CEDAR SPRINGS PUBLIC SCHOOLS

Cedar Trails Elementary School

The Trail to Success Starts Here

2022-2023 PRESCHOOL ENROLLMENT PACKET

Enrollment begins March 7, 2022

More information available at bit.ly/CSPSPreschool

LEARNING OPPORTUNITIES

3 YEAR OLDS

Head Start

HeadStart

Monday-Thursday

Full Day Free*

CEDAR TRAILS ELEMENTARY

Tuition Offerings

Tuesday and Thursday

9 a.m. - 11:30 a.m.

$120/month($960/year)

3 & 4 YEAR OLDS

CEDAR TRAILS ELEMENTARY

Tuition Offerings

Monday, Wednesday, Friday

9 a.m. - 12:30 p.m.

$228/month ($1824/year)

If enough interest, afternoon care may be offered for an additional fee. Check our website for updates.

4 YEAR OLDS

Great Start Readiness Program

Michigan's Nationally Recognized Pre-K Program

Great Start Readiness Program

Monday-Thursday

Full day Free*

CEDAR TRAILS ELEMENTARY

Tuition Offerings

Monday-Thursday

8:40 a.m. - 3:20 p.m.

$350/month ($2800/year)

Children must be 3 or 4 by September 1, 2022 and be potty trained.

*See if you qualify for free preschool online at preschool.kentisd.org/FAQ

HOW TO ENROLL:

CEDAR TRAILS ELEMENTARY This tuition based preschool program is offered through Cedar Springs Public Schools. To enroll, visit bit.ly/CSPSPreschool

Great Start Readiness Program — Michigan's Nationally Recognized Pre-K Program

The Great Start Readiness Program (GSRP) is a state-funded free preschool program for qualifying four-year-old children. To enroll, visit preschool.kentisd.org/Apply

Head Start

Head Start serves preschool children, ages 3 and 4 years old in classrooms located on the Cedar Springs Public Schools campus. To enroll, visit hs4kc.org/

We Will. We Can. We Are. TOGETHER

616-696-9884
ctoffice@csredhawks.org
cedartrails.csredhawks.org

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Cedar Springs Preschool Programs

Tuition Preschool VS Great Start Readiness Program (GSRP)

	Tuition	GSRP
Cost	Set Tuition	Free/Prorated
Location	Cedar Trails Elementary	Red hawk Elementary
Enrollment	Availability	Application
Registration Fee	$35	None
Age	3 and 4	4
Schedule	Half days/Full Days	Full Days
Busing	Possibly	Guaranteed
Lunch	Family Provided	School Provided
Registration	Paper packet	Online/Phone

Tuition Preschool

Cedar Trails Tuition Preschool is a preschool program for 3 or 4-year-olds at Cedar Trails Elementary School. The classes are based on availability and will fill up with first completed enrollment paperwork and $35 registration fee turned in to the office at Cedar Trails Elementary School. Tuition can be paid in full or paid in monthly installments. Busing transportation may be possible, but is not guaranteed. We have half day classes offered along with full day classes. If your child is in the full day class, they will be required to bring a packed lunch every day or purchase a school lunch.

Great Start Readiness Program (GSRP) Preschool

GSRP is a preschool program for 4-year-olds at Red Hawk Elementary School. The availability is based on income and family needs, placing lower income and high needs families first, then continuing until all classes are full. The enrollment application is online or by phone with Kent ISD, they will be your contact for all questions and enrollment concerns. Kent ISD will contact you if you are accepted in their preschool program, and follow up with you to start the school year. Because there are several factors that impact acceptance other than income, it is suggested that everyone apply for this Free/Prorated Program. This application process does take several months, you may not get a response until late July or even August. Busing transportation is offered to every student. GSRP has 4 full days of classes offered with free school lunch for every student.

You can call Cedar Trails Elementary School if you have any questions at 616-696-9884. Or you can call Kent ISD at 616-447-2409 with any questions about the GSRP program.

