



# Enrollment Form



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

Date: \_\_\_\_\_

## REQUIRED DOCUMENTS

The following documents are required in addition to the completed and signed enrollment form. They should be provided before the child's first day of school but must be submitted no later than 30 days from the first day.

- Parent/Guardian photo ID
- Student's birth certificate or birth record
- Student's immunization record or waiver
- Student's most recent transcript or report cards
- Two forms of proof of address, such as:  
Driver's license, Detroit ID, W-2, public assistance documents, pay stub, official government mail, utility bill, etc.

\*Some families may qualify for support with obtaining documents.

## STUDENT INFORMATION

First Name:	Middle Name:	Last Name:	Suffix (Jr., III, etc.)
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Date of Birth: (MM/DD/YYYY)	Preferred Gender: <input type="checkbox"/> Female <input type="checkbox"/> Male
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Primary Parent Phone (if applicable): (      )	Primary Parent Email (if applicable):
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Grade Entering:	School Year:	Is the student a member of multiple births? <input type="checkbox"/> Yes <input type="checkbox"/> No
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### Student's Physical Address:

Street:	Apt #:
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City:	State:	ZIP Code:
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### Mailing Address (if different from Physical Address)

Street:	Apt #:
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City:	State:	ZIP Code:
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What country was the student born in?	If any country other than U.S.A., please answer the following two questions: What year did the student arrive in the U.S.A.? _____ (YYYY) When did the student first enroll in a U.S. school? _____ (MM/DD/YYYY)
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Does the student have an Individualized Education Plan (IEP)?	<input type="checkbox"/> Yes <input type="checkbox"/> No
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Does the student have a 504 Plan?	<input type="checkbox"/> Yes <input type="checkbox"/> No
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If you answered "Yes" to any of the above, please provide a copy of your special education document(s) with your enrollment packet.

Has the student or family moved in the past three years looking for temporary or seasonal employment in agriculture or fishing?
<input type="checkbox"/> Yes <input type="checkbox"/> No

## STUDENT LANGUAGE

Student's native language?  English  Other \_\_\_\_\_

Is a language other than English spoken in the home?  No  Yes: language spoken \_\_\_\_\_

Has student ever been enrolled in a Bilingual, English Language Learner, or Newcomer program?  Yes  No

## STUDENT RESIDENCY

The following questions are given to all students to ensure our district remains in compliance with federal law. Your answers will help school staff to determine if the student is eligible for certain support services.

Does the student live with his/her biological parent(s)?

Yes  No

Does the student live in any of the following types of residences?

- Shelter
- Transitional Housing
- Doubled Up/Shared housing with family, friends or others
- Hotel or motel
- Unsheltered (Such as: Campground, Car, Park, Abandoned Building, Substandard Housing, Bus or Train Station, etc.)

If you answer "no" to the first question OR have checked any of the residences listed above, please complete the McKinney Vento Student Referral Form at [bit.ly/External-DPSCD](http://bit.ly/External-DPSCD).



## FOSTER CARE

Is the student in Foster Care? If so please provide the case worker's contact information:

Yes  No

Name: \_\_\_\_\_

Phone: \_\_\_\_\_

Email: \_\_\_\_\_

## STUDENT ETHNICITY

### SELECT ALL THAT APPLY

If you do not choose an answer, the U.S. Dept. of Education requires the District to supply answer on your behalf.

Student's Race (select all that apply):

- American Indian or Alaska Native
- Asian
- Black or African American
- Hispanic or Latinx
- White (Select one)
  - European
  - Middle Eastern
  - North African
- Native Hawaiian/Other Pacific Islander

## PREVIOUS SCHOOL INFORMATION

### School student most recently attended

Name: \_\_\_\_\_

City/State: \_\_\_\_\_

Student ID Number (current DPSCD students)

## INFORMATION OF PARENT / GUARDIAN 1

First Name:	Last Name:	Relationship to Student:
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Cell Phone: ( )	Home Phone: ( )
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Work Phone (if applicable): ( )	Email:
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Same address as student's physical address?	<input type="checkbox"/> Yes <input type="checkbox"/> No, provide address:
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Street:	Apt #:
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City:	State:	ZIP Code:
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Does the parent/guardian require communication from the school in a language other than English?		
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No  Yes, what language? Written \_\_\_\_\_ Spoken \_\_\_\_\_

Is the parent/legal guardian currently serving in any branch of the Army, Navy, Air Force, Marines, or Coast Guard? This includes the Michigan National Guard or Reserve personnel.		
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Yes  No

## INFORMATION OF PARENT / GUARDIAN 2

First Name:	Last Name:	Relationship to Student:
Cell Phone: (        )	Home Phone: (        )	
Work Phone (if applicable): (        )	Email:	
<b>Same address as student's physical address?</b>		<input type="checkbox"/> Yes <input type="checkbox"/> No, provide address:
Street:		Apt #:
City:	State:	ZIP Code:

**Does the parent/guardian require communication from the school in a language other than English?**

No  Yes, what language? Written \_\_\_\_\_ Spoken \_\_\_\_\_

**Is the parent/legal guardian currently serving in any branch of the Army, Navy, Air Force, Marines, or Coast Guard?**

This includes the Michigan National Guard or Reserve personnel.  Yes  No

## INFORMATION OF PARENT / GUARDIAN 3

First Name:	Last Name:	Relationship to Student:
Cell Phone: (        )	Home Phone: (        )	
Work Phone (if applicable): (        )	Email:	
<b>Same address as student's physical address?</b>		<input type="checkbox"/> Yes <input type="checkbox"/> No, provide address:
Street:		Apt #:
City:	State:	ZIP Code:

**Does the parent/guardian require communication from the school in a language other than English?**

No  Yes, what language? Written \_\_\_\_\_ Spoken \_\_\_\_\_

**Is the parent/legal guardian currently serving in any branch of the Army, Navy, Air Force, Marines, or Coast Guard?**

This includes the Michigan National Guard or Reserve personnel.  Yes  No

## INFORMATION OF PARENT / GUARDIAN 4

First Name:	Last Name:	Relationship to Student:
Cell Phone: (        )	Home Phone: (        )	
Work Phone (if applicable): (        )	Email:	
<b>Same address as student's physical address?</b>		<input type="checkbox"/> Yes <input type="checkbox"/> No, provide address:
Street:		Apt #:
City:	State:	ZIP Code:

