The mission of Jenison Christian School:

- Embrace our community with the love of Christ
- Foster academic growth that is distinctively Christian
- Empower God's children for a life of kingdom service

JCS PRESCHOOL
Loving. Learning. Leading.

Thank you for your interest in the Jenison Christian Preschool program! We are committed to helping your child love God and others, learn more about God's creation, and lead others to Christ. We cherish the opportunity to work alongside your family in the Christian School setting.

Families who enroll in the JCS Preschool program become members of a loving community with the opportunity to make life-long friends. Our community of teachers love children and work together to provide a safe and nurturing environment where each child will flourish. Our Preschool program is a wonderful opportunity to experience a piece of all that Jenison Christian School has to offer!

Please read the following information for enrollment procedures. Open enrollment for Preschool begins on the night of our Early Childhood Open House, the 3rd Tuesday in January, until all classes are full. To learn more about our program and curriculum, please visit our website at www.jenisonchristian.org.

Age Requirements:

- To enroll in the 3 year old class, your child must be 3 years of age and potty trained by September 1.
- To enroll in the 4 year old class, your child must be 4 years of age by November 1.

Enrollment Steps:

- Review all materials in this packet.
- Select your class preferences and complete the enrollment form.
  - Forms for teacher requests are available in the office.
- Return the completed and signed enrollment form to the office along with a $75 payment (non-refundable) that will be applied towards your tuition balance.
- State law requires that prior to the first day of school the **Health Appraisal** (signed by a physician) and the **Immunization Record** must be delivered to the school office.
  - Note: if you choose not to immunize your child, we **must** have a waiver on file for your child. Contact Hannah Stob, Preschool Director, (hstob@jenisonchristian.org or 457-3301 ext. 102) with any questions.

Tuition Payment Policy:

Jenison Christian School wishes to partner with parents in all aspects of school life including procedures to help them meet the financial obligation for Christian education. The Tuition Payment Policy is designed to maintain fiscal health for the school and to help families avoid the stress of becoming seriously delinquent in their payments.

- Tuition payments are due on the 10th of the month September through April. Payment booklets will be mailed in August.
- When an account becomes 60 days past due, the student will not be allowed to continue attending preschool until the account is brought current.
- When there are extenuating circumstances, a family may contact Karen Deters, Financial Secretary, (kdeters@jenisonchristian.org or 457-3301 ext. 162) to discuss an alternative payment plan.
- Jenison Christian School reserves the right to terminate or deny enrollment to families who do not keep current on tuition payments, who choose not to agree to a tuition payment plan, or who do not hold to the commitments as listed on this page. Jenison Christian School may initiate legal action to collect tuition due.

Withdrawal Procedures:

If a parent wishes to withdraw a student from the preschool, a two-week notice is requested. Notice may be delivered to the teacher or preschool director.

Students who withdraw in the middle of a month will owe tuition for the full month. Exceptions will be made if the student leaves the program for reasons of immaturity, health or hardship.

Tuition Reduction Incentive Program (TRIP) a program where local businesses contribute directly to a family's tuition. Parents are encouraged to read the enclosed TRIP information carefully and enroll.

JENISON CHRISTIAN SCHOOL
7726 Graceland
Jenison, MI 49428
Telephone: (616) 457-3301; Fax: (616)457-1430
Email: admissions@jenisonchristian.org

3's PRESCHOOL ENROLLMENT FORM 2018-2019

Child's Legal Name _____
Last First Middle

Preferred Name:_____ Child's Date of Birth _____ Child is ___male___female
Month Day Year
Birth date must be prior to 9-1-15

FAMILY INFORMATION: ☐ **Opt-out box**, check if you do not want to be included in the JCS Directory.

Mother _____ Mother's Phone _____

Address _____ City _____ Zip _____

Email Address _____ Church _____
Please Print Clearly

Father _____ Father's Phone _____

Email Address _____ Church (if different from mother's) _____

Address(if different from mother's) _____ City _____ Zip _____

Please provide information about allergies; physical, mental or emotional challenges of which we should be aware.

_____

_____

Classes Meet from 9:00 – 11:30 AM

CLASS OPTIONS: Please label your **1st, 2nd, and 3rd** preferences below

	Monday/Wednesday/Friday
	Tuesday/Thursday/Friday
	Monday/Wednesday
	Tuesday/Thursday

A minimum enrollment is needed to offer a class and each class has a maximum size. Every effort is made to honor your first choice; and, if a class is full, you will be contacted about alternate placements.

TUITION

2 days per week = $790.
3 days per week = $1,095.

Parent commitment to Jenison Christian School: $_____ (tuition)

$75.00 paid at enrollment towards tuition (non refundable) – $_____

Balance Due to Jenison Christian School $_____ = 8 Monthly Payments of $ _____

AGREEMENT BY PARENTS

1. By enrolling my child at Jenison Christian School I acknowledge I have read the enclosed information, the mission of Jenison Christian School, and support the school's policies to achieve that mission.
2. We commit to pay our tuition and agree to the terms of the tuition payment policy.

Parent Signature _____ Date _____

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

_____ / /
Parent/Guardian Signature Date

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?
☐ 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

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 (HPV4/HPV2)	1	3
	2	
OTHER Vaccines Specify Date & Type	Type of Vaccine(s)	Date of Vaccine(s)
	1	
	2	
	3	

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

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 child's school or local health department.

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

_____ _____ 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 Departments of Human Services, Education, Community Health, 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.