The Ark Preschool

Otsego Church of God
112 Kalamazoo Street
Otsego Michigan 49078
269-694-9481

Our Philosophy

Thank you for the interest in The Ark Preschool for your child. Our preschool program supports the early preparation and enhancement of emotional, social, physical, and intellectual development. Children who attend preschool extend their "early start" into Kindergarten. Their confidence in their learning abilities, comfort with peers and exposure to new ideas and experiences help translate measurably into academic performance and social maturity. Our goal is to offer a Christian based preschool program filled with fun, warm experiences with other children and caring teachers in an atmosphere of love.

- ENROLLING NOW for Fall 2021-2022
- Call Teacher Mrs. Megan VanAtta, 269-694-9481 ext. 205
- Class Opportunities – 3, 4, and 5 year olds – Combined Multi Age Classes
- Typical Day – 9 a.m. - 1 p.m. (See brochure for class schedule.)
- Class Sessions:

3 Year Olds (Must be 3 by 09/01/21)	4 & 5 Year Olds (Must be 4 or 5 by 12/01/21)
☐ MON & WED Tuition: $135 / month **OR** ☐ MON, WED & FRI Tuition: $190 / month	☐ MON & WED Tuition: $135 / month **OR** ☐ MON, WED & FRI Tuition: $190 / month

- Enroll your child – Complete the blue application and return it with a $35 application fee and the first month's tuition (September).
- Enrollment packet – Application and green health form (The health exam must have been completed within the year prior to the school start day). The green health appraisal form must be signed by the examining physician and dated. **Please call the physician to set up an appointment early (appointments in the summer fill up very quickly). Then, please be sure to turn in the completed and signed health appraisal form to the church office by August 31st.**
- Curriculum: Thematic Units, Math, Science, Art, Reading Readiness, Fine Motor, Gross Motor, Social/Emotional, Kindergarten Readiness.
- Fun Field Trips – Gull Meadows Farm, All That Athletics, Bike-A-Thon.
- Discounted rates are available for families enrolling more than one child.

Early Childhood Developmental Preschool Program
Our Program is fully accredited by the State of Michigan

APPLICATION FOR ADMISSION
THE ARK PRESCHOOL
Church of God – Otsego
2021-2022

FOR OFFICE USE ONLY
Date Received _____
Payment Amount $_____
❑Check # _____
❑MO #_____

CHILD INFORMATION:

First Name: _____ Last Name: _____ Nickname: _____

Street Address: _____ City: _____ Zip: _____

Home Phone: _____ ❑Male ❑Female Date of Birth: _____/_____/_____

Child lives with: ❑Both Parents ❑Mom ❑Dad ❑Joint Custody ❑Other: _____

CLASS INFORMATION:

PLEASE INDICATE YOUR CHOICE OF SESSIONS HERE
Combined Classes 9 a.m. – 1 p.m.

3 Year Olds (Must be 3 yrs. old by Sept. 1, 2021)

☐ MON & WED Tuition: $135 per month
OR
☐ MON, WED & FRI Tuition: $190 per month

4 & 5 Year Olds (Must be 4/5 by Dec. 1, 2021)

☐ MON & WED Tuition: $135 per month
OR
☐ MON, WED & FRI Tuition: $190 per month

Enclosed is my application fee of $35.00 plus the first month's tuition totaling $ _____
Make Checks payable to: ***THE ARK PRESCHOOL*** *and mail to:* ***P.O. Box 115, Otsego, MI 49078 (NO CASH)***

FAMILY INFORMATION:

MOTHER: First Name: _____ Last Name: _____

Address: _____ City: _____ Zip: _____

Home Phone: _____ Cell Phone: _____

Employer _____

Employer Phone _____ Work Hours _____

FATHER: First Name: _____ Last Name: _____

Address: _____ City: _____ Zip: _____

Home Phone: _____ Cell Phone: _____

Employer _____

Employer Phone _____ Work Hours _____

BROTHERS & SISTERS *(Please list names and ages)* _____

GENERAL INFORMATION:

Church Affiliation: _____

Family Physician: _____ Phone: _____

PERSON TO CONTACT IN AN EMERGENCY IF UNABLE TO REACH PARENTS:

Name: _____ Phone: _____

Relationship to child: _____

- PLEASE COMPLETE REVERSE SIDE –

PERSON(S) OTHER THAN PARENTS TO WHOM THE CHILD MAY BE RELEASED TO: (Please list by name)
Daycare Provider, Grandparents, Neighbor, etc.