**Does the parent/guardian require communication from the school in a language other than English?**

No  Yes, what language? Written \_\_\_\_\_ Spoken \_\_\_\_\_

**Is the parent/legal guardian currently serving in any branch of the Army, Navy, Air Force, Marines, or Coast Guard?**

This includes the Michigan National Guard or Reserve personnel.  Yes  No

## SIBLINGS AT TENDING DPSCD SCHOOLS

First Name:	Last Name:	Date of Birth: (MM/DD/YYYY)	
Relationship to Student:		School Attending:	Grade:
First Name:	Last Name:	Date of Birth: (MM/DD/YYYY)	
Relationship to Student:		School Attending:	Grade:
First Name:	Last Name:	Date of Birth: (MM/DD/YYYY)	
Relationship to Student:		School Attending:	Grade:
First Name:	Last Name:	Date of Birth: (MM/DD/YYYY)	
Relationship to Student:		School Attending:	Grade:
First Name:	Last Name:	Date of Birth: (MM/DD/YYYY)	
Relationship to Student:		School Attending:	Grade:

## MASS COMMUNICATIONS

Detroit Public Schools Community District uses mass communication tools including phone calls, emails or text messages to notify families about school closures, important news and events.

## ACKNOWLEDGMENTS & SIGNATURE

I certify that the information provided on this Enrollment Form is true and correct. If necessary, I will allow an interview by the District to verify. I understand that incorrect information may be grounds for revoking enrollment. I understand that it is my responsibility to inform the appropriate school office if/when there is a change to any information on this form.

By signing this Enrollment Form, I accept and agree that if any statements and information used to determine residency are not accurate, I will be personally liable to pay to the District tuition and any fees incurred to collect tuition for all periods of time my student was a non-resident.

Parent or Guardian Signature

Print Name

Date

(MM/DD/YYYY)



DPSCD does not discriminate on the basis of race, color, national origin, sex, sexual orientation, gender identity, disability, age, religion, height, weight, citizenship, marital or family status, military status, ancestry, genetic information, or any other legally protected category, in its educational programs and activities, including employment and admissions. Questions? Concerns? Contact the Civil Rights Coordinator at (313) 240-4377 or [dpscd.compliance@detroitk12.org](mailto:dpscd.compliance@detroitk12.org) or 301 West Grand Boulevard, 14th Floor, Detroit MI 48202.



# District Emergency Contact and Medical Authorization Form



School: \_\_\_\_\_ School Year: \_\_\_\_\_

## STUDENT INFORMATION

First Name:	Last Name:	Date of Birth: (MM/DD/YYYY)	
Grade:	Homeroom Teacher:	Homeroom Classroom Number:	
Home Address Street:		City:	ZIP Code:
Student Cell Phone: (        )		Student Email:	
Who does the student live with? Select all that apply: <input type="checkbox"/> Mother <input type="checkbox"/> Father <input type="checkbox"/> Guardian <input type="checkbox"/> Grandparent <input type="checkbox"/> Other Relative <input type="checkbox"/> Other _____			

## EMERGENCY CONTACTS INFORMATION

### PRIMARY CONTACT

First Name:	Last Name:	Cell Phone: (        )	Home Phone: (        )
Employer:		Work Phone: (        )	Email:
Relation to student:	<input type="checkbox"/> Mother <input type="checkbox"/> Step Parent	<input type="checkbox"/> Father <input type="checkbox"/> Legal Guardian	<input type="checkbox"/> Grandparent <input type="checkbox"/> Other _____ <input type="checkbox"/> Foster Parent

### SECONDARY CONTACT

First Name:	Last Name:	Cell Phone: (        )	Home Phone: (        )
Employer:		Work Phone: (        )	Email:
Relation to student:	<input type="checkbox"/> Mother <input type="checkbox"/> Step Parent	<input type="checkbox"/> Father <input type="checkbox"/> Legal Guardian	<input type="checkbox"/> Grandparent <input type="checkbox"/> Other _____ <input type="checkbox"/> Foster Parent

### ADDITIONAL CONTACT

First Name:	Last Name:	Cell Phone: (        )	Home Phone: (        )
Employer:		Work Phone: (        )	Email:
Relation to student:	<input type="checkbox"/> Mother <input type="checkbox"/> Step Parent	<input type="checkbox"/> Father <input type="checkbox"/> Legal Guardian	<input type="checkbox"/> Grandparent <input type="checkbox"/> Other _____ <input type="checkbox"/> Foster Parent

## EMERGENCY CONTACTS INFORMATION - CONTINUED

### ADDITIONAL CONTACT

First Name:	Last Name:	Cell Phone: (        )	Home Phone: (        )
Employer:		Work Phone: (        )	Email:
Relation to student:	<input type="checkbox"/> Mother	<input type="checkbox"/> Father	<input type="checkbox"/> Grandparent
	<input type="checkbox"/> Step Parent	<input type="checkbox"/> Legal Guardian	<input type="checkbox"/> Other _____

  

<b>ADDITIONAL CONTACT</b>			
First Name:	Last Name:	Cell Phone: (        )	Home Phone: (        )
Employer:		Work Phone: (        )	Email:
Relation to student:	<input type="checkbox"/> Mother	<input type="checkbox"/> Father	<input type="checkbox"/> Grandparent
	<input type="checkbox"/> Step Parent	<input type="checkbox"/> Legal Guardian	<input type="checkbox"/> Other _____

## EMERGENCY MEDICAL AUTHORIZATION

### PART 1 - TO GRANT CONSENT

**Only PART 1 or PART 2 below must be completed and signed.**

I hereby give permission for a physician, licensed nurse, or other school employee designated by school administration, to administer medical treatment to my child in an emergency, including as a result of athletic participation, that threatens the life or health of my child. I understand that school staff and medical personnel will be acting in good faith, in accordance with applicable law and in the best interest of my child. DPSCD staff will adhere to applicable policies as well. By providing this consent, to the extent permitted by law, I voluntarily with full knowledge of its significance, release and hold harmless DPSCD, the Board of Education and its staff, contractors, agents, and volunteers from liability resulting directly or indirectly from the medical treatment provided. I further authorize a physician, licensed nurse or other school employee designated by school administration to cause my child to be transported to the nearest hospital for treatment in an emergency. I hereby assume responsibility for the costs of any medical treatment and transportation provided to my child which may include indemnification of DPSCD for such costs.

