

ST. THECLA PRESCHOOL DOCUMENTS

Along with the attached documents,
please also send in a copy of the following:

- Birth Certificate
- Baptismal Certificate
- Updated Immunization Record

**20762 South Nunneley Road
Clinton Township, MI 48035
586.791.2170 | www.stthecla.com**

St. Thecla Catholic School Preschool Handbook Agreement



- I have received a copy of the Preschool Program Handbook
- I understand and agree that it is my responsibility to read and familiarize myself with the policies and procedures of the program
- I understand that the Preschool Program also abides by the school policies in the St. Thecla School Handbook

Please sign this acknowledgment form and return it to your classroom teacher at Orientation.

- ☐ I have read the Preschool Program Handbook Agreement and agree to abide by the rules, procedures and principles stated.

Student Name: _____

Parent Name: _____

Parent Signature: _____

Date: _____

We the community of St. Thecla Catholic School dedicate ourselves to serving God through our growth in faith, education, and love for one another as members of God's Family.

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)	TODAY'S DATE (mm/dd/yy) / /
PARENT/GUARDIAN (Last, First, Middle)			HOME TELEPHONE NUMBER ()
ADDRESS (Number & Street)	(City)	(ZIP Code)	WORK TELEPHONE NUMBER ()

SECTION I - HEALTH HISTORY

Yes	No	Resolved	# Is your child having any of the problems listed below?	Birth History:
<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 Eczema 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	Are there any current or past diagnosis(es) <input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	9 Shortness of Breath	If yes, please describe:
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	10 Speech Problems	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	11 Menstrual Problems	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	12 Dental Problems: Date of Last Exam / /	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Other (please describe):	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	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? <input type="checkbox"/> Yes <input type="checkbox"/> 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	No	Yes	Was child tested for:	Test results:	Normal	Referred	Under Care
<input type="checkbox"/>	<input type="checkbox"/>	VISION	Visual Acuity				<input type="checkbox"/>	<input type="checkbox"/>	HEIGHT & WEIGHT	Height			
		Date: / /	Muscle Imbalance						Weight				
		Other:					<input type="checkbox"/>	<input type="checkbox"/>	Other:				
<input type="checkbox"/>	<input type="checkbox"/>	HEARING	Audiometer				<input type="checkbox"/>	<input type="checkbox"/>	HEMOGLOBIN / HEMATOCRIT				
		Date: / /	Other:				<input type="checkbox"/>	<input type="checkbox"/>	BLOOD PRESSURE	Reading: _____			
<input type="checkbox"/>	<input type="checkbox"/>	URINALYSIS	Sugar				<input type="checkbox"/>	<input type="checkbox"/>	TUBERCULIN	Type: _____			
		Date: / /	Albumin						Neg.: <input type="checkbox"/> Pos.: <input type="checkbox"/> _____ mm				
			Microscopic										
<input type="checkbox"/>	<input type="checkbox"/>	BLOOD LEAD LEVEL	Level _____ ug/dl				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.						
		Date: / /											

Examinations and/or Inspections

Essential Findings Deviating from Normal:
Exam Date: / /

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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 (HepB)	1	3	Hepatitis A (HepA)	1	2
	2		Influenza (IIV/LAIV)	1	3
				2	4
DTaP/DTP/DT/Td	1	4	Meningococcal (MCV4 / MPSV4)	1	2
	2	5	Human Papillomavirus (HPV9/HPV4/HPV2)	1	3
	3	6		2	
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	
Polio (IPV/OPV)	1	3		3	
	2	4	Indicate and attach physician diagnosis or laboratory evidence of immunity as applicable		
Pneumococcal Conjugate (PCV7/PCV13)	1	3	*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.		
	2	4			
Rotavirus (RV1/RV5)	1	3	Parent/Guardian refused immunizations: <input type="checkbox"/>		
	2				
Measles, Mumps, Rubella (MMR)	1	2			
Varicella (Chickenpox)	1	2			
History of Chickenpox Disease? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, date: _____					
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	
<input type="checkbox"/>	<input type="checkbox"/>	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		

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.

