



**SEMINOLE ACADEMY PRESCHOOL**  
1500 MULBERRY STREET • MOUNT CLEMENS, MICHIGAN 48043  
(586) 461-3985 (586) 461-3986  
LEW STASS, GSRP COORDINATOR

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## Enrollment Checklist (GSRP)

### GSRP Enrollment Paperwork:

- ☐ Student Enrollment/Emergency Card
- ☐ Child Information Record
- ☐ Student Transportation Request Form
- ☐ Statement of Varicella Disease
- ☐ Home Language Survey
- ☐ Network and Internet Access Agreement
- ☐ Concussion Awareness Acknowledgement
- ☐ Household Information Survey
- ☐ Health Appraisal
- ☐ ASQ Consent Form
- ☐ GSRP Handbook
- ☐ GSRP Notification of Licensing Notebook

### Required Enrollment Documents:

- ☐ Birth Certificate  
Must be the original certificate.
- ☐ Parent Driver's License/Valid State Photo ID
- ☐ Current Immunization Records\* or current Waiver  
Must be given prior to first day of school
- ☐ 2 Current Proofs of Residency:  
Current lease agreement, current mortgage statement,  
current utility bill, current property/tax statements  
(These all must include parent name, address and date)
- ☐ Income- W2, 2 paystubs, Unemployment wages, alimony,  
food stamps, etc. (Any form of household income)

### Other Legal Documents:

- ☐ Custody, guardianship or foster care paperwork, ALL must  
have content dates and signatures.

*\*Immunizations are available through your family doctor or Macomb County Health Dept.  
at a cost.*





☐ Medical Alert

Mount Clemens Community School District  
STUDENT ENROLLMENT/EMERGENCY FORM

- ☐ Mount Clemens High School  
☐ Mount Clemens Middle School  
☐ Seminole Academy

- ☐ King Academy ECSE  
☐ Great Start Readiness Pgm (GSRP)

School Year 20\_\_ - 20\_\_

Grade: \_\_\_\_\_

STUDENT INFORMATION

Student's Full Legal Last Name		First Name	Middle Name	Sex <input type="checkbox"/> M <input type="checkbox"/> F
Street Address		City, Zip Code		Home Phone
Student Email (if applicable):		Student Cell Phone (if applicable):		
Is the child's living arrangement <input type="checkbox"/> Permanent <input type="checkbox"/> Temporary <u>If Temporary Please Explain</u> : (ie. Motel, hotel, living with family/friends, shelter)				
Child's Date of Birth		Birth City and State <u>OR</u> if born outside U.S.A - Birth Country		
Name of Parent(s) or Guardians(s) with Whom Child Resides Female: _____ Male: _____				
Natural Parent's Marital Status <input type="checkbox"/> Married <input type="checkbox"/> Single <input type="checkbox"/> Divorced <input type="checkbox"/> Deceased <input type="checkbox"/> Separated				

RACE/ETHNIC BACKGROUND

Is your Child of Hispanic or Latino Origin? <input type="checkbox"/> Yes <input type="checkbox"/> No
What Race Is Your Child? <input type="checkbox"/> Black <input type="checkbox"/> White <input type="checkbox"/> Pacific Islander <input type="checkbox"/> Native American <input type="checkbox"/> Asian American <input type="checkbox"/> Other

PREVIOUS SCHOOL INFORMATION (For New Enrollments Only)

Former District	Former School	City, State
Was Child Expelled From The Previous School? <input type="checkbox"/> Yes <input type="checkbox"/> No		
Was Child Receiving Any of the Following Services? (Check at least one) <input type="checkbox"/> Speech/Language <input type="checkbox"/> Social Work <input type="checkbox"/> Special Education <input type="checkbox"/> 504 <input type="checkbox"/> Other: _____ <input type="checkbox"/> None		