Great Start Readiness Program (GSRP)
INCOME ELIGIBILITY GUIDELINES
for Fiscal Year 2021-22
Effective July 1, 2021 to June 30, 2022

Household Size	Quintile #1 Federal Poverty Level* 1 - 50%			Quintile #2 Federal Poverty Level* 51 - 100%			Quintile #3 Federal Poverty Level 101 - 150%			Quintile #4 Federal Poverty Level 151 - 200%			Quintile #5 Federal Poverty Level* 201 - 250%		
	ANNUAL	MONTH	WEEK	ANNUAL	MONTH	WEEK	ANNUAL	MONTH	WEEK	ANNUAL	MONTH	WEEK	ANNUAL	MONTH	WEEK
1	6,440	537	124	12,880	1,074	248	19,320	1,610	372	25,760	2,147	496	32,200	2,684	620
2	8,710	726	168	17,420	1,452	335	26,130	2,178	503	34,840	2,904	670	43,550	3,630	838
3	10,980	915	212	21,960	1,830	423	32,940	2,745	634	43,920	3,660	845	54,900	4,575	1,056
4	13,250	1,105	255	26,500	2,209	510	39,750	3,313	765	53,000	4,417	1,020	66,250	5,521	1,275
5	15,520	1,294	299	31,040	2,587	597	46,560	3,880	896	62,080	5,174	1,194	77,600	6,467	1,493
6	17,790	1,483	343	35,580	2,965	685	53,370	4,448	1,027	71,160	5,930	1,369	88,950	7,413	1,711
7	20,060	1,672	386	40,120	3,344	772	60,180	5,015	1,158	80,240	6,687	1,544	100,300	8,359	1,929
8	22,330	1,861	430	44,660	3,722	859	66,990	5,583	1,289	89,320	7,444	1,718	111,650	9,305	2,148
For each additional family member add	2,270	189	44	4,540	378	87	6,810	568	131	9,080	757	175	11,350	946	219

*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.

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2022-2023Preschool Student Enrollment

Which Preschool Tuition Class would you like to enroll your child in?

☐ **Tuesday/Thursday**	☐ **Monday/Wednesday/Friday**	☐ **Monday-Thursday**
9 a.m. – 11:30 a.m.	9a.m. – 12:30 p.m.	8:40 a.m. – 3:20 p.m.
$120/month	$228/month	$350/month
	I am interested in wrap around care? ☐**Yes** ☐**No**	

Student Information
Last Name _____ First Name_____ Middle _____

Physical Address
Street _____ City _____ State_____ Zip _____

Mailing Address
Street _____ City _____ State_____ Zip _____

Phone Number (_____) _____-_____

Date of Birth: ____/____/_____ (MM/DD/YYYY) **Gender:** Male ☐ Female☐ Grade Level _____

Last School Attended: _____

Ethnicity required by state (please check one): ☐ Non-Hispanic/Latino ☐ Hispanic/Latino

Race required by state (please check one):
☐ American Indian/Alaska Native ☐ Asian
☐ Black/African-American ☐ Native Hawaiian/Pacific ☐ White

Father
Last Name _____ First Name_____ E-Mail _____
Phone (____) _____-_____ Phone (____) _____-_____

Mother
Last Name _____ First Name_____ E-Mail _____
Phone (____) _____-_____ Phone (____) _____-_____

Guardian
Last Name _____ First Name_____ E-Mail _____
Phone (____) _____-_____ Phone (____) _____-_____
Resides With
Last Name _____ First Name_____

Over →

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Siblings

Siblings Name	Grade	Age

Emergency contacts

#1 Mother
Last _____ First _____ Phone (____) _____-_____

#2 Father
Last _____ First _____ Phone (____) _____-_____

#3 Relationship _____
Last _____ First _____ Phone (____) _____-_____

#4 Relationship _____
Last _____ First _____ Phone (____) _____-_____

#5 Relationship _____
Last _____ First _____ Phone (____) _____-_____

If your child receives any special services, please notify the school office.

We suggest anyone interested in the 4-year-old preschool, please consider applying for the Great Start Readiness Program.

Legal Parent / Guardian Signature _____ **Date** ___/_____/_____

CHILD INFORMATION RECORD

State of Michigan - Department of Licensing and Regulatory Affairs - Child Care Licensing

Instructions: Unless otherwise indicated, all requested information must be provided. If the information is not known or does not apply, "unknown" or "none" is the required response. A blank field, a line through a field or "N/A" are not acceptable responses.

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 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.**	**( )**

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 Legal Guardian Initials

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.

