DETROIT edison PUBLIC SCHOOL ACADEMY

1903 Wilkins | Detroit, MI 48207 | Office (313) 833-1100 | Fax (313) 833-8653 | www.detroitedisonpsa.org
Ralph C. Bland – Superintendent

2018-2019 GSRP Pre-School Application

Student Last Name: _____ Student First Name: _____

Grade Level Applying For: _____ School Year: _____

Registration Checklist – GSRP Pre-School

Missing Documentation will be marked only!

- ☐ **DEPSA Application Cover Sheet**
- ☐ Original Birth Certificate
- ☐ Immunization Record
- ☐ IEP, psychological report, speech report, MET report, exit IEP (only if applicable)
- ☐ 504 Plan-with medical documentation
- ☐ Copy of Parent Identification (Driver's License)
- ☐ Health Appraisal signed by Physician
- ☐ Proof of Income (Tax Returns, W2, Pay Stubs, DHS Letter)

"Intelligence plus character – that is the goal of true education."

- Martin Luther King

Comment:

_____

_____

_____

_____

_____

Please contact the Preschool Office for any questions at 313-833-1100 ext. 1254.

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GSRP Pre-School Application Process

2018-2019 Academic School Year

Please Read Through Carefully

Application Deadline:

1. Parents/Guardians of students interested in applying to GSRP Preschool may obtain applications in the school's Main Office.
2. DEPSA cannot assure a sibling priority unless each application clearly states the name(s) of sibling(s) either currently enrolled or also applying for admission. DEPSA defines siblings as a brother or sister living within the same household.

Enrollment Procedures for New Students:

1. All applications **must** include a copy of the requested supporting documents income verification, copy of parent's drivers license, Michigan identification card, or passport birth certificate—original may be requested, health appraisal form, and immunization record. **If for any reason, upon receipt, all information is not complete on an application or one or more of the requested documents are missing, the application will not be considered for acceptance**.
2. **In order for student's names to be changed from their birth certificate, proper documentations from the court must be submitted**.
3. According to state law, all applicants applying for admission into Pre-School that meet GSRP Income Eligibility Guidelines **must be age four (4) by December 1st** of the year in which they are applying. If any applicant applying for Pre-School is accepted, but is proven not to be four (4) by the required date, they will automatically be dropped from enrollment. GSRP is not guaranteed.
4. Completing an application does not guarantee acceptance of enrollment due to enrollment stipulations.
5. It is the parent's responsibility to inform the school's registrar on any changes on their child's application.

Withdrawal:

Students may be withdrawn from the program for the following reasons:

1. Child poses a threat to other students.
2. Child is not potty trained.
3. Child is not off of all bottles or sipping cups.
4. Failure to provide an up to date record of their immunization records.
5. Falsifying information on applications.

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2018-2019 GSRP PRE-SCHOOL APPLICATION

How to complete this application for the 2018-2019 school year.

1. Complete a separate application for each new student you wish to enroll.
2. **Complete all information on the front and back side of this application**, and include a copy of the birth certificate, health appraisal form, immunization record and documentation of income **(only for GSRP applicants). Incomplete applications will not be considered.**

Print or Type **-Student/Parent Information-**

Student Last Name_____ Student First Name_____ Middle Name_____

Male ☐ Female ☐ Date of Birth_____ Age ____ Multi-Birth: ☐Yes ☐No If yes, which birth order _____

Race (Please check one)
☐African American ☐Asian American ☐Caucasian ☐Hispanic/Mexican ☐Native American ☐Multi-Racial ☐Other:_____

Student's Address_____ Apt. No._____

City_____ State _____ Zip Code_____ Student's Home Phone _____

District of Residency: ☐Wayne ☐Oakland ☐Macomb ☐Other _____

The student lives with: ☐one parent ☐two parents ☐a qualified relative ☐friend(s) ☐an adult that is not the legal guardian ☐alone with no adult

Parent/Guardian Last Name, First Name_____ Relation to Student _____

Parent/Guardian Home Phone _____ Parent/Guardian Cell _____

Parent/Guardian Work Number _____

Parent/Guardian Email Address _____

Parent/Guardian Last Name, First Name_____ Relation to Student _____

Parent/Guardian Home Phone _____ Parent/Guardian Cell _____

Parent/Guardian Work Number _____

Parent/Guardian Email Address _____

Pre-school Currently Attending: _____ City_____ State_____

Did your child participate in a Head Start Program? ☐Yes ☐No

List any Preschool, Day Care or Head Start Program your child attended: _____

Did your child receive: GSRP (Formerly known as MSRP) Head Start Funding? ☐Yes ☐No

Name of the School the child received GSRP: _____

Does your student have a past or current IEP? Please attach? (ex. – speech, resource room) ☐Yes☐ No

Does your student receive Special Education Services? ☐Yes ☐No

Does the applicant have a 504 Accommodation Plan? Please attach? Yes ☐ No ☐

Answer all questions, attach required student records.

CIVIL RIGHTS INFORMATION FOR NEW STUDENTS IS REQUIRED FOR COMPLIANCE WITH FEDERAL CIVIL RIGHTS MANDATES.

Please check✓ one

Disability Code

☐ 00- Not disabled	☐ D- Emotionally Disabled	☐ H – Multiply Disabled	☐ L – Traumatic Brain Injury
☐ A – Autistic	☐ E- Hard of Hearing	☐ I – Orthopedically Impaired	☐ M – Visually Impaired
☐ B- Deaf	☐ F – Learning Disabled	☐ J – Other Health Impaired	☐ C – Deaf-Blind
☐ G – Cognitively Impaired	☐ K – Speech Impaired		

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Answer all questions, attach required student records.