PARENT/GUARDIAN INFORMATION

Natural Father / Legal Guardian (Full Legal Name) Last Name: _____ First Name: _____ Middle Initial: _____			
Address	City, State, and Zip Code	Resides with Student <input type="checkbox"/> Yes <input type="checkbox"/> No	Contact with Student* <input type="checkbox"/> Yes <input type="checkbox"/> No
Employer Name	Address (Street, City, State, Zip Code)		Work Phone
Cell Phone	Email	Are you a member active or inactive of Armed Forces? What branch??	
Natural Mother / Legal Guardian ( Full Legal Name) Last Name: _____ First Name: _____ Middle Initial: _____			
Address	City, State, and Zip Code	Resides with Student <input type="checkbox"/> Yes <input type="checkbox"/> No	Contact with Student* <input type="checkbox"/> Yes <input type="checkbox"/> No
Employer Name	Address (Street, City, Zip Code)		Work Phone
Cell Phone	Email	Are you a member active or inactive of Armed Forces? What branch??	

PLEASE COMPLETE INFORMATION ON REVERSE SIDE

\*As required by legal court documentation (Divorce Decree)

### OTHER CHILDREN IN FAMILY

Name	School	Grade	Age
Name	School	Grade	Age
Name	School	Grade	Age
Name	School	Grade	Age
Name	School	Grade	Age

### EMERGENCY INFORMATION

If your child has any special problems or conditions such as severe allergies, epilepsy, diabetes, asthma, or cardiac conditions, or is currently taking medication, please provide this information below.

Any Medical Conditions/Allergies	Medications Child is Taking
Does your child wear glasses? <input type="checkbox"/> Yes <input type="checkbox"/> No Does your child wear a hearing aid? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Family Physician	Physician's Phone
Local Hospital Preference	Address, City, and Zip Code

If my child becomes ill or injured, in the event that I cannot be notified, please proceed with first aid and emergency medical care for my child. ☐ Yes ☐ No

### EMERGENCY CONTACTS

*Responsible Step-parent, Relative, or Neighbor to Contact to release Student to if Parent(s)/Guardian(s) cannot be notified.*

1) Name	Relationship to Student	Home Phone
Street Address, City	Zip Code	Cell Phone
2) Name	Relationship to Student	Home Phone
Street Address, City	Zip Code	Cell Phone
3) Name	Relationship to Student	Home Phone
Street Address, City	Zip Code	Cell Phone

### PRESS/VIDEO RELEASE

Mount Clemens Community Schools has my permission to use photographs and/or videos of my child to show school activities (including yearbook) to the public. I understand that the personally identifiable information may be used at the discretion of the media, involving no financial compensation to Mount Clemens Community Schools, the student, or family of the student. I understand that I have the right to deny consent to the release of photographs and/or information specified above, by refusing to sign this form. If you consent, please sign here.

\_\_\_\_\_  
Parent or Guardian Signature

\_\_\_\_\_  
Date

If press/video release permission is denied, please write "DENIED" on the signature line above.

I CERTIFY THAT THE ABOVE INFORMATION ON THIS FORM IS TRUE AND CORRECT TO THE BEST OF MY KNOWLEDGE

Signature of  
Parents/Guardians



\_\_\_\_\_  
Father/Guardian

\_\_\_\_\_  
Date

\_\_\_\_\_  
Mother/Guardian

\_\_\_\_\_  
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		City		State	
		Zip Code				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.)							

AL-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.)

	(     )	(     )
	(     )	(     )
	(     )	(     )

**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.)

	(     )	2.	(     )
	(     )	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.

