The Ark Preschool

Otsego Church of God
112 Kalamazoo Street
Otsego Michigan 49078
269 -686-6613

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 2023-2024
- Call Teacher Ms. Amy Seelye, 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 9/01/23)	4 & 5 Year Olds (Must be 4 or 5 by 12/01/23)
☐ MON & WED Tuition: $155 / month	☐ MON & WED Tuition: $155 / month
OR	**OR**
☐ MON, WED & FRI Tuition: $210 / month	☐ MON, WED & FRI Tuition: $210 / 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

Required Immunizations for Michigan Childcare/Preschool Attendance

Communicable disease rules are the minimum standard for preventing disease outbreaks in child care settings.
Healthcare professionals in Michigan should follow the
2016 Recommended Immunization Schedule at www.cdc.gov/vaccines or www.michigan.gov/immunize to protect patients from all diseases

****All doses of vaccines must be given with appropriate spacing between doses and at appropriate ages to be considered valid.**

Age → Vaccine**↓	**Childcare/Preschool Entry Requirements**						
	Birth through 1 month	2 months through 3 months	4 months through 5 months	6 months through 15 months	16 months through 18 months	19 months through 4 years	5 years
Diphtheria, Tetanus, Pertussis	None	**1** dose DTaP	**2** doses DTaP	**3** doses DTaP	**3** doses DTaP	**4** doses DTaP	
Pneumococcal Conjugate (PCV 13)	None	**1** dose	**2** doses	**3** doses	**4** doses **OR** age appropriate complete series	**1** dose on or after 24 mo **OR** age appropriate complete series	None
H. influenzae type b	None	**1** dose	**2** doses		**1** dose on or after 15 months of age **OR** age appropriate complete series		None
Polio	None	**1** dose	**2** doses		**2** doses	**3** doses	
Measles,* Mumps,* Rubella*	None	None	None	None	**1** dose on or after 12 months of age		
Hepatitis B*	None†	**1** dose	**2** doses		**2** doses	**3** doses	
Varicella* (Chickenpox)	None	None	NoneNone		**1** dose on or after 12 months of age **OR** current lab immunity **OR** reliable history of disease		

*If vaccination is not administered, current laboratory evidence of immunity is required.
† Hepatitis B may be administered as early as birth. This table represents **the minimum required** immunizations for childcare centers.
Parents/guardians must obtain a certified nonmedical waiver from a local health department.

Rev. March 31, 2016

APPLICATION FOR ADMISSION
THE ARK PRESCHOOL
Church of God – Otsego
2023-2024

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, 2023)

☐ MON & WED Tuition: $155 per month
OR
☐ MON, WED & FRI Tuition: $210 per month

4 & 5 Year Olds (Must be 4/5 by Dec. 1, 2023)

☐ MON & WED Tuition: $155 per month
OR
☐ MON, WED & FRI Tuition: $210 per month

Tuition payments are due each month September through May.

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

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

FOR ARK INFORMATION OR TUITION QUESTIONS, CALL BETH AT (269)686-6613 or email thearkpreschoolotsego@gmail.com

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?	Birth History:
h	h	h	1 Allergies or Reactions (for example, food, medication or other)	
h	h	h	2 Hay Fever, Asthma, or Wheezing	
h	h	h	3 Eczema or Frequent Skin Rashes	
h	h	h	4 Convulsions/Seizures	
h	h	h	5 Heart Trouble	
h	h	h	6 Diabetes	
h	h	h	7 Frequent Colds, Sore Throats, Earaches (4 or more per year)	Are there any current or past diagnosis(es) h Yes h No
h	h	h	8 Trouble with Passing Urine or Bowel Movements	If yes, please describe:
h	h	h	9 Shortness of Breath	
h	h	h	10 Speech Problems	
h	h	h	11 Menstrual Problems	
h	h	h	12 Dental Problems: Date of Last Exam / /	
h	h	h	Other (please describe):	
h	h		Does your child take any medication(s) regularly?	If yes, list medications:
			Reason for Medication	

_______________ / /
Parent/Guardian Signature Date

Was the health history reviewed by a health professional?
h Yes h 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
h	h	VISION Date: / /	Visual Acuity			
			Muscle Imbalance			
			Other:			
h	h	HEARING Date: / /	Audiometer			
			Other:			
h	h	URINALYSIS Date: / /	Sugar			
			Albumin			
			Microscopic			
h	h	BLOOD LEAD LEVEL Date: / /	Level ____ ug/dl			

No	Yes	Was child tested for:	Test results:	Normal	Referred	Under Care
h	h	HEIGHT & WEIGHT	Height			
			Weight			
h	h	Other: ______	Other			
h	h	HEMOGLOBIN / HEMATOCRIT				
h	h	BLOOD PRESSURE	Reading: ______			
h	h	TUBERCULIN Date: / /	Type: ______ Neg.: h Pos.: h ______ 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? h Yes h 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: h

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)

Yes	No	
h	h	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:
h	h	Should the child's activity be restricted because of any physical defect or illness? If yes, check and explain degree of restriction(s): h Classroom h Playground h Gymnasium h Swimming Pool h Competitive Sports h 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.