Parent or Guardian Signature

Print Name

Date

(MM/DD/YYYY)

*Note: The above information will be shared with appropriate staff as necessary. This includes, but is not limited to, administrators, teachers, support staff, bus drivers, food service staff, custodians, coaches, and substitute employees. Please, notify the school nurse of any concerns.*

### PART 2 - REFUSAL TO CONSENT

**Do not complete PART 2 if you completed PART 1.**

**I DO NOT give my consent** for emergency medical treatment of my child. In the event of illness or injury requiring emergency treatment, I wish school/district authorities to take the following action:

Parent or Guardian Signature

Print Name

Date

(MM/DD/YYYY)



DPSCD does not discriminate on the basis of race, color, national origin, sex, sexual orientation, gender identity, disability, age, religion, height, weight, citizenship, marital or family status, military status, ancestry, genetic information, or any other legally protected category, in its educational programs and activities, including employment and admissions Questions? Concerns? Contact the Civil Rights Coordinator at (313) 240-4377 or [dpscd.compliance@detroitk12.org](mailto:dpscd.compliance@detroitk12.org) or 301 West Grand Boulevard, 14th Floor, Detroit MI 48202.



# Annual Health Information



**Dear Parent/Guardian:** The information on this form will be used to meet your child's health needs at the school. Please complete all sections of the form and then sign and return it to your child's teacher as soon as possible. Every student must have a new form completed each year.

School Name:		Grade:	Is your child new to the district? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Student's First Name:	Middle Name:	Last Name:	Suffix (Jr., III, etc.)	
Date of Birth: (MM/DD/YYYY)				
Parent/Guardian Name:		Relationship to Student:		
Home or Cell Phone: ( )		Work Phone: ( )		
What type of health insurance does your child have?	If your child has Medicaid, please mark the plan name:  <input type="checkbox"/> Medicaid <input type="checkbox"/> Aetna <input type="checkbox"/> Molina <input type="checkbox"/> Private <input type="checkbox"/> Blue Cross Complete <input type="checkbox"/> Total Health Care <input type="checkbox"/> Unsure <input type="checkbox"/> HAP Midwest <input type="checkbox"/> United <input type="checkbox"/> My child does not currently have health insurance <input type="checkbox"/> McLaren <input type="checkbox"/> Other <input type="checkbox"/> Meridian			What type of dental insurance does your child have?  Healthy Kids ( <i>please select which plan</i> ) <input type="checkbox"/> Blue Cross Blue Shield <input type="checkbox"/> Delta Dental <input type="checkbox"/> Unsure which Healthy Kids plan  <input type="checkbox"/> Private <input type="checkbox"/> Unsure

## Does your child have any of the following health conditions?

HEALTH CONDITION	YES	NO	HEALTH CONDITION	YES	NO	HEALTH CONDITION	YES	NO
Severe allergies (food, insects, drugs, latex)			Allergies ( <i>seasonal</i> )			Heart Problems		
			Anxiety			Lead Poisoning		
If yes, please state what your child is allergic to (certain foods, insects, latex, etc)			Asthma or breathing problems			Pregnant		
			Attention Deficit Hyperactivity Disorder			Seizures		
			Behavioral Problems			Sickle Cell Disease		
			Bladder or Bowel Problems			Speech Problems		
			Dental Problems			Vision Problems		
			Depression			Wears Glasses		
If yes, please check the reaction that occurs:			Diabetes			Other Health Conditions, please list:		
<input type="checkbox"/> Hives <input type="checkbox"/> Swelling <input type="checkbox"/> Trouble breathing <input type="checkbox"/> Other			Head Injury or Concussions					
			Hearing Problems					

## MEDICATIONS AND/OR SPECIAL PROCEDURES\*

Does your child require any daily medications to be taken at school?	<input type="checkbox"/> Yes* <input type="checkbox"/> No
Does your child require any emergency medications be kept at school?	<input type="checkbox"/> Yes* <input type="checkbox"/> No
Does your child require any special procedures to be done at school? <i>(g-tube feeding, catheterization, etc.)</i>	<input type="checkbox"/> Yes* <input type="checkbox"/> No

\* If you answered yes to any of the above questions under Medications and Special Procedures, please complete the Authorization for Release of Medical Information form. If needed, please have your provider complete the Prescribed Medication form. Both forms are available at [detroitk12.org/enrollnow](http://detroitk12.org/enrollnow) and must be renewed every year.

## MEDICAL CARE PROVIDERS

Doctor's Name:	Phone: (       )	Address:
Date of last physical: (MM/DD/YYYY)	<input type="checkbox"/> Unsure	
Dentist's Name:	Phone: (       )	Address:
Date of last dental exam: (MM/DD/YYYY)	<input type="checkbox"/> Unsure	
Medical Specialist (optional):	Local Hospital:	
Phone: (       )	Emergency Room Phone: (       )	
Address:	Address:	

## FAMILY NEEDS

In the last 12 months, did you ever eat less than you felt you should because there wasn't enough money for food?

Yes     No

## ACKNOWLEDGMENTS & SIGNATURE

I certify that this information is correct to the best of my knowledge and understand that it is my responsibility to inform the school if any of this information changes. I also understand that this information may be shared with need-to-know staff at my child's school in order to keep my child safe and protected while at school.

Parent or Guardian Signature

Print Name

Date

(MM/DD/YYYY)

## TO BE COMPLETED BY OFFICE STAFF

	DATE	STAFF PERSON
Form received		
Information entered into Student Information System		



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# Consent to Release Health Information



## STUDENT INFORMATION

First Name:	Middle Name:	Last Name:	Date of Birth: (MM/DD/YYYY)
Parent/Guardian First Name:	Parent/Guardian Last Name:	Home or Cell Phone: (      )	

## CONSENT FOR RELEASE OF INFORMATION

By signing this Consent to Release Information form, I consent to the following:

- I authorize my child's school to disclose the following student information to the individuals/groups listed below: child's family and emergency contact information, attendance and disciplinary records, immunization history, results of health screenings such as hearing and vision, psychological evaluations, special education records, section 504 accommodation plan and any information related to medical conditions, such as asthma, diabetes or seizures.
  - My child's Health Care Provider(s)
  - My child's Health Insurance Plan
  - Michigan Dept. of Health and Human Services and Detroit Health Dept. (Immunization records only)
  - School-based health service providers – see below
- I understand that sharing this information will allow DPSCD to work with each of these individuals/groups to coordinate care, provide outreach services if necessary, and keep my child healthy and safe at school.
- I understand that I am entitled to receive a copy of any disclosed records. (*If you wish to receive a copy please provide an email or street address to which where the records should be sent.*)
- I understand that these individuals may further use records provided by DPSCD for contacting me and/or verifying information for student health related purposes.
- I understand that my authorization to allow sharing the above information is voluntary and that it expires when my child leaves the school district, or graduates. **I understand that I may revoke this authorization at any time by submitting a note or letter in writing to the school administration office.**

School-based health service providers may include any of the following:

- School Based Health Centers (SBHC): ability to diagnose and treat many common conditions such as sore throats, headaches, and ear infections, and also manage chronic health conditions. The SBHC may also provide behavioral health services.
- Dental Services: may include oral health education, screenings, fluoride varnish application, preventative care and cleaning, restorative/corrective care.
- Vision Services: may include screening, examination, treatment and/or corrections such as eyeglasses.
- Immunization Services
- Behavioral Health Services

In order for your child to receive these services, from these providers, you will need to complete a separate enrollment form with each of the providers.

Parent/Guardian Name:	Relationship to Child:	Date: (MM/DD/YYYY)
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## Permission for Collaboration for Your Child's Health Health Care providers, Health Plans and Health Departments



### FAMILY EDUCATIONAL RIGHTS AND PRIVACY ACT (FERPA)

#### **What is FERPA?**

The Family Educational Rights and Privacy Act (FERPA) is a Federal law that protects the privacy of student education records. Generally, schools must have written permission from the parent, or student if over 18, in order to release any information from a student's education record.

#### **Permission for what?**

Detroit Public Schools Community District is requesting your consent because we may need to share information contained in our student records with your child's Health Care Provider, Health Insurance Plan, a School-Based Health Service Provider, or as required by law, including to the Michigan and Detroit Departments of Health. Health Care Providers are the physician(s) or nurse practitioner(s) who take care of your child, as noted in the district's records. A Health Plan is an organization that administers your child's health care benefits, such as Medicaid or a health insurance company.

#### **Why is this important?**

This consent form allows the district, when requested or necessary by law, and/or to assist with coordination of health care, including benefits, by sharing health information from the student's education record. Without your consent, the district is limited in how it can collaborate with your child's Health Care Provider, Health Insurance Plan, or a School-Based Health Service Provider to help you or your child.

#### **What this form does not do.**

- This form only authorizes the district to disclose information for limited purposes, with your consent. Each Health Care Provider, Health Insurance Plan, or a School-Based Health Service Provider may have its own way of getting permission from you for them to share information with the district.
- Your signature does not authorize the district to obtain medical treatment for your child on your behalf.

**Please help us link you and your child to health services  
by signing and returning the previous page.**



## VACCINES FOR CHILDREN

Immunizations play an important role in keeping students healthy by preventing the onset and spread of disease.

The Michigan Public Health Code requires all children who attend school in Michigan to have an up-to-date immunization history or a valid waiver on file.

### Childhood Recommended Immunizations (\*School Required)

- Diphtheria, Tetanus, Pertussis (DTP, Dtap, Tdap)\*
- Polio\*
- Measles, Mumps, Rubella (MMR)\*
- Hepatitis B\*
- Meningococcal Conjugate (MenACWY)\*
- Meningitis B\* (16 & Older)
- Varicella (Chickenpox)\*
- Influenza
- Hepatitis A
- Human Papillomavirus Vaccine (HPV)
- Pneumococcal
- *H. influenzae* type B (Hib)\*



COVID-19 Vaccines are available for students, for more information visit  
<https://bit.ly/375Cyhs>



For more information on Immunizations, visit <https://bit.ly/3DWhE0f>

*Michigan law requires that each student possess a certificate of immunization at the time of registration or no later than the first day of school. Please provide this certificate to your school administrative team.*



# Directory Information Opt-Out



The Family Educational Rights and Privacy Act, a federal law, and Detroit Public School Community District ("District") Board Policy allows districts to disclose designated "directory information" to third parties, unless a student's parent or legal guardian opts out.

Directory information includes the student's name, school name, participation in officially recognized activities and sports, height and weight (if member of an athletic team), date of graduation, awards received, telephone numbers and/or home addresses (for inclusion in school or PTA directors), and school photos or videos of students participating in activities, events or programs. Only directory information regarding a student shall be released to any person or party, other than the student or his/her parent, without written consent.

Director information is commonly used in school publications, yearbooks, activity and athletic programs, television productions, web sites, as well as inquiries from community partners, other schools, and potential employers. In addition, the District is required by law to provide, upon request, military recruiters with the same access to directory information as is provided to prospective employers.

We take student data privacy seriously. Parents or guardians should complete this Directory Information Opt-Out Form if they do not want some or all the directory information shared with third parties. **The form can be completed online at <https://bit.ly/DPSCDoptout>.**

**Vaccine Consent Form**

Student Name: \_\_\_\_\_ Birth Date: \_\_\_\_\_ Age: \_\_\_\_\_

Street Address: \_\_\_\_\_ City, State, Zip: \_\_\_\_\_

Telephone: \_\_\_\_\_ Male \_\_\_\_\_ Female \_\_\_\_\_

School Name: \_\_\_\_\_ Grade: \_\_\_\_\_

VFC Eligibility:

Insurance Type (circle): **Private Medicaid No Insurance Under-insured American Indian/Alaskan Native**

Parent/Guardian Name: \_\_\_\_\_

**CONSENT FOR VACCINATION:** Detroit Public Schools Community District (DPSCD) will review my child's information in the Michigan Care Improvement Registry (MCIR). Based on the information in MCIR, I authorize the DPSCD and/or its School-Based Health Center Partners to administer all recommended or needed vaccines for his/her age. This consent form authorizes the administration of multiple doses of a vaccine, as medically indicated. Combination vaccines will be used as available, unless contraindicated.

I have read and understood the Vaccine Information Statement(s) available online at [MDHHS - Vaccine Information Statements \(VIS\) \(michigan.gov\)](http://MDHHS - Vaccine Information Statements (VIS) (michigan.gov)) for the recommended vaccine(s). I understand the benefits and risks of the recommended vaccine(s) and I understand the immunization(s) administered is entered into MCIR. This consent form will expire after the last vaccination is given in a vaccine series.