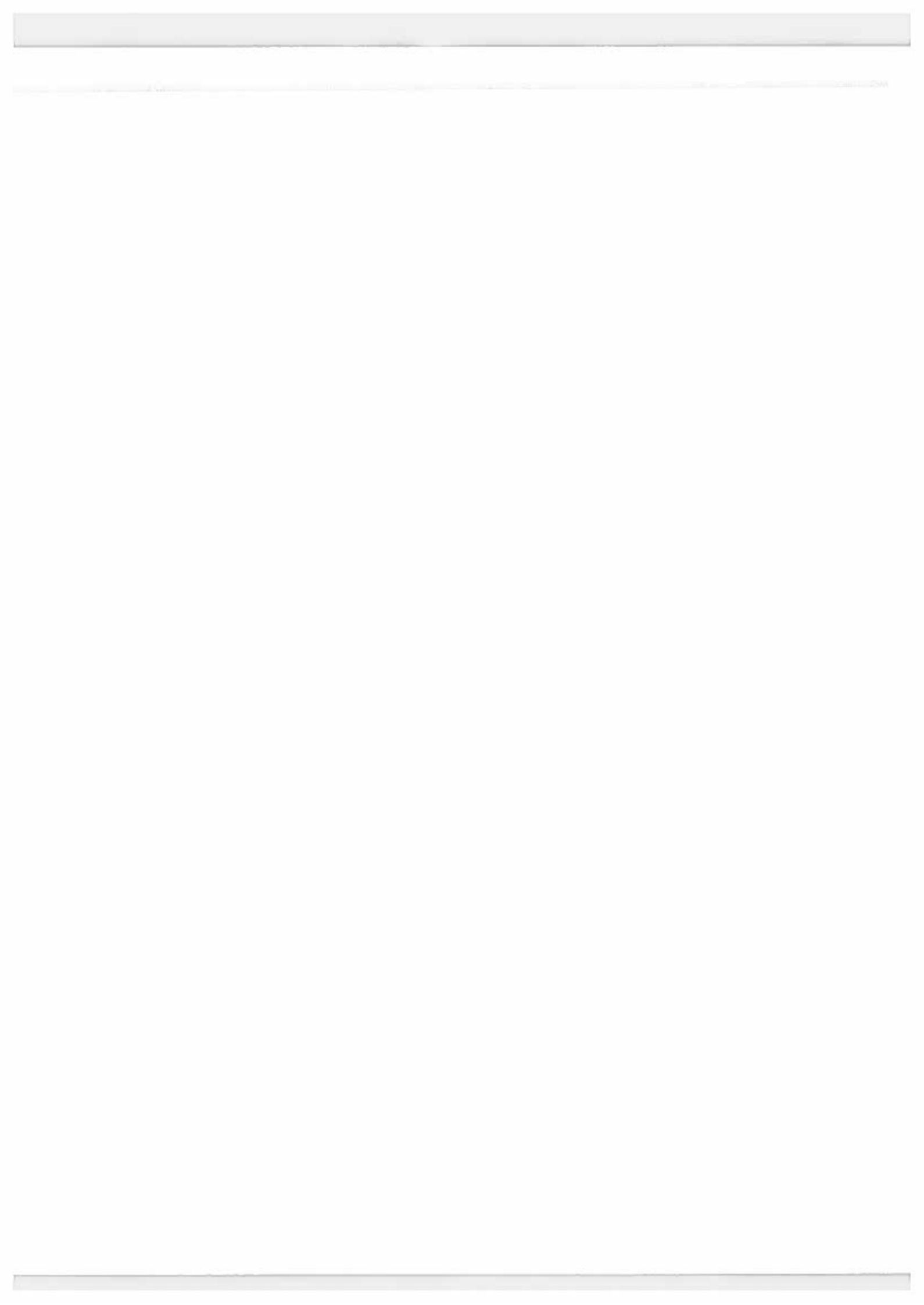
Signature of Parent or Guardian \_\_\_\_\_ Date Signed \_\_\_\_\_

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.

AL-3731 (Rev. 7-18) Previous edition 6-17 may be used.