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.

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Good Health Statement

I _____ verify that my child,
(Parent/Guardian Name)

_____ is in good health
(Child's Name)

and his/her immunizations are up-to-date. I assume responsibility for my
child's state of health while at St. Thecla Catholic Preschool.

The following activity restrictions apply to my child:

1. _____
2. _____
3. _____
4. _____

(PRINT PARENT/GUARDIAN NAME)

(PARENT/GUARDIAN SIGNATURE)

(DATE)

Reviewed and Updated:

Date

Parent/Guardian Initials

***"We, the community of St. Thecla Catholic School, dedicate ourselves to serving God through our growth in
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Student's Full Name _____ Nickname _____

Names of people child lives with (age/grade if a sibling) _____

Language(s) spoken in home _____

Mother's Occupation _____ Father's Occupation _____

Previous day care or preschool experience? _____ If yes, please describe your child's experience. _____

Is your child fully potty trained (able to clean self)? _____

Can your child: Button _____ Snap _____ Zip _____

Can your child recite their first name? _____ Recite last name? _____

Do you have any concerns I should know about, such as:

Health concerns, allergies _____

Emotional concerns, such as fear and anxieties _____

Is there anything else you would like me to know? _____

What are your expectations of the Preschool program? _____

Who will be dropping off and picking up your child? _____

WRITTEN INFORMATION PACKET DOCUMENTATION

Michigan Department of Licensing and Regulatory Affairs
Bureau of Community and Health Systems

Child(ren)'s Name(s) (Last, First)	Center Name
------------------------------------	-------------

A written information packet has been provided at the time of enrollment. The packet included all the following information:

- Criteria for admission and withdrawal.
- Schedule of operation, denoting hours, days, and holidays during which the center is open and services are provided.
- Fee policy.
- Discipline policy.
- Food service program.
- Program philosophy.
- Typical daily routine.
- Parent notification plan for accidents, injuries, incidents, illnesses.
- Exclusion policy for child illnesses.
- Notice of the availability of the center's licensing notebook.
 - The licensing notebook contains all the licensing inspection and special investigation reports and related corrective action plans since May 28, 2010.
 - The licensing notebook is available to parents during regular business hours.
 - Licensing inspection and special investigation reports from at least the past two years are available on the child care licensing website at www.michigan.gov/michildcare.
- Other _____

I certify that I received all of the above items.

Parent/Guardian Signature

Date

Note: A single BCAL-4340 form may be used for all children in the same family.

BCAL-4340 (10-16) MS Word

LARA is an equal opportunity employer/program.

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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**.

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.

BCAL-5053 (10-16) MS Word

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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)				Child's Date of Birth	
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.)					

Emergency Contact & Release of Child: 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 individual, attach additional sheets.)		
1.	()	()
2.	()	()
3.	()	()

Release of Child Only: 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.	()

Parent/Legal Guardian Initials:	
_____ I give permission to _____, licensed by the Department of Licensing and Regulatory Affairs to secure emergency medical for the above named minor child while in care.	
_____ I do not give permission to _____, licensed by the Department of Licensing and Regulatory Affairs to secure emergency medical for the above named minor child while in care.	

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

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

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Student Name: _____

ST. THECLA EARLY CHILDHOOD DISMISSAL RELEASE FORM

Parents: Please indicate below the people who are allowed to pick up your child from school. **Be sure to include yourselves** on this form. Upon dismissal, teachers will ask people picking up children to show ID to verify identity. Please be sure to tell everyone on this list to be prepared to show photo identification upon picking up your child. **We cannot and will not release your child to anyone who is not on this list.** Thank you for your understanding. 😊

_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

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PARENT PERMISSION FORM

Dear Parent or Legal Guardian:

As part of our early childhood curriculum at St. Thecla, we visit various areas in our school building other than our early childhood classrooms. These activities will take place under the guidance and supervision of our early childhood teachers. Please sign your consent for your child to visit:

- Church
- Other St. Thecla meeting areas for various educational activities

Destination: St. Thecla (same building as the early childhood program)

Designated Supervisor of Activity: Classroom Teacher

Date(s) Permission Slip is Effective: 2020/2021 School Year

Student Cost: \$0

*****STATEMENT OF CONSENT*****

I hereby consent to participation by my child, _____, in attending the church, and other St. Thecla meeting areas for educational activities. I understand that these activities will take place on school/parish grounds and that my child will be under the supervision of the designated school/parish employee on the stated dates. I further consent to the conditions stated above on participation in this event.

(Print Parent's Name)

(Parent's Signature)

(Date)

Student Name:_____

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St. Thecla Catholic School

Handwashing

St. Thecla Catholic School early childhood program takes the health and welfare of our students seriously. Below is our health care plan.

Children and Staff Hand Washing:

Children must wash their hands before eating and after using the restroom. Adults must wash their hands prior to passing out food (even though they use food service gloves) and after using the restrooms. Hands must be washed as follows: wet hands, lather up with soap and rub for at least 20 seconds, rinse, and dry.

Handling Children's Bodily Fluids:

Caregivers must use gloves when handling children's bodily fluids. Gloves must be thrown away immediately after. Soiled clothing must be put in sealed plastic bags and given to the parents at dismissal. If clothing is placed in a backpack, caregivers **must** notify parents that soiled clothing is there in case they don't check.

Cleaning and Sanitizing All Toys and Surfaces:

All surfaces, including toys and tables, **must** be cleaned and sanitized using the three-step cleaning process with bleach and water (air drying).

Controlling Infection:

All children who are ill will be excluded from the early childhood program until they are feeling better. Any communicable diseases will be reported to the main office and a letter will be sent home to all parents, when applicable.

Name: _____ Signature: _____

Date: _____

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Student Name: _____

St. Thecla Early Childhood

STAFF/VOLUNTEER SCREENING STATEMENTS

- I am aware of and understand that abuse and neglect of children is against the law.
- I have been informed of and understand the school's policies on child abuse and neglect.
- I attest that I will not abuse, neglect, shame, humiliate, harm, or mistreat the children that are placed in my care in any way.
- I understand that, as a caregiver, I am mandated by law to report any case of abuse and/or neglect of children to the Department of Human Services Agency Children's Protective Services within 24 hours.
- I have not been convicted of a crime other than a minor traffic violation.
- I have never been accused of or involved in a substantiated case of abuse or neglect of children.
- I consent to having a background check performed before I work with the children.

MT CLEMENS OFFICE:

Unit:

Children's Protective Services

Daytime Phone:

877-412-6109

After Hours Phone:

877-412-6109

Name

Signature

Name

Signature

Date

"We, the community of St. Thecla Catholic School, dedicate ourselves to serving God through our growth in faith, education, and love for one another as members of God's Family."

Student Name: _____

Change of Clothing Waiver

During the course of events in the Early Childhood Program, it may become necessary for your child to require changing their clothes. This may be due to one of various reasons ranging from a simple spill to vomiting or a bathroom accident. Children MUST be able to perform this task themselves with supervision. By signing this waiver you are agreeing to two things:

1. To supply a complete set of clothes (including socks and underwear) in a bag labeled with your child's name, to be kept in your child's backpack just in case they are needed, and to be replaced by the following school day in the backpack.
2. You are giving permission for St. Thecla staff members to be present to supervise your child as necessary.

Please be aware:

IF YOU DO NOT SIGN AND RETURN THIS WAIVER, YOU WILL BE CALLED AND REQUIRED TO COME TO THE SCHOOL AND ASSIST YOUR CHILD SHOULD THEY SOIL THEIR CLOTHING TO THE EXTENT THAT IT REQUIRES CHANGING.

I, the undersigned, agree to supply St. Thecla with a complete change of clothes for my child and to replenish items used by the next school day.

