked as a Page 2.

3. TOTAL MONTHLY HOUSEHOLD INCOME – Report income for all members of household excluding Foster Children. If you have reported a case number above, you do not need to fill in this section. Simply sign and date form.

Type of Income	Income	Circle if No Income
1. Gross Monthly Earnings: Wages, Salary, Commissions	$	
2. Monthly Welfare Payments, Child Support, Alimony	$	
3. Monthly Payments from Pensions, Retirement, Social Security	$	
4. Monthly Dividends or Interest on Savings	$	
5. Monthly Worker's Compensation, Unemployment, Strike Benefits	$	
6. Other Monthly Income (SSI, VA, Disability, Farm, other)	$	
Total Monthly Household Income (Add lines 1-6)	$	

4. SIGNATURE - If Income Section is completed, the adult signing the form must also list the last four (4) digits of his or her Social Security Number or check the "I do not have a Social Security Number" box below.

I certify (promise) that all information on this application is true and that all income is reported. I understand that the sponsor will be eligible for certain federal and/or state funds based on the information I give. I understand that sponsor officials may verify (check) the information. I understand that if I purposely give false information, my child may lose benefits and I may be prosecuted.

Sign Here: X_____ Print Name: _____ Date: _____

Last Four (4) Digits of Adult Social Security Number: XXX-XX-_____ ☐ I do not have a Social Security Number

Address City Zip Code

Home Phone	Work Phone	Email Address
		By providing your email address, you may be contacted via email by the district.

Child's Name: _____

Parent's Name: _____

Acknowledgement of Application to GSRP

I submitted an application for my child to attend Oak Park Schools GSRP Pre-K Program.

I understand that:

- I will not find out if my child has been admitted into the GSRP program until at least July 1, and maybe not until as late as September 15.

- Entrance into the GSRP Program is based on a series of eligibility factors and/or family income and not necessarily based on the time of submission.

Parent Signature

_____Date_____

Staff Signature:

_____Date_____

This material was developed under a grant awarded by the Michigan Department of Education.