## STUDENT TRANSPORTATION REQUEST FORM

➔ This form can be submitted online here: [Drivergent.com/MCCSBusRequest](http://Drivergent.com/MCCSBusRequest)

School: \_\_\_\_\_ Start Date: \_\_\_\_\_

Student Name: \_\_\_\_\_ Birth Date: \_\_\_\_\_ Grade: \_\_\_\_\_

Parent/Guardian Name(s): \_\_\_\_\_

Home Address: \_\_\_\_\_ City/Zip: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_

Parent/Guardian Email(s): \_\_\_\_\_

### Emergency Contacts & Pickups:

Name: \_\_\_\_\_ Phone: \_\_\_\_\_ Days: \_\_\_\_\_

Name: \_\_\_\_\_ Phone: \_\_\_\_\_ Days: \_\_\_\_\_

\* DO NOT release my child to: \_\_\_\_\_

List all important health and transportation needs staff should be aware of: \_\_\_\_\_

Are you New enrollee into the district, Moving within the district, or Re-Enrolling for transportation?

☐

NEW

☐

MOVING

☐

RE-ENROLLING

Did you receive district transportation last school year at this same home address? ☐ Yes ☐ No

If so, what was your bus stop location? \_\_\_\_\_

I agree that if my child is eligible for transportation, I will explain the bus rules to my child(ren). If they fail to abide by the rules or disobey the driver/aide's instructions, they will be subject to a write up and discipline that can include suspension from bus privileges for a period of time based on school policy, and I agree to honor the suspension.

\* Please note – new transportation requests may take up to 2-3 business days for processing before starting.

Parent/Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Received by School Staff: \_\_\_\_\_ Submitted to Transportation Dept.: \_\_\_\_\_







Health  
Department

## Statement of Varicella Disease **CHICKENPOX**

The Michigan Public Health Code Act 368 of 1978 Part 92 Immunization and Macomb County Immunization Regulations require all children admitted to any public, private, parochial, special education, alternative education, adult education, career/technical education, homeschool cooperative, virtual school or charter academy, childcare center, nursery school, preschool, camp, or any other organized care or educational facility operating in Macomb County to present a certificate indicating dates of all required immunizations.

Complete the portion below **only** if your child has had varicella (chickenpox) disease. **This form must be signed and witnessed at your child's school/childcare program.**

I certify my child: \_\_\_\_\_  
Last Name First Name M.I.

Birth Date Grade Date of School Enrollment

Has had varicella disease \_\_\_\_\_  
(When did varicella occur: Age or Date?)

Signature: \_\_\_\_\_ Date: \_\_\_\_\_  
(Parent or Legal Guardian)

Witnessed by: \_\_\_\_\_ Date: \_\_\_\_\_  
(School/Program Staff)

School District: \_\_\_\_\_

School/Childcare Program: \_\_\_\_\_

**PLACE THIS FORM IN THE CHILD'S PERMANENT RECORD**





# MOUNT CLEMENS COMMUNITY SCHOOLS

167 Cass Avenue, Mount Clemens, MI 48043 • [www.mtcps.org](http://www.mtcps.org) • PHONE (586) 469-6100 • FAX (586) 469-5569

## STATE BOARD OF EDUCATION APPROVED HOME LANGUAGE SURVEY\*

The Mount Clemens Community School 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. Would you please help by providing the following information?

Thank you very much for you cooperation.

Student's Name: \_\_\_\_\_ Grade: \_\_\_\_\_ Age: \_\_\_\_\_

Name of School Building: \_\_\_\_\_

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

\_\_\_\_\_ No \_\_\_\_\_ Yes

What is the Language? \_\_\_\_\_

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

\_\_\_\_\_ No \_\_\_\_\_ Yes

What is the Language? \_\_\_\_\_

3. What country was your child born in? \_\_\_\_\_

4. When did your child enter the United States? \_\_\_\_\_

"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.

\*All kindergarteners and any student new to this district.



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## DIRECCIÓN DE EDUCACIÓN DEL ESTADO APROBADA LENGUA CASERA SURVEY\*

El distrito escolar de la comunidad de Mount Clemens está recogiendo la información con respecto al fondo de la lengua de cada uno de sus estudiantes. Esta información será utilizada por el distrito para determinar el número de niños que deban ser instrucción bilingüe proporcionada según las secciones 380.1152-380-1157 del código de la escuela de 1995, ley de la educación bilingüe de Michigan. ¿Usted ayudaría por favor proporcionando la información siguiente? Muchas gracias por su cooperación.

