

# Registration and General Information



[www.tcaps.net/earlychildhood](http://www.tcaps.net/earlychildhood)

Learn



Laugh



Share

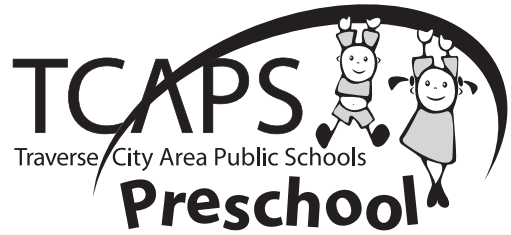


Develop



Grow





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## **TCAPS Preschool Programs offer your child opportunities to grow and learn in the following areas:**

**Physical Skills:** So much of a young child's learning takes place by way of large and small muscle movements. TCAPS classrooms provide a variety of opportunities for important gross motor movement (running, jumping, balancing, dancing) and fine motor skills development (writing, cutting, gluing, painting). Free motor movement and planned movement activities with structured physical skill development are provided to guide children to be active and healthy at preschool and for a lifetime.

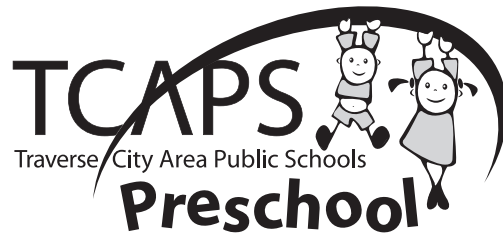
**Music/Movement:** Learning takes place when music is involved! Research supports music as an integral feature for helping children gain math and reading skills. Music helps children learn patterns and counting, and supports vocabulary development, while learning to follow directions. Music enhances the learning process by involving children in listening activities, group experience and opportunities to experiment with new materials and instruments in a fun and exciting environment.

**Spanish Instruction:** Language development is at its height during the ages of birth to five. In terms of brain development, learning a second language during this time is optimal. A trained Spanish teacher will provide vocabulary, basic phrases and cultural awareness. We believe that exposure to other cultures is important even for our youngest learners. With the addition of Spanish into our preschool curriculum, we know our preschoolers will be enriched, well-rounded learners.

**Literacy:** Vocabulary knowledge and other aspects of oral language are particularly important predictors of children's reading comprehension. Your child will be exposed to a language-rich environment that promotes these skills. Alphabet knowledge and phonological awareness is fostered in TCAPS classrooms, preparing children for later proficiency in reading and writing. Exposure to books and environmental print is a standard aspect of the learning environment. A love for reading and writing is encouraged by providing multiple developmentally appropriate opportunities for all our preschool students.

**Social/Emotional:** Children's social and emotional development predicts classroom functioning. Independence, responsibility, self-regulation and cooperation are indicators of how well children make the transition to a school setting and how they fare in the early grades. Self-regulation in young children predicts later abilities in areas such as problem solving, planning and focused attention while contributing to success with future learning. Our classrooms provide daily experiences that promote following instructions, relating to others and overall emotional well-being. Children experiencing supportive relationships with caring adults in a quality early childhood environment have a great start in mastering these important developmental and life-long skills.

# General Information



## TCAPS Offers

- Qualified, caring, trained and experienced staff
- Outstanding facilities including a school library, gymnasium, playground and cafeteria
- Safe and nurturing environment with an emphasis on literacy and language development
- State of Michigan licensed program
- Nutritious, balanced food program
- Creative Curriculum™
- Spanish instruction
- Music instruction
- Fun!
- Extended Day before and after school programs [www.tcaps.net/extendedday](http://www.tcaps.net/extendedday)

## Activities/Curriculum

All TCAPS preschool programs use Creative Curriculum. Creative Curriculum is a literacy rich curriculum with daily activities addressing individual developmental needs. Activities are built around the GOLD assessment looking at 36 objectives organized into six areas of development and learning: social-emotional, physical, language, cognitive, literacy and mathematics. Our programs also feature purposeful play and rest, with quality enhancement always at the forefront.

## Who is Eligible

All three, four and five year old children are welcome. Students need to be toilet-trained before entering a program.

## Admission Policy

To enroll in a preschool program a parent/guardian will complete the enrollment forms, submit a \$30 non-refundable registration fee and pay tuition equal to one half of first tuition payment. Payments must be made bi-weekly by the 1<sup>st</sup> and the 15<sup>th</sup> of each month via check, PaySchools, or ACH Debit. Enrollment will be on a first-come, first-served basis. All children enrolled will follow TCAPS and State of Michigan licensing, health and immunization policies. All immunizations must be up-to-date before attending. See your program manager for questions or call (231) 933-1759 for more information.

## Program Hours

Preschool programs operate on the same calendar and hours as the regular school program. Before and after school care may be available at the school building for an additional fee.\*

\* Not available at the Bayview Wesleyan Church location.

## Locations

See back cover.