Print Name Signature Date

I, the undersigned, give permission for St. Thecla school staff member to clean and change my child if circumstances arise in which the aforementioned becomes necessary.

Print Name Signature Date

"We, the community of St. Thecla Catholic School, dedicate ourselves to serving God through our growth in faith, education, and love for one another as members of God's Family."

Student Name: _____

St. Thecla Preschool Behavior Policy Agreement

I have read the St. Thecla Preschool Behavior Policy described on pages 12 and 13 of the Preschool Handbook and the Preschool Behavior Rubric. I have discussed this with my child and agree to comply with the discipline policies and procedures of the St. Thecla Preschool Program.

Parent/Legal Guardian Signature

Date

Parent/Legal Guardian Name Printed

St. Thecla Catholic School Behavior Rubric – 3 Year & 4 Year Preschool

	Behavior	1 st Time	2 nd Time	3 rd Time	4 th Time
Level 1	Lack of Self Control: excessive talking, making noises, obnoxious behavior	-Warning	-Warning -3-5 Minute Timeout	-Warning -5-7 Minute Timeout -Think Sheet	-Warning -Think Sheet -Contact parent -Silent Lunch
Level 2	Horseplay: play-fighting, grabbing, pushing, shoving, hitting, tripping or running in classroom Teasing: behaviors that would hurt the feelings or bodies of others, and name-calling	-Warning -3-5 Minute Timeout	-Warning -5-7 Minute Timeout -Think Sheet	-Warning -Think Sheet -Contact parent -Sent to Principal's office	-Warning -Think Sheet -Contact parent -Sent to Principal's office -Silent Lunch
Level 3	Disrespectful Behavior/Defiance: arguing, shouting, refusal to follow directions, back-talk or walking away while a staff member is talking	-Warning -5-7 Minute Timeout -Think Sheet -Student/principal call parent	-Warning -Think Sheet -Contact parent -Sent to Principal's office for timeout	-Warning -Think Sheet -Contact parent -Sent to Principal's office for timeout -Silent Lunch	-Warning -Think Sheet -Contact parent -Sent to Principal's office for timeout & discussion -2 Silent Lunches
Level 4	Physical Contact: hitting, pushing, shoving, slapping, tripping, etc... in an attempt to hurt others Stealing/Damaging Property: from students, staff or school facility	-Warning -5-7 Minute Timeout -Think Sheet -Student/principal call parent	-Warning -Think Sheet -Contact parent -Sent to Principal's office for timeout -Silent lunch	-Warning -Think Sheet -Contact parent -Sent to Principal's office for timeout & discussion -2 Silent lunches	-Warning -Think Sheet -Contact parent -Sent to Principal's office for timeout & discussion -3 silent lunches -Parent/Teacher Conference
Level 5	Severe Physical Contact: punching, kicking, fighting, spitting or similar behaviors	-Office Referral -Think Sheet -Student/principal call parent -Silent lunch -Parent conference	-Office Referral -Think Sheet -Student/principal call parent -2 silent lunches -Parent conference	-Office Referral -Think Sheet -Student/principal call parent -3 silent lunches -Parent conference	To be determined by Principal & Pastor

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Student Name: _____

Photo Release

When preparing work for internal, external publications, or use on the Internet, parental permission is required for publication of their child's photo. It is required to have parental permission for photo publication. Names of students will not be used on Internet projects. Please review the information and return the signed document to school.

Thank You,
Ms. Karwoski

SIGN AND RETURN TO SCHOOL (Please check the appropriate box)

☐

St. Thecla has my permission to publish a photo of my child for internal/external publication and/or Internet publication.