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

Please check Yes or No	Yes	No
Does the child have any allergies to medication, food, a vaccine component, or latex?		
Has the child had a serious reaction to a vaccine in the past?		
Has the child had a health problem with lung, heart, kidney, or metabolic disease (diabetes), asthma, or a blood disorder? Is he/she on long term aspirin therapy?		
Has the client, a sibling, or a parent had a seizure? Has the client had brain or other nervous system problems?		
Does the client have cancer, leukemia, HIV/AIDS, or any other immune system problem?		
In the past 3 months, has the client taken medications that weaken their immune system, such as cortisone, prednisone, other steroids, or anticancer drugs, or had radiation treatments?		
In the past year, has the client received a transfusion of blood or blood products, or been given immune (gamma) globulin or an antiviral drug?		
Is the client pregnant or is there a chance she could become pregnant during the next month?		
Has the client received vaccinations in the past 4 weeks?		
Has the client received a TB skin test this month?		

**Students Rise. We all Rise**

**PLEASE NOTE!!!! VACCINE REFUSAL SECTION BELOW****COMPLETE SECTION BELOW IF YOU DO NOT WANT YOUR CHILD TO RECEIVE A VACCINE****VACCINE REFUSAL:** Place a check next to the vaccine(s) that you **do not** want your child to receive and **sign**.

<input type="checkbox"/> DTaP/Tdap/Td	<input type="checkbox"/> Pneumococcal	<input type="checkbox"/> Meningococcal ACWY	<input type="checkbox"/> Polio
<input type="checkbox"/> Hib	<input type="checkbox"/> MMR	<input type="checkbox"/> Influenza	<input type="checkbox"/> HPV
<input type="checkbox"/> Hepatitis A	<input type="checkbox"/> Hepatitis B	<input type="checkbox"/> Men B	<input type="checkbox"/> Varicella

My child, as named above, should not receive the above vaccines as indicated by a check mark. I understand the possible consequence(s) of not allowing my child to receive the recommended vaccines.

**Parent/Guardian Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_**For Staff Use Only:****Verbal Consent for Vaccination**Name of DPSCD Staff Member Making the Call:  
\_\_\_\_\_  
  
Name of Parent or Guardian: \_\_\_\_\_  
  
Date: \_\_\_\_\_  
  
Time: \_\_\_\_\_  
  

Parent/Guardian has provided authorization for DPSCD and/or its School-Base Health Center Partners to Provide Vaccines to the student. Please circle the appropriate answer. (Yes)      (No)

Additional Comments: \_\_\_\_\_  
\_\_\_\_\_**Students Rise. We all Rise**



# STUDENT MEDIA RELEASE



## PLEASE PRINT ALL INFORMATION

To the parent or guardian of: \_\_\_\_\_  
*(Print Student's Name)*

On occasion, Detroit Public Schools Community District-approved non-commercial video, photographic and/or audio production crews may be present at the school or at a Detroit Public Schools Community District-sanctioned activity your child attends, in order to highlight the activity, school, student, original student work or the District in the interest of promoting public education. If you consent to your child's participation or showcase of their original work in the video/photographic/ audio, productions/interviews/activities or social media postings that may take place, please sign below after reading the following.

I, \_\_\_\_\_, am the parent/guardian of the above-named student.  
*(Print Parent/Guardian Name)*

In the interest of public education, I hereby authorize the Detroit Public Schools Community District, its Board of Education, and the non-commercial production crews, acting through their authorized employees or agents, to use, publish, and copyright audio and/or visual reproductions of the above-named student's voice and/or image, and/or original student work alone or with other persons, with or without the use of the student's name for the sole use in the interest of public education connected with a DPSCD authorized project.

This release is in effect in perpetuity from the date \_\_\_\_\_  
*(Print Student's Name)*

becomes a student of \_\_\_\_\_ until the date his/her  
*(Print School Name)*

status at DPSCD or at the school as a student terminates. I hereby release and hold the Detroit Public Schools Community District harmless from any liability, any and all injuries, claims, damages or costs arising from the use of images or recordings of any type and waive any request for remuneration.

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

\_\_\_\_\_  
Date

\_\_\_\_\_  
Address, City, Zip

**KEEP THE COMPLETED FORM AT YOUR SCHOOL.**

**Office of Communications & Office of Marketing**  
**ph: 313-873-3494 | communications@detroitk12.org**



Detroit Public Schools Community District and Detroit Public Library  
have joined forces to offer a

## Free Public Library Card to Students in Grades K-12

*Give your child access to the resources of Detroit Public Library  
at school, in the library, and at home.*

### Library Card Application

Student Name	
First Name	
Middle Name	
Last Name	
School	Grade

*Cards are valid for one school year.*

**Parents will receive their child's library card number and user information via email.**

*For more information on the benefits and responsibilities of library card ownership,  
go to [www.detroitpubliclibrary.org/DPSCD](http://www.detroitpubliclibrary.org/DPSCD), call 313-481-1400, or  
email [ask-a-librarian@detroitpubliclibrary.org](mailto:ask-a-librarian@detroitpubliclibrary.org)*

### Parent/Guardian Consent

I accept responsibility for the choice and use of library resources on this card (including the open internet); I accept responsibility for the return of materials borrowed and fees for lost items; and my child and I agree to abide by the policies of the Detroit Public Library.

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

*There are no fines for late returns!*



# One-to-One Student Technology



## Program Overview

The One-to-One Student Technology Initiative was launched to increase anytime, anywhere access to online learning resources, academic enrichment, and interventions to support student academic achievement. Through the One-to-One Student Technology Initiative, students will receive a learning device (iPad for PK-2<sup>nd</sup> grades or laptop for 3<sup>rd</sup>-12<sup>th</sup> grades) as an academic support tool. Students are responsible for the safekeeping and condition of their learning device, including reporting technical issues, damage, or loss. All equipment is the property of Detroit Public Schools Community District and must be returned in good working condition at the end of the school year or upon exit from the district.