## Fees\*\*

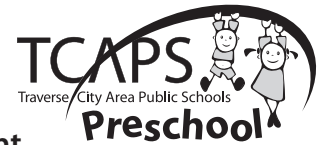
1. Fees are based on enrollment, not attendance. See fee schedule on page 3.
2. Lunch is available at regular school price of \$2.50.

Note: Families who meet income guidelines may be eligible for Department of Human Services (DHS) financial assistance. Parents/Guardians are expected to pay preschool fees in full until DHS reimbursement occurs. Parents/Guardians are responsible for any fees not covered by DHS. Contact DHS for information at (231) 941-3900.

A \$25.00 fee will be assessed for all returned checks.

\*\*Fees subject to change.

# Payment Schedule



Payment must be received by the 1<sup>st</sup> and 15<sup>th</sup> of each month. Families will receive one courtesy reminder per school year, in the event of delinquent preschool payments. The next reminder call results in a \$10 late fee. Additional late payments will result in discontinuation of service. To make payments online visit: [www.tcaps.net/payschools](http://www.tcaps.net/payschools).

## \*FULL DAY OPTIONS

Five full days per week (M, T, W, Th, F)		
Yearly \$5310	Monthly (divided over 9 months) \$590	Bi-Weekly (1 <sup>st</sup> and 15 <sup>th</sup> of each month) \$295
Three full days per week (M, W, F)		
Yearly \$3105	Monthly (divided over 9 months) \$345	Bi-Weekly (1 <sup>st</sup> and 15 <sup>th</sup> of each month) \$172.50
Two full days per week (T, Th)		
Yearly \$2205	Monthly (divided over 9 months) \$245	Bi-Weekly (1 <sup>st</sup> and 15 <sup>th</sup> of each month) \$122.50

## \*HALF-DAY OPTIONS

Five half days per week (M, T, W, Th, F, all a.m. or all p.m. only)		
Yearly \$3555	Monthly (divided over 9 months) \$395	Bi-Weekly (1 <sup>st</sup> and 15 <sup>th</sup> of each month) \$197.50
Three half days per week (M, W, F, all a.m. or all p.m. only)		
Yearly \$2070	Monthly (divided over 9 months) \$230	Bi-Weekly (1 <sup>st</sup> and 15 <sup>th</sup> of each month) \$115
Two half days per week (T, Th, all a.m. or all p.m. only)		
Yearly \$1485	Monthly (divided over 9 months) \$165	Bi-Weekly (1 <sup>st</sup> and 15 <sup>th</sup> of each month) \$82.50

*\*Payment is due by the 1<sup>st</sup> and the 15<sup>th</sup> of each month. Payment will also be accepted in monthly increments. Fees are subject to change. Fee schedule above does not apply to TCAPS Montessori Preschool Programs.*

### Program Handbook

A participant handbook describing additional details about the operation of the program is available. To obtain this guide, contact a TCAPS elementary school or call the Early Childhood Department at (231) 933-1759 or visit [www.tcaps.net/earlychildhood](http://www.tcaps.net/earlychildhood).

### For More Information About:

Program locations, hours, staff, curriculum, etc., please contact:

Traverse City Area Public Schools  
412 Webster Street  
Traverse City, MI 49686  
Early Childhood Office (231) 933-1759  
Child Care Coordinator (231) 933-7967

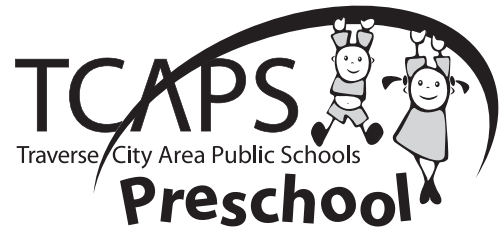
**Web Site:**  
[www.tcaps.net/earlychildhood](http://www.tcaps.net/earlychildhood)

**Television:**  
TCAPS TV/190

**Scan Me:**



*It is the district policy of Traverse City Area Public Schools not to discriminate on the basis of sex, educational programs, activities, or employment policies as applicable by State and Federal Statute.*



# Enrollment Option Form

Today's Date: \_\_\_\_\_ Start Date: \_\_\_\_\_ School Year Applying For: \_\_\_\_\_

Child's Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Elementary School Attendance Area or Intended Preschool Location: \_\_\_\_\_

Alternate Preschool Location: \_\_\_\_\_

- Program Option Chosen:
- |  |   |   |
|--|---|---|
| <input type="checkbox"/> Five Full Days        | <input type="checkbox"/> Three Full Days (M, W, F)        | <input type="checkbox"/> Two Full Days (T, TH)        |
| <input type="checkbox"/> Five Half Days – a.m. | <input type="checkbox"/> Three Half Days – a.m. (M, W, F) | <input type="checkbox"/> Two Half Days – a.m. (T, TH) |
| <input type="checkbox"/> Five Half Days – p.m. | <input type="checkbox"/> Three Half Days – p.m. (M, W, F) | <input type="checkbox"/> Two Half Days – p.m. (T, TH) |

## Registration Fee/Non-Refundable

\$30 For first child enrolled

\$10 For each additional child

- Make checks payable to: **Traverse City Area Public Schools**
- **CREDIT CARDS ACCEPTED**
- Online payments accepted at: **[www.tcaps.net/payschools](http://www.tcaps.net/payschools)**

Please return the enrollment form, registration fee, and half of first tuition payment to the school site selected.