Nombre del estudiante: \_\_\_\_\_

Grado: \_\_\_\_\_ Edad: \_\_\_\_\_

1. ¿Es la lengua materna de su niño una lengua con excepción de inglés?

No \_\_\_\_\_ Sí \_\_\_\_\_ ¿Cuál es la lengua? \_\_\_\_\_

2. ¿Es la lengua primaria usada en la ambiente familiar de su niño una lengua con excepción de inglés?

No \_\_\_\_\_ Sí \_\_\_\_\_ ¿Cuál es la lengua? \_\_\_\_\_

3. ¿En qué país era su niño nacido? \_\_\_\_\_

4. ¿Cuándo su niño entró en los Estados Unidos? \_\_\_\_\_

La "lengua primaria" significa la lengua dominante usada por una persona para la comunicación.

\*Translation of this survey form in Spanish, Arabic, French, Italian, and Ojibwa is available at the Office of Field Services at (517) 373-6066.

\*All kindergarteners and any student new to this district.



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## NETWORK AND INTERNET ACCESS AGREEMENT FOR STUDENTS

This agreement is entered into this \_\_\_\_\_ day of \_\_\_\_\_, 20\_\_\_\_ between \_\_\_\_\_  
(STUDENT'S NAME – Please Print) hereinafter referred to as Student, and the Mount Clemens Community School District,  
hereinafter referred to as District.

The purpose of this agreement is to provide Network (Electronic Mail and Electronic Bulletin Board) and Internet access, hereinafter referred to as Network, for educational purposes to the Student. As such, this access will (1) assist in the collaboration and exchange of information, (2) facilitate personal growth in the use of technology and (3) enhance information gathering and communication skills.

The intent of this contract is to ensure that students will comply with all Network and Internet acceptable use policies by the district. In exchange for the use of the Network resources either at school or away from school, I understand and agree to the following.

- A. The use of the Network is a privilege which may be revoked by the District at any time and for any reason. Appropriate reasons for revoking privileges include, but are not limited to, the altering of system software, the placing of unauthorized information, computer viruses or harmful programs on or through the computer system in either public or private files or messages. The District reserves the right to remove files, limit or deny access, and refer the Student for other disciplinary actions.
- B. The District reserves all rights to any material stored in files which are generally accessible to others and will remove any material which the District at its sole discretion, believe may be unlawful, obscene, pornographic, abusive, other otherwise objectionable. Students will not use their District approved computer account/access to obtain, view, download, or otherwise gain access to such materials.
- C. All information services and features contained on District or Network resources are intended for the private use of its registered users and any use of these resources for commercial, for profit or other unauthorized purposes (i.e. advertisements, political lobbying), in any form is expressly forbidden.
- D. The District and/or Network resources are intended for the exclusive use by their registered users. The student is responsible for the use of his/her account/password and/or access privilege. My problems which arise from the use of a Student's account are the responsibility of the account holder. Use of an account by someone other than the registered account holder is forbidden and may be grounds for loss of access privileges.
- E. Any misuse of the account will result in suspension of the account privileges and/or other disciplinary action determined by the District. Misuse shall include, but not be limited to:
  - Intentionally seeking information on, obtaining copies of, or modifying files, other data, or passwords belonging to other users.
  - Misrepresenting other users on the Network.
  - Disrupting the operation of the Network through abuse of the hardware or software.
  - Malicious use of the Network through hate mail, harassment, profanity, vulgar statements, or discriminatory remarks.
  - Interfering with others use of the Network.
  - Extensive use for non-curriculum related communication.
  - Illegal installation of copy righted software.
  - Unauthorized down-sizing, copying, or use of licensed or copyrighted software.
- F. Allowing anyone to use an account other than the account holder.
  - The use of District and/or Network resources are for the purpose of (in order of priority):
    - Support of the academic program
    - Telecommunications
    - General Information