## Program Requirements:

- Parents must complete the [Family Orientation](#) to participate in the One-to-One program. [Scan the QR code below to watch the video.](#)
- Parents are required to complete the DPSCD One-to-One Program Agreement for their student to receive a device.
- Students must adhere to the Technology Acceptable Use Policy (po7540.03), Student Care of District Property Policy (po5513) and the Student Code of Conduct while using DPSCD devices and accessing the district network (email) and learning resources.
- In accordance with the Student Code of Conduct and State law, students who cause damage to district property shall be subject to disciplinary measures, and their parents shall be held financially responsible for such damage to the extent of the law. The District reserves the right to impose fines for the loss, damage, or destruction of district equipment.
- Any loss or theft of laptop or iPad must be reported to the school immediately to lock and disable the device. A police report should be filed with DPSCD Police Department for stolen equipment.

## Internet-at-Home. Do you have reliable Internet access available at home?

Reliable Internet access is defined as Wi-Fi provided by an Internet Service Provider (Comcast, AT&T, Wow, Dish, Spectrum, etc.) connected at the residence/home; not using the Internet on a cell/mobile device, as this connection is not classified as reliable for student learning.

Yes  No

## Acknowledgement:

I have completed the [One-to-One Student Technology Initiative Family Orientation](#) (video links below) and understand the program requirements, expectations for device use and care, and technical support available. I have discussed expectations for device care and use for educational purposes with my student as well. I certify consent for my child to participate and receive a learning device from Detroit Public Schools Community District.

Parent Name

Parent Signature

Student Name

Student DOB

One-to-One Student Technology Initiative Family Orientation



SPANISH- One-to-One Student Technology Initiative Family Orientation



ARABIC- One-to-One Student Technology Initiative Family Orientation





# Student Technology Use Agreement



## AGREEMENT FOR STUDENT USE OF LAPTOP COMPUTER

This Agreement is made by and between Detroit Public Schools Community District ("DPSCD") and the student ("Student") named in this online form and is effective upon submission. DPSCD and Student agree as follows:

**A. Purpose of Agreement.** DPSCD is pleased to make available for Student's use, in connection with his/her enrollment with the District, a laptop computer and/or LTE internet hotspot for the purpose of conducting schoolwork. It is intended only for the use of the DPSCD student to whom it is assigned. Student's permission to use the laptop is strictly subject to the terms and conditions of this Agreement. Read the Agreement for Student Use of Laptop Computer to understand the terms of use for district technology. For the purposes of this Agreement, the term "laptop" or "laptop computer" shall refer to the laptop computer assigned to the Student, along with all accompanying peripherals, including an LTE internet hotspot, received with the laptop computer or as may from time to time be provided for Student's use under this Agreement.

## B. Student's Rights and Responsibilities.

**1. Term of Use of the Laptop.** Student shall be granted use of the laptop computer while enrolled in good standing with DPSCD. The use of the laptop shall be governed by the DPSCD Student Acceptable Use and Safety Policy (7540.03).

**2. Care of the Laptop.** Student shall maintain appropriate oversight and security of the laptop. Student may take the laptop computer home, or to other locations outside of school hours. Student is responsible, at all times, for the care, security and appropriate use of the laptop computer. Negligence found in securing items that are otherwise damaged, stolen, or misplaced may result in disciplinary action and/or repair or replacement fees.

**3. Return of Laptop to DPSCD.** Student must return the laptop to DPSCD within five (5) days upon the occurrence of any of the following events:

- a. Student ceases to be enrolled by DPSCD;
- b. DPSCD provides Student with five (5) days' notice that the laptop must be returned; or
- c. Student fails to perform any of his/her obligations under this Agreement.

Upon return of the laptop to DPSCD, DPSCD shall have an absolute right to any and all information or data on the laptop and will have no liability whatsoever for the loss, destruction, or misuse of information or data on the laptop.

**4. Failure to Return Laptop.** If Student fails to return the laptop as required, DPSCD may exercise all options available to it under DPSCD policies and applicable state or federal law.

**5. Alterations and Attachments.** Student may not make any alterations in or add attachments, hardware, or software to the laptop computer absent express written permission from DPSCD, which permission is at the sole option of DPSCD.

**6. Risk of Loss.** Student agrees that from the time the delivery of the laptop is accepted and until the laptop is returned to DPSCD in its original condition, normal wear and tear excepted, Student shall be responsible for any loss or damage thereto. If the laptop computer is lost, stolen, destroyed, damaged where the repair costs exceeds the value of laptop or in the event of any confiscation, seizure or expropriation by government action, or if the laptop is not returned to DPSCD upon the events and within the time and manner required by this Agreement, then the Student shall be liable to DPSCD immediately upon demand for the payment of an amount calculated by DPSCD that is equal to the full replacement value of the laptop at the time of loss. Hardware or software additions made to the laptop at Student's expense are at Student's risk and will not be a factor in the fair market value of the laptop. If part of the laptop is damaged but repairable Student shall be liable for the expense of repairing that item if not covered by the manufacturer's warranty. If payment is not received, DPSCD, may exercise all options available to it, under applicable law.

**7. Notification of Loss, Damage, or Malfunctioning.** Student agrees to immediately notify DPSCD upon the occurrence of any loss to, damage to, or malfunctioning of any part of the laptop for any reason and cooperate in any police investigation required following the loss or theft of the laptop. DPSCD, at its option, may then terminate Student's right to use the laptop and any right Student may have to further participate in the staff laptop program. The laptop computer is configured for optimal use on the DPSCD network. Detroit Public Schools Community District's Technology Division will not assist Student at his or her home in order to connect the laptop to other Internet providers.

**8. Inspection by DPSCD.** Upon reasonable notice, Student shall permit persons designated by DPSCD to examine the laptop computer.

### C. DPSCD Rights and Responsibilities

**1. Ownership of Laptop.** The laptop computer is and shall remain DPSCD property.

**2. Enforcement of Manufacturer's Warranty.** Upon receipt of a written request from Student during the term of this Agreement, DPSCD shall determine if it will take all reasonable effort to enforce any manufacturer's warranty, express or implied, issued on or applicable to the laptop computer and which is enforceable by DPSCD in its own name. DPSCD will make reasonable efforts to obtain for Student and Parent all service furnished by the manufacturer in connection, therewith; provided, however that, DPSCD shall not be obligated to commence or resort to any litigation to enforce any such warranty. If any such warranty is enforceable by Student in his or her own name, upon receipt of a written request from DPSCD during the term of this Agreement, Student shall take all reasonable action requested by DPSCD to enforce that warranty, and Student shall obtain for DPSCD all service furnished by the manufacturer in connection therewith. **DPSCD SHALL HAVE NO LIABILITY WHATSOEVER FOR THE LOSS, DESTRUCTION OR MISUSE OF ANY INFORMATION, SOFTWARE OR DATA EXISTING ON THE EQUIPMENT. PROTECTION AND BACKUP OF DATA ON AND FOR THE EQUIPMENT IS STUDENT'S SOLE RESPONSIBILITY.**

### Acknowledgement:

I have read and understand the Student Technology Use Agreement.