# Preschool Enrollment Packet

To enroll, the following items need to be completed and turned in to the preschool manager:

- TCAPS Preschool Enrollment Option Form** (this page)
- TCAPS Student Registration Form** (pages 5-8)
- DHS Child Information Record** (page 9)
- TCAPS Parent Consent Form** (page 10)  
(Also located on the last page of the Parent Handbook)
- DHS Preschool Health Appraisal Form - COMPLETED BY PHYSICIAN** (page 11-12)  
(Note: Copy of child's immunization card may be attached instead of writing in the dates)
- Original Copy of Birth Certificate** (we will make a copy)
- \$30 Registration Fee** (non-refundable) (\$10 for each additional child)
- Half of first bi-weekly tuition payment due if enrolling before June 1**  
(second half due by July 1)
- First bi-weekly tuition payment due if enrolling after July 1**

# Student Registration Form

(Translation of this document will be available upon request)

School \_\_\_\_\_

Date \_\_\_\_\_

## STUDENT INFORMATION (PLEASE PRINT)

Legal Last Name		First Name		Middle Name		Gender <input type="checkbox"/> M <input type="checkbox"/> F	Grade
Street Address		Street Name	Apt#	P.O. Box	City	Zip	
Home Phone ( )		Unlisted <input type="checkbox"/> Yes <input type="checkbox"/> No		MONTH	Date of Birth DATE	YEAR	
What is this students' race? <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Native Hawaiian or other Pacific Islander <input type="checkbox"/> Black or African American <input type="checkbox"/> White		Is this student Hispanic/Latino? <input type="checkbox"/> No, not Hispanic or Latino <input type="checkbox"/> Yes, Hispanic or Latino		What language did this student first speak?*		<input type="checkbox"/> English <input type="checkbox"/> Other _____	
Primary language spoken at home:*		What other languages are spoken in this student's home or environment?*					
<input type="checkbox"/> English <input type="checkbox"/> Other _____							
Has this student ever attended a TCAPS program? <input type="checkbox"/> Yes <input type="checkbox"/> No							
If yes, where _____ Dates _____							
Is there a current <b>Order of Protection</b> or <b>No Contact Order</b> which concerns this student? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, please provide a copy.							

## PARENT/GUARDIAN INFORMATION

Last Name		First Name		Middle Initial	Relationship	Email Address	
Street Address (if different from above)		Street Name	Apt#	P.O. Box	City	Zip	
Home Phone (if different from above) ( )		Cell Phone ( )		Does this student reside with you? <input type="checkbox"/> Yes <input type="checkbox"/> No		Are you legally responsible for this student? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Place of Employment					Work Phone & Extension ( ) ext.		
Last Name		First Name		Middle Initial	Relationship	Email Address	
Street Address (if different from above)		Street Name	Apt#	P.O. Box	City	Zip	
Home Phone (if different from above)		Cell Phone		Does this student reside with you? <input type="checkbox"/> Yes <input type="checkbox"/> No		Are you legally responsible for this student? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Place of Employment					Work Phone & Extension ( ) ext.		

## LEGAL/JOINT CUSTODY (IF DIFFERENT THAN ABOVE)

Last Name		First Name		Middle Initial	Relationship	Email Address	
Street Address		Street Name	Apt#	P.O. Box	City	Zip	
Home Phone ( )		Cell Phone ( )		Does this student reside with you? <input type="checkbox"/> Yes <input type="checkbox"/> No		Are you legally responsible for this student? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Place of Employment					Work Phone & Extension ( ) ext.		
Is this address an additional residence for this student during the school week? <input type="checkbox"/> Yes <input type="checkbox"/> No				If yes, please explain			

\*If the answers to any of these questions is "other", a Home Language Survey will be provided in your native language.