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- G. The District and/or Network does not warrant that the functions of the system will meet any specific requirements the user may have, or that it will be error free or uninterrupted; nor shall it be liable for any direct or indirect, incidental or consequential damages (including lost data, information or time) sustained or incurred in connection with the use, operation, or inability to use the system.
- H. The Student will diligently delete old mail messages on a daily basis from the personal mail directly to avoid excessive use of the electronic mail disk space.
- I. The District and/or Network will periodically make determinations on whether specific uses of the Network are consistent with the acceptable — use practice. The District and/or Network reserve the right to log Internet use and/or monitor the electronic mail space utilization by users.
- J. The Student may transfer files from Information services and electronic bulletin board services. For each file received through a file transfer, the Student agrees to check the file with a virus detection program before opening the file for use. Should the Student transfer a file, shareware, or software which infects the Network with a virus and causes damage, the student will be liable for any and all repair costs to make the Network once again fully operational and may be subject to other disciplinary measures as determined by the District.
- K. The Student may not transfer file, shareware, or software from Information services and electronic bulletin boards without the permission of the Technology Coordinator. The Student will be liable to pay the cost or fee of any file, shareware, or software transferred, whether intentional or accidental, without such permission.
- L. The Student may only log on and use the Network under the immediate supervision of a staff member and only with his/her authorized account number.
- M. The District reserves the right to log computer use and to monitor fileserver space utilization by users.  
The District reserves the right to remove a user account on the Network to prevent further unauthorized activity.

In consideration for the privileges of using the District and/or Network resources, and in consideration for having access to the information contained on the Network, or by the Network, I hereby release the District, Network, and their operators and administration from any and all claims of any nature arising from my use, or inability to use the District and/or Network resources.

## SIGNATURES

I agree to abide by such rules and regulations of system usage as may be further added from time to time by the District and/or Network. These rules will be available in hard copy form in the Principals office.

\_\_\_\_\_  
Student Signature

\_\_\_\_\_  
Date

As the student's parent/legal guardian, I agree to this agreement and will indemnify the District for any fees, expenses, or damages incurred as a result of my child's use or misuse of the Network equipment.

\_\_\_\_\_  
Parent/Guardian Signature

\_\_\_\_\_  
Date

## Educational Material for Parents and Students (Content Meets MDCH Requirements)

Sources: Michigan Department of Community Health, CDC and the National Operating Committee on Standards for Athletic Equipment (NOCSAE)

### UNDERSTANDING CONCUSSION

#### Some Common Symptoms

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

#### 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** – 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. Don't hide it, report it. 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 health 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 should be kept out of athletic play the day of the injury. The student should only return to play with permission from a health care professional experienced in evaluating for concussion. 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.







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## 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 **MOUNT CLEMENS COMMUNITY SCHOOLS (Sponsoring Organization)**.

\_\_\_\_\_  
Participant Name Printed

\_\_\_\_\_  
Parent or Guardian Name Printed

\_\_\_\_\_  
Participant Name Signature

\_\_\_\_\_  
Parent or Guardian Name Printed

\_\_\_\_\_  
Date

\_\_\_\_\_  
Date

Return this signed form to the sponsoring organization that must keep on file for the duration of participation or age 18.

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



## HOUSEHOLD INFORMATION REPORT SY 2021 - 2022

District: MOUNT CLEMENS COMMUNITY SCHOOLS      School: \_\_\_\_\_

To determine eligibility for various additional state and federal program benefits that your school may qualify for, please complete, sign and return this form to the school office.