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

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

Student Name \_\_\_\_\_

Student DOB \_\_\_\_\_

# 2025-2026 Wayne County GSRP Intake Application

These materials were developed under a grant awarded by the Michigan Department of Education

Federal Poverty Level (FPL): \_\_\_\_\_

Total Number of Eligibility Factors: \_\_\_\_\_

Child's Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Place of Birth: \_\_\_\_\_

Home Language: \_\_\_\_\_ Gender: \_\_\_\_\_

Parent/Guardian Name: \_\_\_\_\_

Parent/Guardian Name: \_\_\_\_\_

Licensed Site Name: \_\_\_\_\_

Teacher Name: \_\_\_\_\_

**\*\*Staff MUST initial next to each document as it is received from the parent/guardian.\*\***

<b>Enrollment File</b>		<b>Family Engagement File</b>
<b><u>GSRP Forms required before enrollment:</u></b>		ASQ-3 Summary Sheet: Date Entered into system: _____
	GSRP Intake Application Date Received: _____	COR or GOLD Report Dates: 1 _____ 2 _____ 3 _____
	Income Documentation (If applicable) Type: _____ Date Received: _____	Individualized Development Plan Dates: _____
	Birth Certificate or Alternative* Type: _____ Date Received: _____	CACFP or NSLP Participant Form
	Parent Identification Type: _____ Date Received: _____	McKinney-Vento Form (If applicable)
<b><u>Licensing Forms required before enrollment:</u></b>		Additional Documents used by subrecipient
	Child Information Record Date Received: _____	<b>Eligibility Factors: Check all that apply</b>
	Immunizations Date Received: _____	1 _____ 2 _____ 3 _____ 4 _____ 5 _____ 6 _____ 7 _____
	Written Information Packet Documentation Date Received: _____	EF Documentation: _____
<b><u>Licensing Form due within 30 calendar days of start date:</u></b>		EF Documentation: _____
	Health Appraisal Date Received: _____	EF Documentation: _____

\*See [Eligibility Factors Defined](#) document for acceptable alternatives and for information about what documentation is acceptable.

## Application

### GSRP Child

Child's Name: \_\_\_\_\_

Child's Address: \_\_\_\_\_ City: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Which of the following is the student's race (if multi-racial, place a check mark for each that applies):

American Indian or Alaska Native \_\_\_\_\_ Black or African-American \_\_\_\_\_ White \_\_\_\_\_  
 Asian American \_\_\_\_\_ Native Hawaiian or other Pacific Islander \_\_\_\_\_ Hispanic or Latino \_\_\_\_\_

### Parent/Guardian

Name: \_\_\_\_\_

Address (if not child's address): \_\_\_\_\_ City: \_\_\_\_\_ Zip Code: \_\_\_\_\_

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

E-mail address: \_\_\_\_\_

**Marital Status:**    Married \_\_\_\_\_ Single \_\_\_\_\_ Divorced \_\_\_\_\_ Widowed \_\_\_\_\_ Separated \_\_\_\_\_

**Employment Status:**    Unemployed \_\_\_\_\_ Part Time \_\_\_\_\_ Full Time \_\_\_\_\_ Seasonal \_\_\_\_\_

### Parent/Guardian

Name: \_\_\_\_\_

Address (if not child's address): \_\_\_\_\_ City: \_\_\_\_\_ Zip Code: \_\_\_\_\_

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

E-mail address: \_\_\_\_\_

**Marital Status:**    Married \_\_\_\_\_ Single \_\_\_\_\_ Divorced \_\_\_\_\_ Widowed \_\_\_\_\_ Separated \_\_\_\_\_

**Employment Status:**    Unemployed \_\_\_\_\_ Part Time \_\_\_\_\_ Full Time \_\_\_\_\_ Seasonal \_\_\_\_\_

### Who has legal custody of the child?

Mother \_\_\_\_\_ Father \_\_\_\_\_ Foster Care \_\_\_\_\_ Legal Guardian \_\_\_\_\_ Grandparent \_\_\_\_\_

If guardian or foster parent (other than biological parent), please complete:

**Legal Guardian's Name(s):** \_\_\_\_\_ **Case Number:** \_\_\_\_\_

### How did you hear of the Great Start Readiness Program?

Radio Ad \_\_\_\_\_ TV Ad \_\_\_\_\_ Billboard \_\_\_\_\_ Flyer \_\_\_\_\_ Email \_\_\_\_\_

Digital Ad \_\_\_\_\_ Print Ad \_\_\_\_\_ Social Media \_\_\_\_\_ Family/Friend \_\_\_\_\_

Other \_\_\_\_\_, please explain \_\_\_\_\_

## Income Verification

- To calculate the Federal Poverty Level use the [Federal Poverty Level Calculator](#).
- Families at or below 400% automatically qualify for Eligibility Factor 1.**
- Over-income (at or above 401%): Should not exceed 15% of your total enrollment and must be prioritized based on FPL percent. See [Income Eligibility Guidelines](#) for more information.
- If a family provides income that is 2xM: multiply it by 2 to get a monthly amount which can be entered into the calculator.
- If a family provides documentation with two different pay frequencies, calculate them to be the same pay frequency. For example: if mom gets **monthly** income and dad gets **biweekly** income, multiply mom's amount by **12** and dad's amount by **26**, then add them together to get the total (i.e.  $\$700 \times 12$  months =  $\$8,400$ ;  $\$300 \times 26 = \$7,800$ ;  $\$8,400 + \$7,800 = \$15,800$  annually).