(Please clearly print child's name)

(Parent signature)

(Date)

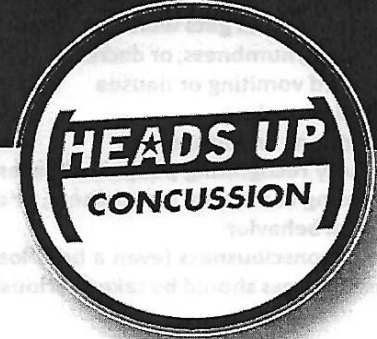
☐

St. Thecla **DOES NOT** have my permission to publish a photo of my child for internal/external publication on the Internet.

(Please clearly print child's name)

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CONCUSSION FACT SHEET FOR PARENTS



WHAT IS A CONCUSSION?

A concussion is a type of traumatic brain injury. Concussions are caused by a bump or blow to the head. Even a "ding," "getting your bell rung," or what seems to be a mild bump or blow to the head can be serious.

You can't see a concussion. Signs and symptoms of concussion can show up right after the injury or may not appear or be noticed until days or weeks after the injury. If your child reports any symptoms of concussion, or if you notice the symptoms yourself, seek medical attention right away.

WHAT ARE THE SIGNS AND SYMPTOMS OF CONCUSSION?

If your child has experienced a bump or blow to the head during a game or practice, look for any of the following signs of a concussion:

SYMPTOMS REPORTED BY ATHLETE:

- Headache or "pressure" in head
- Nausea or vomiting
- Balance problems or dizziness
- Double or blurry vision
- Sensitivity to light
- Sensitivity to noise
- Feeling sluggish, hazy, foggy, or groggy
- Concentration or memory problems
- Confusion
- Just not "feeling right" or is "feeling down"

SIGNS OBSERVED BY PARENTS/ GUARDIANS:

- Appears dazed or stunned
- Is confused about assignment or position
- Forgets an instruction
- Is unsure of game, score, or opponent
- Moves clumsily
- Answers questions slowly
- Loses consciousness (even briefly)
- Shows mood, behavior, or personality changes



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DANGER SIGNS

Be alert for symptoms that worsen over time. Your child or teen should be seen in an emergency department right away if s/he has:

- One pupil (the black part in the middle of the eye) larger than the other
- Drowsiness or cannot be awakened
- A headache that gets worse and does not go away
- Weakness, numbness, or decreased coordination
- Repeated vomiting or nausea
- Slurred speech
- Convulsions or seizures
- Difficulty recognizing people or places
- Increasing confusion, restlessness, or agitation
- Unusual behavior
- Loss of consciousness (even a brief loss of consciousness should be taken seriously)

WHAT SHOULD YOU DO IF YOU THINK YOUR CHILD HAS A CONCUSSION?

1. **SEEK MEDICAL ATTENTION RIGHT AWAY.**
A health care professional will be able to decide how serious the concussion is and when it is safe for your child to return to regular activities, including sports.
2. **KEEP YOUR CHILD OUT OF PLAY.**
Concussions take time to heal. Don't let your child return to play the day of the injury and until a health care professional says it's OK. Children who return to play too soon - while the brain is still healing - risk a greater chance of having a second concussion. Repeat or later concussions can be very serious. They can cause permanent brain damage, affecting your child for a lifetime.
3. **TELL YOUR CHILD'S COACH ABOUT ANY PREVIOUS CONCUSSION.**
Coaches should know if your child had a previous concussion. Your child's coach may not know about a concussion your child received in another sport or activity unless you tell the coach.

HOW CAN YOU HELP YOUR CHILD PREVENT A CONCUSSION OR OTHER SERIOUS BRAIN INJURY?

- Ensure that they follow their coach's rules for safety and the rules of the sport.
- Encourage them to practice good sportsmanship at all times.
- Make sure they wear the right protective equipment for their activity. Protective equipment should fit properly and be well maintained.
- Wearing a helmet is a must to reduce the risk of a serious brain injury or skull fracture.
 - However, helmets are not designed to prevent concussions. There is no "concussion-proof" helmet. So, even with a helmet, it is important for kids and teens to avoid hits to the head.

HOW CAN I HELP MY CHILD RETURN TO SCHOOL SAFELY AFTER A CONCUSSION?