### Part A: Student Information - Complete for each student Pre-K through 12th Grade

Student's Last Name	Student's First Name	Grade Level	School	Identify H If Homeless M If Migrant R If Runaway F If Foster

### Part B: Benefits Received (If applicable)

If any member of your household receives Food Assistance Program (FAP), Family Independence Program (FIP), or FDIPIR, 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: \_\_\_\_\_

Part C: Household Size	Part D: Annual Household Income - Select the appropriate range of combined annual income for all people in the household (Include all income before taxes)		
<input type="checkbox"/> 1 →	<input type="checkbox"/> At or below \$16,744	<input type="checkbox"/> Between \$16,745 and \$23,828	<input type="checkbox"/> At or above \$23,829
<input type="checkbox"/> 2 →	<input type="checkbox"/> At or below \$22,646	<input type="checkbox"/> Between \$22,647 and \$32,227	<input type="checkbox"/> At or above \$32,228
<input type="checkbox"/> 3 →	<input type="checkbox"/> At or below \$28,548	<input type="checkbox"/> Between \$28,549 and \$40,626	<input type="checkbox"/> At or above \$40,627
<input type="checkbox"/> 4 →	<input type="checkbox"/> At or below \$34,450	<input type="checkbox"/> Between \$34,451 and \$49,025	<input type="checkbox"/> At or above \$49,026
<input type="checkbox"/> 5 →	<input type="checkbox"/> At or below \$40,352	<input type="checkbox"/> Between \$40,353 and \$57,424	<input type="checkbox"/> At or above \$57,425
<input type="checkbox"/> 6 →	<input type="checkbox"/> At or below \$46,254	<input type="checkbox"/> Between \$46,255 and \$65,823	<input type="checkbox"/> At or above \$65,824
<input type="checkbox"/> 7 →	<input type="checkbox"/> At or below \$52,156	<input type="checkbox"/> Between \$52,157 and \$74,222	<input type="checkbox"/> At or above \$74,223
<input type="checkbox"/> 8 →	<input type="checkbox"/> At or below \$58,058	<input type="checkbox"/> Between \$58,059 and \$82,621	<input type="checkbox"/> At or above \$82,622

**\* Special Instructions for households with more than 8 people: DO NOT check the boxes above. Instead, fill in items below:**

Household size (# people): \_\_\_\_\_ Total annual income: \_\_\_\_\_

**Part E: Certification - The head of household or adult designee who completed this form must complete this certification section**

I certify (promise) that all information on this form is true and that all income is reported to the best of my knowledge. I understand that this form may impact the amount of State or Federal funding allocated to my local school district. I understand that the information I have provided may be verified.

(Signature) \_\_\_\_\_ (Printed Name) \_\_\_\_\_ (Date) \_\_\_\_\_

(Address) \_\_\_\_\_ (City) \_\_\_\_\_ (Zip) \_\_\_\_\_

(Email Address) \_\_\_\_\_ (Home Phone) \_\_\_\_\_ (Work Phone) \_\_\_\_\_





King Academy  
400 Clinton River Drive  
Mount Clemens, MI 48043  
586-461-3100



### ASQ Parent/Guardian Consent Form

The ASQ consists of a series of questionnaires that screen and monitor a child's development between two months and five years old. The results determine the need for specialized services. Research has shown that the sooner children are identified as having delays and the sooner they get help, the better their chances of making significant developmental strides. Sooner is better! The activities discussed in each questionnaire reflect developmental milestones for each group. Questions will address all areas of development---communication, gross motor, fine motor, problem-solving, and social emotional.

We complete screenings 1 time during the school year in the Fall. Notice of completion due date will be provided by your child's teacher during the school year/

If you have any questions, please contact Melissa Laseck, Director of GSRP at 586-461-3100 or [LaseckM@mtcps.org](mailto:LaseckM@mtcps.org).

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Child's Name

Date of Birth

\* I understand my signature below gives consent for my child to participate in a developmental monitoring program using the standardized Ages and Stages Questionnaire. I also acknowledge that I will receive a copy of the assessment results.

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Parent/Guardian Signature

Date

A copy of the signed form will be in the student's file.



## PARENT NOTIFICATION OF THE LICENSING NOTEBOOK

Child Care Organizations Act, 1973 Public Act 116

Michigan Department of Licensing and Regulatory Affairs

All child care centers must maintain a licensing notebook which includes all licensing inspection reports, special investigation reports and all related corrective action plans (CAP). The notebook must include all reports issued and CAPs developed on and after May 27, 2010 until the license is closed.