List <b>ALL</b> household members for which you are financially responsible (include self, other adults, and children).					
Name	Relationship to Child	Age	Name	Relationship to Child	Age
	<b>GSRP Child</b>				

### Income Verification: EF-1 (Family qualifies for EF-1 if 400% of the FPL or lower)

Income Type*:		Frequency:		Gross Pay Amount:	
Income Type:		Frequency:		Gross Pay Amount:	
Income Type:		Frequency:		Gross Pay Amount:	
Income Type:		Frequency:		Gross Pay Amount:	
Total income from all sources:					

Total Number Supported: \_\_\_\_\_ Total income from all sources: \_\_\_\_\_

Federal Poverty Level (FPL): \_\_\_\_\_ Is this family at or below 400% FPL: Yes \_\_\_\_\_ No \_\_\_\_\_

Income-eligible for: \_\_\_\_\_ **Head Start (<100% FPL)** \_\_\_\_\_ **GSRP (0-400%FPL)** \_\_\_\_\_ **OI (400%+ FPL)**

<b>Documentation of No Income (<i>complete only if parent has no income</i>)</b>	
<input type="checkbox"/> I affirm that I do not receive income from any source	<input type="checkbox"/> I am a student
<input type="checkbox"/> I am supported by family members	<input type="checkbox"/> Other: _____
Parent/Guardian's Name: _____ Date: _____	
Parent/Guardian's Signature: _____	

**<100% FPL: I understand that my family qualifies for Head Start and acknowledge that I have been given information regarding Head Start services and locations and that my name and phone number can be shared with local Head Start agencies.**

## Eligibility Factors (EF)

Guidance: The bolded responses mean that the family qualifies for that eligibility factor.

Child's Name: \_\_\_\_\_

### EF-2

Has your child been diagnosed with a disability or developmental delay? Yes \_\_\_\_\_ No \_\_\_\_\_

If YES, please explain: \_\_\_\_\_

*Parents **MUST** provide the most current IEP to the GSRP office during the application process.*

### EF-3

Has your child been expelled from preschool or a childcare center? Yes \_\_\_\_\_ No \_\_\_\_\_

### EF-4

Is the GSRP child from a multi-lingual home?: Yes \_\_\_\_\_ No \_\_\_\_\_

What language is spoken in your home? \_\_\_\_\_

### EF-5

Did one or both parents/guardian complete high school/GED? Yes \_\_\_\_\_ No \_\_\_\_\_

If only one parent/guardian completed high school/GED, mark NO.

### EF-6

Has someone in your home ever been a victim of abuse and/or neglect? Yes \_\_\_\_\_ No \_\_\_\_\_

### EF-7: If a family answers yes to any or all of these questions it is considered ONE EF-7

Has your child lost a parent due to death, divorce, incarceration, military service, or absence? Yes \_\_\_\_\_ No \_\_\_\_\_

Does your child have a sibling with: a chronic illness, behavior issues, a disability? Yes \_\_\_\_\_ No \_\_\_\_\_

Has your child lost a sibling? Yes \_\_\_\_\_ No \_\_\_\_\_

Were one or both parents teen parents when your *first child* was born? Yes \_\_\_\_\_ No \_\_\_\_\_

Do you live in a high-risk neighborhood? Yes \_\_\_\_\_ No \_\_\_\_\_

High-risk neighborhood includes:

Daily exposure to environmental pollutants (lead, rodents, insect infestations)

High crime

Violence

Risk for injury

Unsafe or crowded housing

Drug abuse

Lack of utilities

High death rate

No space for children's play

Has your child been exposed to toxic substances, either before birth or after? Yes \_\_\_\_\_ No \_\_\_\_\_

Toxic substances include:

Fetal Alcohol Syndrome

Children born addicted

Environmentally-induced respiratory problems

Did the family answer yes to any of the EF-7 questions above? Yes \_\_\_\_\_ No \_\_\_\_\_

Eligibility Factors: 1 \_\_\_\_\_ 2 \_\_\_\_\_ 3 \_\_\_\_\_ 4 \_\_\_\_\_ 5 \_\_\_\_\_ 6 \_\_\_\_\_ 7 \_\_\_\_\_ Total Number of EFs: \_\_\_\_\_

**By signing this application, you certify that the information given is true and accurate to the best of your knowledge.**

Parent/Guardian's Name (please print): \_\_\_\_\_

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

**By signing this intake application, I certify that I completed this form with the parent/guardian and the information is correct to the best of my knowledge.**

Staff Name (please print): \_\_\_\_\_

Staff Signature: \_\_\_\_\_ Date: \_\_\_\_\_



## Detroit Public Schools Community District CACFP Child Enrollment Form

School Name: \_\_\_\_\_

Room #: \_\_\_\_\_

School Address: \_\_\_\_\_

School Phone #: \_\_\_\_\_

Instructions:

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

Child's First and Last Name	Typical Days in Care	List Time in Care	Meals/Snack Received	Ethnicity	Race
	<input type="checkbox"/> Mon – Thu		<input type="checkbox"/> Breakfast <input type="checkbox"/> Lunch <input type="checkbox"/> Snack		

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

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

\_\_\_\_\_  
Parent/Guardian Phone Number

\_\_\_\_\_  
Parent/Guardian Address

\_\_\_\_\_  
Date

### 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 Program 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: U.S. Department of Agriculture, Office of the Assistant Secretary for Civil Rights, 1400 Independence Avenue, SW, Washington, D.C. 20250-9410; (2) fax: 202-690-7442; or (3) email: [program.intake@usda.gov](mailto:program.intake@usda.gov). This institution is an equal opportunity provider.



**Detroit Public Schools Community District  
Foundation for Early Learners  
Prekindergarten Programs**

## **RELEASE OF LIABILITY**

I, \_\_\_\_\_ authorize the following  
Print Parent's Name

people, who are listed on the Child Information Record, to pick up my child,

from \_\_\_\_\_ .

Name	Relationship	Age

I understand that I, \_\_\_\_\_ assume all  
Print Parent's Name

responsibility associated with this action.

\_\_\_\_\_  
Signature of Parent

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of Witness

\_\_\_\_\_  
Date

## **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 \_\_\_\_\_

LARA is an equal opportunity employer/program.

# 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)					
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

<b>Emergency Contact &amp; Release of Child:</b> 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.	(      )	(      )	
<b>Release of Child Only:</b> 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.	(      )

<b>Parent/Legal Guardian Initials:</b>	
____ 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.	

<b>I certify that I accurately completed this form and if anything changes, I will notify the provider by updating this form.</b>	
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
						AUTHORITY: 1973 PA 116	
						COMPLETION: Required	
						PENALTY: Rule Violation Citation.	
LARA is an equal opportunity employer/program.							

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