Children and teens who return to school after a concussion may need to:

- Take rest breaks as needed
- Spend fewer hours at school
- Be given more time to take tests or complete assignments
- Receive help with schoolwork
- Reduce time spent reading, writing, or on the computer

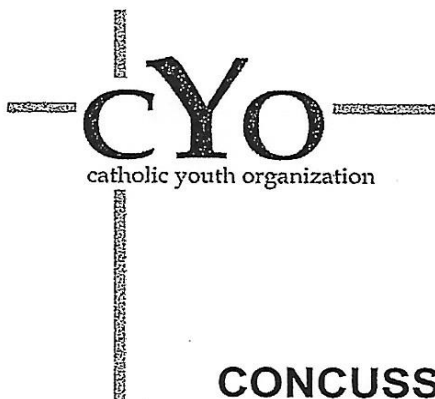
Talk with your child's teachers, school nurse, coach, speech-language pathologist, or counselor about your child's concussion and symptoms. As your child's symptoms decrease, the extra help or support can be removed gradually.



JOIN THE CONVERSATION → www.facebook.com/CDCHeadsUp

TO LEARN MORE GO TO

Content Source: CDC's Heads Up Program. Created through a grant to the CDC Foundation from the National Operating Committee on Standards for Athletic Equipment (NOCSAE).



CONCUSSION AWARENESS

EDUCATIONAL MATERIAL ACKNOWLEDGEMENT

By my name and signature below, I acknowledge in accordance with Public Acts 342 and 343 of 2012 that I have received and reviewed the Concussion Fact Sheet for Parents and Students provided by _____

School/Parish

Student Name Printed

Parent or Guardian Name Printed

Student Name Signature

Parent or Guardian Signature

Student Date of Birth

Date

Date

Return this signed form to the School/Parish. The School/Parish must keep this on file for the duration of enrollment/participation and until age 25.

Students and parents should review and keep the educational materials available for future reference.



Catholic Schools
Teaching Minds. Reaching Hearts.

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ST. THECLA CATHOLIC SCHOOL

Date: September 2020

Name of Parent/Guardian: _____

Student Name(s): _____

As the parent/guardian of this student(s), I have read and agreed to the online version of Electronic Information Access and User for Educational Purpose Policy and the Parent Handbook for the 2020-2021 school year. St. Thecla School has taken precautions to prohibit access to inappropriate materials. However, I also recognize it is impossible for St. Thecla School to restrict access to all inappropriate or copyrighted materials and I will not hold them responsible for materials acquired on or through St. Thecla School Systems. Further, I accept full responsibility for supervision if and when my child's use of any School Systems is not in a school setting.

Users are responsible for attending appropriate training sessions in the use and care of all School Systems and should refrain from using any technology for which they have not received training. Users may be required to make full financial restitution for any damages to School Systems or unauthorized expenses incurred through the use of School Systems. I hereby give permission to issue a membership account to my child.

I acknowledge that I have read online and agreed to the terms of the updated Parent Handbook, Behavior Rubric, and expectations here at St. Thecla Catholic School.

Thank You,
Ms. Karwoski

Please sign and return to the main office: Attention Ms. Karwoski
Agreed and Accepted:

My signature on this document acknowledges that I have read online and agreed to the Electronic Information Access and User for Educational Purpose Policy, the Parent Handbook, and Behavior Rubric for the 2020-2021 school year. I agree to abide by its conditions:

X
[Signature(s) of the parent/guardian]

[Date]

[Student(s) name and grade level]

20762 South Nunneley Road Clinton Twp., MI 48035-1698
(586) 791-2170 Fax: (586) 791-2356 www.sthecla.com

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MEDICAL TREATMENT RELEASE FORM

To Whom It May Concern:

As parent/guardian, I do hereby authorize the treatment of a qualified and licensed physician of any condition which, in the opinion of the physician, is deemed necessary and appropriate. This authority is granted only after a reasonable effort has been made to reach me.