## HEALTH INFORMATION *Please note any pertinent medical information about this student.*

Does student have any chronic health problems?  Yes  No If yes, please describe \_\_\_\_\_  
 (Example: asthma, diabetes, seizures, vision, hearing)

Does student use Epi-Pen or other emergency medications?  Yes  No If yes, will it be at school?  Yes  No  
**(Medication/Treatment Authorization form required)**

List any allergies/sensitivities:

Food: \_\_\_\_\_ Reaction: \_\_\_\_\_

Medicine: \_\_\_\_\_ Reaction: \_\_\_\_\_

Environmental: \_\_\_\_\_ Reaction: \_\_\_\_\_

Insect Bites: \_\_\_\_\_ Reaction: \_\_\_\_\_

List ALL medications (including over-the-counter) that the student takes in a 24-hour period.  
 (Check box if received at school. **Medication/Treatment Authorization form required**)

- |                                |                                |
|--------------------------------|--------------------------------|
| <input type="checkbox"/> _____ | <input type="checkbox"/> _____ |
| <input type="checkbox"/> _____ | <input type="checkbox"/> _____ |
| <input type="checkbox"/> _____ | <input type="checkbox"/> _____ |

A history of developmental delays?  Yes  No If yes, please describe \_\_\_\_\_

A history of mental health concerns; worries, anxiety, fears, depression?  Yes  No If yes, please describe \_\_\_\_\_

Sleeping patterns/problems/nightmares?  Yes  No If yes, please describe \_\_\_\_\_

Family history of learning disabilities, ADHD?  Yes  No If yes, please describe \_\_\_\_\_

What additional information do you want us to know about your child?

## SPECIAL EDUCATION - SECTION 504

Has this student ever received any special education services or attended special education classes?  Yes  No

Is this student currently receiving special education services?  Yes  No If yes, please provide a copy of the current individual education plan (IEP).

Does this student currently have a Section 504 plan?  Yes  No

## CHILD CARE

Child Care Name	Phone ( )	Child Care Name	Phone ( )
-----------------	--------------	-----------------	--------------

Street Address	Street Name	Apt#	P.O. Box	City	Zip	Street Address	Street Name	Apt#	P.O. Box	City	Zip
----------------	-------------	------	----------	------	-----	----------------	-------------	------	----------	------	-----

Days of the week for child care <input type="checkbox"/> A.M. <input type="checkbox"/> P.M. <input type="checkbox"/> Monday <input type="checkbox"/> Tuesday <input type="checkbox"/> Wednesday <input type="checkbox"/> Thursday <input type="checkbox"/> Friday	Days of the week for child care <input type="checkbox"/> A.M. <input type="checkbox"/> P.M. <input type="checkbox"/> Monday <input type="checkbox"/> Tuesday <input type="checkbox"/> Wednesday <input type="checkbox"/> Thursday <input type="checkbox"/> Friday
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## EMERGENCY CONTACTS *If we are unable to contact you, please list two LOCAL emergency contacts that TCAPS may notify and/or release this student to.*

Last Name	First Name	Middle Initial	Relationship
-----------	------------	----------------	--------------

Home Phone ( )	Cell Phone ( )
-------------------	-------------------

Work Phone & Extension ( )	ext.
-------------------------------	------

Last Name	First Name	Middle Name	Relationship
-----------	------------	-------------	--------------

Home Phone ( )	Cell Phone ( )
-------------------	-------------------

Work Phone & Extension ( )	ext.
-------------------------------	------



**FAMILY INFORMATION** *Please list all children in the family (by birth order, oldest first).*

Name	Gender <input type="checkbox"/> M <input type="checkbox"/> F	Date of Birth	School
Name	Gender <input type="checkbox"/> M <input type="checkbox"/> F	Date of Birth	School
Name	Gender <input type="checkbox"/> M <input type="checkbox"/> F	Date of Birth	School
Name	Gender <input type="checkbox"/> M <input type="checkbox"/> F	Date of Birth	School
Name	Gender <input type="checkbox"/> M <input type="checkbox"/> F	Date of Birth	School
Name	Gender <input type="checkbox"/> M <input type="checkbox"/> F	Date of Birth	School

**FAMILY RESIDENCE**

If your enrolled student is experiencing a loss of housing, he or she may be eligible for assistance through TCAPS' Students in Transition Empowerment Program (STEP).

The McKinney-Vento Homeless Assistance Act, reauthorized by Title X, Part C, of the No Child Left Behind Act, requires school districts to remove any barriers to the attendance, full participation, and success of students, Pre-K through grade 12, who lack a "fixed, regular, and adequate overnight residence." **The federal law includes a definition of who is considered "homeless," or as more commonly referenced "in transition," for the purposes of the Act and, therefore, eligible for the rights and protections it provides.**

**CONFIDENTIAL INFORMATION**

Based on the above definition, please indicate your child's living situation below if: (1) this describes your child's current living situation; OR (2) the student enrolling is not living with a parent or legal guardian.

- \_\_\_\_\_ Goodwill Inn \_\_\_\_\_ Pete's Place \_\_\_\_\_ Host Home \_\_\_\_\_ Women's Resource Center
- \_\_\_\_\_ With relatives or friends due to economic hardship or loss of housing
- \_\_\_\_\_ Train or bus station, park, or car
- \_\_\_\_\_ Motel/hotel
- \_\_\_\_\_ Campground
- \_\_\_\_\_ Abandoned apartment or building
- \_\_\_\_\_ Foster Care, if less than 6 months in the same placement
- \_\_\_\_\_ Other Describe \_\_\_\_\_

# Public Act 328

Public Act 328 (effective January 1, 1995) requires public school districts to expel any student who possesses a dangerous weapon in a weapon-free school zone or commits either arson or rape in a school building or on school property (including school buses and/or other school transportation).