Has the student ever been suspended/expelled from school or does the student have any discipline records? ☐Yes ☐ No

If yes, please state reason _____

Is the student's native tongue a language other than English? ☐Yes ☐ No What is the language? _____

Is the primary language used in the student's home or environment a language other than English? ☐Yes ☐No

What is the language? _____

Does the student receive bilingual education services? ☐Yes ☐No

Does the applicant live with a foster parent? ☐Yes ☐No

Does the applicant have a parent that is active in the military? ☐Yes ☐ No If yes, please list _____

Does your student have a past or current IEP? (ex. – speech, resource room) ☐Yes ☐No

Does your student receive Special Education Services? ☐Yes ☐No

Does the applicant have 504 Accommodation Plan? ☐Yes ☐No

Does the student have any allergies? ☐Yes ☐No If yes, please list _____

Is the student potty trained? ☐Yes ☐No

Is student off all bottles and sipping cups? ☐Yes ☐No

Is the **applicant** currently eligible for **free ☐ or reduced lunch? ☐** ☐Yes ☐No

Do you and your student live in a fixed, regular, adequate nighttime residence? ☐Yes ☐No

Do you and the student live in: ☐ shelter ☐ motel/hotel ☐ temporarily with another family in a house, mobile home, or apartment ☐ in a car or RV ☐ at a campsite ☐ transitional housing ☐ other location: _____

Are any siblings currently attending the Detroit Edison Public School Academy (Note: DEPSA defines siblings as a brother or sister living within the same household)?
(Please check one) ☐Yes ☐No If yes, please list names and current grades below.

Name _____ Grade____ Name _____ Grade____

Name _____ Grade____ Name _____ Grade____

Are any siblings applying for admissions as NEW applicants to the Detroit Edison Public School Academy for the 2018 – 2019 school year? (Please check one) ☐Yes ☐ No
If yes, please list names and grades.

Name _____ Grade____ Name _____ Grade____

Name _____ Grade____ Name _____ Grade____

Parent/Guardian Signature: _____ **Date:** _____

The Detroit Edison Public School Academy offers GSRP Pre-School serving student who become 4 years of age by December 1, 2018. With no admissions test, the Detroit Edison Public School Academy will serve students in grades Pre-School through Grade 12th that are representative of Michigan's diversity.

The Board of Directors of the Detroit Edison Public School Academy does not discriminate in its student admission procedures or course offerings provided to any student on the basis of race, sex, color, creed, national origin, religion or handicapping condition as required by Title VI of the Civil Rights Act of 1964, Title IX of the Education Amendments of 1972, Section 504 of the Rehabilitation Act of 1973, the Age Discrimination Act of 1975, Title II of the Americans with Disabilities Act of 1990, and the individuals with Disabilities Education Act (IDEA 1997).

FOR OFFICE USE ONLY

☐Walk-In ☐Faxed ☐Postmark _____ Date Received: _____ Time: _____

Received By: _____

☐Complete ☐Incomplete

Missing Information:

☐Birth Certificate ☐Immunization Record ☐Parent Identification ☐Health Appraisal ☐Proof of Income (W2)
☐Proof of Residency ☐Vision and Hearing Exam ☐IEP, psychological report, speech report, MET report, exit IEP

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

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

VACCINES (Circle Type)	DATE ADMINISTERED MM/DD/YYYY	
Hepatitis A (HepA)	1	2
Influenza (IIV/LAIV)	1	3
	2	4
Meningococcal (MCV4 / MPSV4)	1	2
Human Papillomavirus (HPV9/HPV4/HPV2)	1	3
	2	
OTHER Vaccines Specify Date & Type	Type of Vaccine(s)	Date of Vaccine(s)
	1	
	2	
	3	

Indicate and attach physician diagnosis or laboratory evidence of immunity as applicable

*NOTE: According to Public Act 368 of 1978, any child enrolling in a Michigan school for the first time must be adequately immunized, vision tested and hearing tested. Exemptions to these requirements are granted for medical, religious and other objections, provided that the waiver forms are properly prepared, signed and delivered to school administrators. Forms for these exemptions are available at your provider office for medical waiver forms and through your local health department for nonmedical waiver forms.

Parent/Guardian refused immunizations: ☐

I certify that the immunization dates are true to the best of my knowledge

_____ _____ / /

Health Professional's Signature Title Date

SECTION IV - RECOMMENDATIONS

(Required for Child Care and Head Start/Early Head Start)

No	Yes	
☐	☐	Is there any defect of vision, hearing or other condition for which the school could help by seating or other actions? If yes, please explain:
☐	☐	Should the child's activity be restricted because of any physical defect or illness? If yes, check and explain degree of restriction(s): ☐ Classroom ☐ Playground ☐ Gymnasium ☐ Swimming Pool ☐ Competitive Sports ☐ Other

Other Recommendations

SECTION V - DENTAL EXAMINATION AND RECOMMENDATIONS (OPTIONAL)

I have examined _____ 's teeth. As a result of this examination, my recommendation for treatment is: _____

child's name

_____ / /

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.

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Developed in Cooperation with the Department of Health and Human Services, Education, Michigan American Association of Pediatrics, Early Childhood Investment Corporation, Child Care Licensing, Head Start, Michigan State Medical Society, Michigan Association of Osteopathic Physicians and Surgeons.