Name of Minor: _____ Relationship to you: _____

Reason for which release is intended: _____

Address of Minor: _____ City: _____

Emergency Phone(s): _____

Family Physician: _____ Phone: _____

Physician Address: _____ City: _____

List allergies, medication, contract, or other pertinent comments:

Health Insurance Data:

Company: _____ Policy: _____

Group: _____ Contract: _____

I further authorize the person who presents the minor to sign the Acknowledgment of Receipt of Notice Privacy Rights that may be presented by the physician or health care facility.

This authorization is completed and signed of my own free will with the sole purpose of authorizing medical treatment deemed necessary and appropriate by the treating physician. I acknowledge that it is my responsibility to submit a new form if any of the above information changes.

Date: _____

Signed: _____
(Parent or Guardian)

ARCHDIOCESE OF DETROIT
ANNUAL PESTICIDE APPLICATION NOTIFICATION LETTER

Dear Parent or Guardian:

The St. Thecla Catholic School / day care center utilizes an Integrated Pest Management (IPM) approach to control pests. IPM is a pest management system that utilizes multiple techniques to prevent pests from reaching unacceptable levels or to reduce an existing population to an acceptable level. Pest management techniques emphasize pest exclusion and biological controls. However, as with most pest control programs, **pesticides may also be utilized** at our facility.

This notice has been provided in compliance with MCL324.8316 and must be provided before the beginning of the school year (for schools) or in September (for day care centers). We are also required to notify you of your right to review the IPM Plan and IPM records. An IPM plan and records are required for pesticide applications inside the school and daycare center, exclusive of sanitizer, disinfectant, germicide, and anti-microbial applications.

You also have the right to be informed prior to any application of a pesticide in or at the school grounds or buildings during this school year, with the exception of bait, gel, sanitizer, disinfectant, germicide, and anti-microbial applications. In certain emergencies, such as an infestation of stinging insects, pesticides may be applied without prior notice to prevent injury to students, but you will be notified following any such application.

At least 48 hours before an application, advance notification will be given by:

- 1) posting at commonly used entrances to the facility **and**
- 2) by one of the following
 1. Posting on facility's website

Advance notification signs will be posted at the following commonly used entrances: *The front door of the school.*

The following individual is responsible for pesticide application procedures:

Name: Matthew Wozniak

Telephone Number: (586) 791-2170

E-mail address (if available): _____

In addition to the above methods of notice, **the parent/guardian is entitled to receive the notice by first-class U.S. mail postmarked at least 3 days before the application.**

If you need prior notification, please complete the information below and return to Ms. Karwoski:

PRIOR NOTIFICATION REQUEST

PARENT NAME: _____

STUDENT NAME: _____

ADDRESS: _____

DAY PHONE #: _____

EVENING PHONE #: _____

Please Check the Following:

- ☐ I wish to be notified prior to a scheduled pesticide application inside of the school building.
- ☐ I wish to be notified prior to a scheduled pesticide application on the outside grounds of the school building.
- ☐ Both of the above.
- ☐ I do NOT wish to be notified during months when school is not in session.

Signature

Date

Notification (July, 2009)

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ST. THECLA CATHOLIC SCHOOL

Annual Parent/Teacher Asbestos Notification

TO: Parents and Staff of St. Thecla Catholic School

DATE: September 1, 2020

St. Thecla has had an Asbestos Management Plan prepared in compliance with the USEPA Asbestos Hazard Emergency Response Act (AHERA). This plan and subsequent updates are available for inspection Monday through Friday during normal school hours in the Main school Office.

A six-month Periodic Surveillance review, required by the AHERA regulation, was conducted by qualified personnel to re-evaluate the condition of asbestos containing materials at the facility.

The (Three-Year Re-inspection or Surveillance review) also evaluated Operations and maintenance procedures that will keep asbestos materials in good condition.

If you have any questions, please contact (Matthew Wozniak, Asbestos Coordinator), our designated person for asbestos activities.

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