A dangerous weapon is defined as "a firearm, dagger, dirk, stiletto, knife with blade over three (3) inches in length, pocket knife opened by a mechanical device, iron bar, or brass knuckles or other devices designed to or likely to inflict bodily harm, including, but not limited to, air guns, and explosive devices."

Check One:

1. Has not been expelled from another school.
2. Has been expelled from another school (or has expulsion charges pending).
3. Is currently under suspension from another school.

If you checked box 2 or 3, please explain the circumstances below:

\_\_\_\_\_

\_\_\_\_\_

**CONTINUED ON BACK**

# Records Request to be faxed

Student Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

SCHOOL HISTORY					
Last school this student attended				Date Left	
Street address of last school attended	City	State	Zip Code	Phone	Fax

## DIRECTORY INFORMATION

The Board designates as student "directory information" a student's name, address, telephone number, date and place of birth, photograph, video and/or electronic images, major field of study, participation in officially recognized activities and sports, height and weight, if a member of an athletic team, dates of attendance, date of graduation, awards received, honor rolls, and scholarships. If you have any objections regarding the release of this information about your child, please notify the school your child will be attending in writing.

## PARENT CONSENT

- ***In case of illness, accident, or injury serious enough to warrant immediate medical attention, I hereby give permission to transport the above named child to the nearest hospital. I understand I am responsible for any and all costs incurred.***
  
- ***The Board may establish online access for the parents or the eligible student to the student's confidential academic and attendance records. Please be reminded that the account and confidential information about the student is only as secure as the parents or student keeps their information. The parent, eligible student, or unauthorized party will hold neither the District nor its employees responsible for any breach of this information.***
  
- ***I understand, for the health, safety, and/or educational needs of my child, information may need to be shared with individuals working with my child. Typically, this would include the building administrator, secretary, teachers, aides, counselors, school social workers, noon duty staff, transportation staff, school nurse, and truancy program coordinator.***

I understand that:

1. *Traverse City Area Public Schools will request records for this student from previous school(s); and*
2. *enrollment is conditional until records are received and reviewed by the school; and*
3. *if student records received from the previous school(s) are not as represented, this student may be excluded from Traverse City Area Public Schools immediately without further recourse.*

Schools may send a student's educational record to officials at schools in which the student seeks or intends to enroll, upon condition that the student's parents be notified of the transfer, receive a copy of the record if desired, and have opportunity to challenge the content of the record. Please send to the school listed below, the educational records including psychological and special education files for the child listed above.

\_\_\_\_\_  
Signature (Parent/Guardian/or student if 18 years of age or more)

\_\_\_\_\_  
TCAPS School

\_\_\_\_\_  
School Phone Number School Fax Number

\_\_\_\_\_  
School Address, City, State, Zip Code



## CHILD INFORMATION RECORD

### State of Michigan Department of Human Services - Bureau of Children and Adult 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.

<b>For Provider Use Only:</b>		Date of Admission	Date of Discharge		
Name of Child (Last, First, Middle Initial)				Child's Date of Birth	
Address (Number and Street, Building/Apartment Number)			City		State
Address (Number and Street, Building/Apartment Number)			City		Zip Code
Father/Legal Guardian's Name		Home Phone (   )		Mother/Legal Guardian's Name	
Home Address (if not child's address)		Cell Phone (   )		Home Address (if not child's address)	
Home Address (if not child's address)		Cell Phone (   )		Home Address (if not child's address)	
City		State		Zip Code	
City		State		Zip Code	
Email Address (optional)			Email Address (optional)		
Employer Name		Work Phone (   )		Employer Name	
Employer Name		Work Phone (   )		Employer Name	
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. 7-12) Previous editions 9-09, 3-08, 10-07, & 1-06 may be used until 12/31/13.

**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. (   )

I give permission to _____, licensed by the Department of Human Services (Provider's Name)	
to secure emergency medical and/or emergency surgical treatment for the above named minor child while in care.	
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

Department of Human Services (DHS) will not discriminate against any individual or group because of race, religion, age, national origin, color, height, weight, marital status, sex, sexual orientation, gender identity or expression, political beliefs or disability. If you need help with reading, writing, hearing, etc., under the Americans with Disabilities Act, you are invited to make your needs known to a DHS office in your area.

AUTHORITY: 1973 PA 116  
COMPLETION: Required  
PENALTY: Rule Violation Citation.

BCAL-3731 (Rev. 7-12) Previous editions 9-09, 3-08, 10-07, & 1-06 may be used until 12/31/13.