This form can be signed electronically by selecting the "I Accept" box below and typing your name on the signature line or you can print and sign the form manually. The form can be returned to us securely by saving the form and attaching the saved form to My Messages in the Patient Portal, or you can mail, fax or bring the the form to the office.

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:

☐ *I Accept. By selecting the "I Accept" button and typing your name below, you are signing this Agreement electronically.*

_____ / /

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 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: / /

DATE OF BIRTH (mm/dd/yy)
/ /

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.

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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.

State Board of Education Approved
Home Language Survey*

The Cedar Springs Public Schools 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. Would you please help by providing the following information?

Thank you very much for you cooperation.

Name of Student _____ Grade _____ Age _____

1. Is your child's native language other than English?

❑ Yes ❑ No What is that language? _____

2. Is the primary language[1] used in your child's home or environment a language other than English?

❑ Yes ❑ No What is that language? _____

_____ _____ _____
Signature of Parent or Guardian Address Date

[1] "Primary language" means the dominant language used by a person for communication.
*Translation of this survey form in Spanish, Arabic, French, Italian, and Ojibwa is available at the Office of Field Services at 517-373-6066.

Encuesta Sobre El Idioma Del Hogar

El necesita informatción acerca de los idiomas que sus estudiantes hablan o entienden; y acerca de los languages en que han nacido aunque aparentemente no los hablen o entiendan. Esta información sobre su hijo(a) será usada por el distrito escolar para determinar el núde estudiantes que pueden calificar para recibir educación bilingüe de acuerdo a las Secciones 380.1151 – 380.1158 del Código Escolar de 1976, Ley sobre Educación Bilingüe de Michigan. Por favor responda a las preguntas que abajo se hacen.

Muchas gracias por su cooperación.

Nombre del estudiante _____ Grado _____ Edad _____

1. ¿Es el idioma nativo[1] de su hijo(a) otro aparte del inglés?

❑ Si ❑ No ¿Cuál es ese idioma? _____

2. ¿Es el idioma principal[2] usado en la casa o "barrio" de su hijo(a) un idioma diferente al inglé?

❑ Si ❑ No ¿Cuál es ese idioma? _____

_____ _____ _____
Firma del Padre o Guardián Domicilio Fecha

[1] Idioma nativo significa "El idioma en que el/la niño(a) primero comenzó a entenderse con sus padres."
[2] "Idioma principal" significa "el idioma dominante usado por una persona para comunicarse."

Cedar Springs Public Schools
Student Medical / Field Trip Information

Excellence & Innovation

_____

Child's Last Name First Name Grade

NOTE: This form is required for all students. This information is requested so that the school and parent can work together to meet the physical, intellectual and emotional needs of the child. The form will be filed in the student's cumulative record and the information will be kept confidential.

❑ **YES** ❑ **NO** **My child has permission to travel to and from the field trip in a school vehicle driven by a staff member this school year.**

Check all of the following which apply to your child. Please use the comment section for explanations or comments as you feel necessary.

Yes	No		Explanation or Comment
		ADHD / ADD	
		Asthma	Inhaler:
		Epilepsy/Convulsions/Seizures	
		Allergies	Specify:
		Diabetes	

Please indicate medication which your child takes on a regular basis:
Medication_____ Reason for the medication: _____

Please indicate other information of which your child's teacher should be aware: _____ ____

_____

_____

For illness or accident when parent cannot be reached, please contact:
(Please use Emergency Contact Information from Student Enrollment Form)

Emergency contact #1 _____ Relationship _____
(other than Mother & Father)
Phone Number _____ *(area code) + phone number*

Emergency contact #2 _____ Relationship _____
(other than Mother & Father)
Phone Number _____ *(area code) + phone number*

Emergency contact #3 _____ Relationship _____
(other than Mother & Father)
Phone Number _____ *(area code) + phone number*

MEDICATION POLICY:

- The school cannot dispense any kind of medication without written parent/guardian consent.
- A permission form for prescribed medication must be completed by the parent/guardian and physician/authorized prescriber.
- Medication must be taken to the office and dispensed from the office.
- Medication will be kept in a locked cabinet or drawer.

In the event that my child needs to take medication during the school day, I give my permission for a designated member of the school staff to dispense the medication according to the written directions.

_____ _____ _____
Signature of **Legal** Parent or Guardian Contact Phone Number Date

_____
Print Name