- This center maintains a licensing notebook of all licensing inspection reports, special investigation reports and all related corrective action plans.
- The notebook will be available to parents for review during regular business hours.
- Licensing inspection and special investigation reports from at least the past two years are available on the Bureau of Community and Health Systems website at [www.michigan.gov/michildcare](http://www.michigan.gov/michildcare).

I have read the above statement issued by \_\_\_\_\_  
Name of Child Care Center

Child(ren)'s Name(s) \_\_\_\_\_

Parent Name \_\_\_\_\_

Parent Signature \_\_\_\_\_ Date \_\_\_\_\_





Return this completed form to: M.L. King Academy, 400 Clinton River Drive, Mount Clemens, MI 48043, 586-461-3100  
**Participant Enrollment Form**

**Instructions:**

1. List full name of participant enrolled in care
2. Circle the typical days each participant is in care
3. List times each participant typically receives while in care
4. Circle the meals and snacks each participant using the following codes: H = Hispanic or Latino, N = Not Hispanic or Latino\*, A/I = American Indian or Alaskan
5. Select the ethnicity of each participant using the following codes: A/I = American Indian or Alaskan, H/PI = Native Hawaiian or Pacific Islander, W = White\*
6. Select one or more racial designations of each participant using the following codes: A/I = American Indian or Alaskan, H/PI = Native Hawaiian or Pacific Islander, W = White\*
7. Sign and date the form and return to your care center

Participant's First and Last Name	Typical Days in Care (circle all that apply)	List Times in Care	Meals/Snacks Received (circle all that apply)	Ethnicity	Race
	Mon Tues Wed Thu Fri Sat Sun		Breakfast AM Snack Lunch PM Snack Supper Evening Snack		
	Mon Tues Wed Thu Fri Sat Sun		Breakfast AM Snack Lunch PM Snack Supper Evening Snack		
	Mon Tues Wed Thu Fri Sat Sun		Breakfast AM Snack Lunch PM Snack Supper Evening Snack		
	Mon Tues Wed Thu Fri Sat Sun		Breakfast AM Snack Lunch PM Snack Supper Evening Snack		

\* This information is voluntary. This will assist us in assuring the Child and Adult Care Food Program is administered in a nondiscriminatory manner.

Adult/Parent/Guardian's Phone Number

Adult/Parent/Guardian's Address

Date Signed

Signature of Adult/Parent/Guardian

**Non-Discrimination Statement**

In accordance with Federal civil rights law and U.S. Department of Agriculture (USDA) civil rights regulations and policies, the USDA, its Agencies, offices, and employees, and institutions participating in or administering USDA programs are prohibited from discriminating based on race, color, national origin, sex, disability, age, or reprisal or retaliation for prior civil rights activity in any program or activity conducted or funded by USDA. Persons with disabilities who require alternative means of communication for program information (e.g. Braille, large print, audiotape, American Sign Language, etc.), should contact the Agency (State or local) where they applied for benefits. Individuals who are deaf, hard of hearing or have speech disabilities may contact USDA through the Federal Relay Service at (800) 877-8339. Additionally, program information may be made available in languages other than English.

To file a program complaint of discrimination, complete the [USDA Complaint and Discrimination Complaint Form](http://www.ascr.usda.gov/complaint_filing_cust.html) (AD-3027) ([http://www.ascr.usda.gov/complaint\\_filing\\_cust.html](http://www.ascr.usda.gov/complaint_filing_cust.html)) online, and at any USDA office, or write a letter addressed to USDA and provide in the letter all of the information requested in the form. To request a copy of the complaint form, call (866) 632-9992. Submit your completed form or letter to USDA by: (1) mail: 632-9992. Submit your completed form or letter to USDA by: (2) fax: (202) 690-7442; or (3) email: [usda.ascr@usda.gov](mailto:usda.ascr@usda.gov). This institution is an equal opportunity provider.