# Parent Consent and Program Guarantees to the Terms and Conditions Outlined in the Participant Handbook

## Preschool, Extended Day Child Care Programs, Montessori Program, Summer Adventure Day Camps and Young Family Teen Parent Program

**Please complete and sign this page and return it to the Program Manager.**

1. I hereby acknowledge that I have read and understand the TCAPS Preschool, Montessori Program, Extended Day Child Care Programs, Young Family Teen Parent Program and Summer Adventure Day Camp Participant Handbook, including the outlined provisions and requirements. I am fully aware of all policies herein stated. I am in agreement with such conditions, and will abide by the same.
2. I have read, understand, and will abide by the registration, fees and payment policies as written in the Participant Handbook.
3. I give permission for my child to attend regularly scheduled field trips as outlined to me by the Program Manager.  
 YES     NO
4. I agree to PREPAY for the services for which I am enrolling my child(ren).  
 YES

### Directory Information

The Family Educational Rights and Privacy Act (FERPA) allows school districts to disclose, without consent, appropriately identified “directory” information unless a parent/guardian or eligible student have advised the District to the contrary in accordance with District procedures. The Board designates as student “directory information”: a student’s name, parent/guardian name, address, telephone number, email address, date and place of birth, photograph, video and/or electronic images, participation in officially recognized activities and sports, height and weight of members of athletic teams, dates of attendance, honors, degrees and awards received, grade placement, most recent previous school attended, major field of study and information generally found in yearbooks. Parents/Guardians or eligible students who do not want the Traverse City Area Public Schools district to release any or all directory information must inform the District of their objection(s) by providing written notification to the District or school building principal by the third Friday in October.

I hereby represent that I am the legal guardian of the child enrolled and acknowledge that it is my responsibility to keep all information, authorizations, required forms and health records pertaining to my child current and up-to-date.

### Parent Notification of the Licensing Notebook Requirement

#### Child Care Organizations Act, 1973 Public Act 116

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 actions plans.
- The notebook will be available to parents for review during regular business hours.
- Licensing inspection and special investigation reports from the past two years are available on the Bureau of Children and Adult Licensing website at [www.michigan.gov/michildcare](http://www.michigan.gov/michildcare).

Student’s Name: \_\_\_\_\_

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

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

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

**Required**

**DHS PRESCHOOL HEALTH APPRAISAL - TO BE COMPLETED BY PHYSICIAN**

**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**

<table style="width:100%; border-collapse: collapse;"> <tr> <th style="width:10%; text-align: center;">Yes</th> <th style="width:10%; text-align: center;">No</th> <th style="width:10%; text-align: center;">Resolved</th> <th style="width:70%;"># Is your child having any of the problems listed below?</th> </tr> <tr> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> <td>1 Allergies or Reactions (for example, food, medication or other)</td> </tr> <tr> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> <td>2 Hay Fever, Asthma, or Wheezing</td> </tr> <tr> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> <td>3 Exzema or Frequent Skin Rashes</td> </tr> <tr> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> <td>4 Convulsions/Seizures</td> </tr> <tr> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> <td>5 Heart Trouble</td> </tr> <tr> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> <td>6 Diabetes</td> </tr> <tr> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> <td>7 Frequent Colds, Sore Throats, Earaches (4 or more per year)</td> </tr> <tr> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> <td>8 Trouble with Passing Urine or Bowel Movements</td> </tr> <tr> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> <td>9 Shortness of Breath</td> </tr> <tr> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> <td>10 Speech Problems</td> </tr> <tr> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> <td>11 Menstrual Problems</td> </tr> <tr> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> <td>12 Dental Problems: Date of Last Exam / /</td> </tr> <tr> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> <td>Other (please describe): _____</td> </tr> <tr> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> <td>Does your child take any medication(s) regularly?</td> </tr> <tr> <td colspan="3"></td> <td>Reason for Medication _____</td> </tr> <tr> <td colspan="3"></td> <td>_____ / /</td> </tr> <tr> <td colspan="3"></td> <td style="text-align: right;"><b>Parent/Guardian Signature</b> _____ <b>Date</b> _____</td> </tr> </table>	Yes	No	Resolved	# Is your child having any of the problems listed below?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	1 Allergies or Reactions (for example, food, medication or other)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	2 Hay Fever, Asthma, or Wheezing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	3 Exzema or Frequent Skin Rashes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	4 Convulsions/Seizures	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	5 Heart Trouble	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	6 Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	7 Frequent Colds, Sore Throats, Earaches (4 or more per year)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	8 Trouble with Passing Urine or Bowel Movements	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	9 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Reason for Medication _____				_____ / /				<b>Parent/Guardian Signature</b> _____ <b>Date</b> _____	<p><b>Birth History:</b></p> <p>Are there any current or past diagnosis(es) <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>If yes, please describe:</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>If yes, list medications:</p> <p>_____</p> <p>_____</p> <p>Was the health history reviewed by a health professional? <input type="checkbox"/> Yes <input type="checkbox"/> No <b>Examiner's Initials:</b> _____</p>
Yes	No	Resolved	# Is your child having any of the problems listed below?																																																																						
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**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	No	Yes	Was child tested for:	Test results:	Normal	Referred	Under Care
<input type="checkbox"/>	<input type="checkbox"/>	VISION Date: ____/____/____	Visual Acuity				<input type="checkbox"/>	<input type="checkbox"/>	HEIGHT & WEIGHT	Height			
			Muscle Imbalance							Weight			
			Other:							Other: _____			
<input type="checkbox"/>	<input type="checkbox"/>	HEARING Date: ____/____/____	Audiometer				<input type="checkbox"/>	<input type="checkbox"/>	HEMOGLOBIN / HEMATOCRIT	_____			
			Other:							BLOOD PRESSURE	Reading: _____		
<input type="checkbox"/>	<input type="checkbox"/>	URINALYSIS Date: ____/____/____	Sugar				<input type="checkbox"/>	<input type="checkbox"/>	TUBERCULIN Date: ____/____/____	Type: _____			
			Albumin							Neg.: <input type="checkbox"/> Pos.: <input type="checkbox"/> _____ mm			
			Microscopic										
<input type="checkbox"/>	<input type="checkbox"/>	BLOOD LEAD LEVEL Date: ____/____/____	Level _____ ug/dl				<p><b>NOTE:</b> 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.</p>						