_____ _____ _____

IS THERE ANYTHING ELSE ABOUT YOUR CHILD THAT WOULD BE PARTICULARLY HELPFUL FOR THE TEACHER TO KNOW? *(Allergies, recent parent divorce or separation, previous preschool experiences, etc.)*

PUBLICATION:
Picture permission for outside publications: (Please initial one.)

I hereby give permission_____I expressly withhold permission_____
For my child's picture and/or first name only to be published on the Ark Preschool web page or on the internet. I understand this is for the preschool publication/activities and could be a single picture or as part of a large group photo.

STATEMENT OF CONSENT: I hereby give permission for the ARK to seek emergency care at Borgess/Pipp Medical Center if the family physician is not available.

My child is toilet trained and meets the minimum age requirements. I agree to pay the monthly tuition at the regular class rate.

Parent/Guardian Signature _____ **Date** _____

CHURCH OFFICE HOURS:
Monday through Friday 9:00 – 2:00 PM
Phone: 269-694-9481, Ext. 205 *Email:* otsegochog@hotmail.com

RETURN COMPLETED FORM TO: THE ARK
PO BOX 115
OTSEGO MI 49078

FOR ARK INFORMATION OR TUITION QUESTIONS, CALL BETH AT (269)686-6613

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 _____ child's name 's teeth. As a result of this examination, my recommendation for treatment is: _____

Dentist's Signature _____ / / Date

PHYSICIAN'S SIGNATURE

Examiner's Signature _____ / / Date _____ *Examiner's Name (Print or Type)* _____ Degree or License _____

Number & Street _____ City _____ MI _____ ZIP Code _____ (_____) Telephone _____

Information required for:

Early On - Hearing and Vision Status; Diagnosis; Health Status

Child Care Licensing - Physical Exam, Restrictions, Immunizations

Head Start/Early Head Start - Determination that child is up-to-date on a schedule of age-appropriate preventive and primary health care, including medical, dental, and mental health. The schedule must incorporate the well-child care visit required by EPSDT and the latest immunizations schedule recommended by the Centers for Disease Control and Prevention, State, tribal, and local authorities. An EPSDT well-child exam includes height, weight, and blood tests for anemia at regular intervals based on age.

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

PARENTS Vaccines Required for Child Care and Preschool in Michigan

MDHHS

Whenever infants and children are brought into group settings, there is a chance for diseases to spread. Children must follow state vaccine laws in order to attend child care and preschool. These laws are the minimum standard for preventing disease outbreaks in group settings. The best way to protect your child from other serious diseases is to follow the recommended vaccination schedule at www.cdc.gov/vaccines. Talk to your health care provider to make sure your child is fully protected.

	2-3 months	4-5 months	6-15 months	16-18 months	19 months–4 years	5 years
Diphtheria, Tetanus, Pertussis (DTaP)	1 dose DTaP	2 doses DTaP	3 doses DTaP		4 doses DTaP	
Pneumococcal Conjugate (PCV13)	1 dose	2 doses	3 doses or Age-appropriate complete series	4 doses or Age-appropriate complete series		None
H. influenzae type b (Hib)	1 dose	2 doses		1 dose at or after 15 months or Age-appropriate complete series		None
Polio	1 dose	2 doses			3 doses	
Measles, Mumps, Rubella (MMR)*	None			1 dose at or after 12 months		
Hepatitis B*	1 dose	2 doses			3 doses	
Varicella (Chickenpox)*	None			1 dose at or after 12 months or Current lab immunity or History of varicella disease		

These rules apply to children who are the above ages upon entry into child care or preschool. During disease outbreaks, incompletely-vaccinated children may be excluded from child care and preschool. Parents and guardians choosing to decline vaccines must obtain a certified non-medical waiver from a local health department. Read more about waivers at www.michigan.gov/immunize.

*If the child has not received these vaccines, documented immunity is required. All doses of vaccines must be valid (correct spacing and ages) for child care and preschool entry purposes.

Updated March 1, 2017