**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		VACCINES (Circle Type)	DATE ADMINISTERED MM/DD/YYYY	
Hepatitis B (Hep B)	1	3	Hepatitis A (Hep A)	1	2
	2			Influenza TIV/LAIV	1
DTaP/DTP/DT/Td	1	4	2		4
	2	5	Meningococcal MCV4 / MPSV4	1	2
	3	6		2	3
Tdap	1		OTHER Vaccines Specify Date & Type	Type of Vaccine(s)	Date of Vaccine(s)
Haemophilus Influenzae type b (HIB)	1	3		1	
2	4	2		2	
Polio - IPV / OPV	1	3	3		
Pneumococcal Conjugate (PCV7/PCV13)	1	3	<i>Indicate and attach physician diagnosis or laboratory evidence of immunity as applicable</i>  *NOTE: According to Public Act 368 of 1978, any child enrolling in a Michigan school for the first time must be adequately immunized, vision tested and hearing tested. Exemptions to these requirements are granted for medical, religious and other objections, provided that the waiver forms are properly prepared, signed and delivered to school administrators. Forms for these exemptions are available at your child's school or local health department.		
	2	4			
Rotavirus (RV1/RV5)	1	3	History of Chickenpox Disease? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, date: _____ Parent/Guardian refused immunizations: <input type="checkbox"/>		
2					
Measles, Mumps, Rubella (MMR)	1	2	I certify that the immunization dates are true to the best of my knowledge  _____ / ____ / ____ Health Professional's Signature Title Date		
Varicella (Chickenpox)	1	2			

		<b>SECTION IV - RECOMMENDATIONS</b> (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: _____ _____
<input type="checkbox"/>	<input type="checkbox"/>	Should the child's activity be restricted because of any physical defect or illness? If yes, check and explain degree of restriction(s): <input type="checkbox"/> Classroom <input type="checkbox"/> Playground <input type="checkbox"/> Gymnasium <input type="checkbox"/> Swimming Pool <input type="checkbox"/> Competitive Sports <input type="checkbox"/> Other _____ _____
Other Recommendations		

<b>PHYSICIAN'S SIGNATURE</b>			
_____ <i>Examiner's Signature</i>	_____ Date	_____ <i>Examiner's Name (Print or Type)</i>	_____ Degree or License
_____ Number & Street	_____ City	MI _____ ZIP Code	(_____) _____ Telephone

## REVISED CHILDCARE PAYMENT OPTIONS

Due to new federal regulation regarding the storage of credit card information, we are no longer using the credit card authorization form to process payments. Please choose from one of the following payment options.

1. ACH
  - a. This option is a debit to your checking or savings account.
  - b. \*You must complete the Authorization Agreement for Direct Payments (ACH Debits) if you choose this option. (page 15)  
\*First debit would take place on Sept. 15.
  
2. PaySchools
  - a. Log on to [www.tcaps.net/payschools](http://www.tcaps.net/payschools)
  - b. Select a category (school)
  - c. Choose an item (program)
  
3. Check/Money Orders must be received in the Business Office by the 1<sup>st</sup> or 15<sup>th</sup>.
  
4. Credit Card
  - a. This option is only available if you call the TCAPS Business Office at (231) 933-1736 each time you choose to authorize payment.
  - b. Please do not leave credit card information on her voicemail.
  
5. Cash (is accepted, but not recommended) must be received in the Business Office by the 1<sup>st</sup> or 15<sup>th</sup>.

*Reduced tuition option is available to those families who enroll their child five full days and qualify for free or reduced lunch. Call the Early Childhood office at (231) 933-1759 for more information.*

If you have any questions, please contact Carrie Sattler at (231) 933-1736 or Dawn Smith at (231) 933-1771.

Thank you!

# How to Make Online Payment Through PaySchools

## **PAYSCHOOLS Procedures:**

1. Go to [www.tcaps.net/payschools](http://www.tcaps.net/payschools) or click on "PAYSCHOOLS" icon on right side of TCAPS home page.  
\*First-time users will need to register to use the site.
2. Select the Category to which you would like to make a payment.
3. Select the program (Extended Day, Preschool, or Registration Fee) for which you would like to make a payment by clicking "Add to Cart" next to the name of that program.
4. Enter the amount you would like to pay for the item selected (for example: 20.00 to make a payment of twenty dollars).
5. If you would like to add additional items to your cart, select Continue Shopping.
6. If finished, select Check Out.
7. Enter email address and password.
8. If a student is already associated with your account, select the student for which the payment applies and click Continue.
9. If you need to add a student to your account, the student ID is NOT required, although it appears to be a requirement, you may proceed without entering the student ID.
10. Once all the items have been entered into your cart, you may pay by credit card or debit card.
11. You will receive an email confirmation from PaySchools as your receipt.







Traverse City Area Public Schools  
Great Community, Great Schools

# SCHOOL YEAR 2015/16

**AUTHORIZATION AGREEMENT  
FOR DIRECT PAYMENTS (ACH DEBITS)**

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

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

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

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

Name of Student(s): \_\_\_\_\_

School \_\_\_\_\_

Check appropriate boxes:

Preschool

Extended Day

I (we) hereby authorize TRAVERSE CITY AREA PUBLIC SCHOOLS, hereinafter called COMPANY, to initiate debit entries for preschool/child care expenses incurred to my (our) account indicated below at the depository financial institution named below, hereinafter called DEPOSITORY, and to debit the same to such account. I (we) acknowledge that the origination of ACH transactions to my (our) account must comply with the provisions of U.S. law.

TCAPS will debit your account automatically on or after the 1<sup>st</sup> and 15<sup>th</sup> of each month for preschool child care expenses incurred.

***Please use the bank information below***

***Or use bank information already on file***

\_\_\_\_\_  
Depository Name

Checking

Savings

\_\_\_\_\_  
Routing Number

\_\_\_\_\_  
Account Number

This authorization is to remain in full force and effect until COMPANY has received written notification from me (or either of us) of its termination in such time and in such manner as to afford COMPANY and DEPOSITORY a reasonable opportunity to act on it.

Name(s) \_\_\_\_\_

Signature \_\_\_\_\_

Date \_\_\_\_\_

NOTE: WRITTEN DEBIT AUTHORIZATION MUST PROVIDE THAT THE RECEIVER MAY REVOKE THE AUTHORIZATION ONLY BY NOTIFYING THE ORIGINATOR IN THE MANNER SPECIFIED IN THE AUTHORIZATION.



Thank you for choosing Traverse City Area Public Schools preschool program. In partnership with a caring community and quality caring staff, the TCAPS early childhood programs provide our youngest learners the opportunity to create, explore, think and reason in environments that are nurturing, respectful, engaging and fun. Early childhood is where a lifetime of success begins! Thank you for allowing us to be a part of your child's educational journey.

# Preschool Locations



## **Bayview Wesleyan Church\***

720 Wayne Street  
Traverse City, MI 49690  
(231) 933-1792

## **Central Grade School**

301 West Seventh Street  
Traverse City, MI 49684  
(231) 933-7882

## **Cherry Knoll Elementary School**

1800 Three Mile Road  
Traverse City, MI 49696  
(231) 933-8958

## **Courtade Elementary School**

1111 Rasho Road  
Traverse City, MI 49696  
(231) 933-5827

## **Eastern Elementary School**

1600 Eastern Avenue  
Traverse City, MI 49686  
(231) 933-1687

## **Long Lake Elementary School**

7600 N. Long Lake Road  
Traverse City, MI 49685  
(231) 933-7811

## **Oak Park Elementary School\*\***

301 S. Garfield Avenue  
Traverse City, MI 49686

## **Old Mission Peninsula School**

2699 Island View Road  
Traverse City, MI 49686  
(231) 933-7424

## **Silver Lake Elementary School**

5858 Culver Road  
Traverse City, MI 49685  
(231) 933-5771

## **TCAPS International School at Bertha Vos**

3723 Shore Road  
Willamsburg, MI 49690  
(231) 933-6420

## **Westwoods Elementary School**

1500 Fisher Road  
Traverse City, MI 49685  
(231) 933-8524

## **Willow Hill Elementary School**

1250 Hill Street  
Traverse City, MI 49684  
(231) 933-8561

\* Pending enrollment

\*\* For TCAPS staff only