Pre-school Document Package

2022-2023

"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."

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

Important Reminders

- All documents in this packet must be completed, dropped off and reviewed before your student will be able to attend school.

- Along with these documents, please remember we must have a copy of
  - Birth Certificate
  - Baptismal Certificate (if applicable)
  - Updated Immunization Record

- Preschool Paperwork Drop off is August 17th 6:00 pm – 7:00 pm

- Parents only on August 17th (no exceptions please)

- This is just a paperwork drop off, our official Meet Your Teacher is the Welcome Back Mass / Ice Cream Social on April 27th 4:00 pm

- You will not be able to drop off this paperwork with your student on the first day. *It must be reviewed by staff before the student may start school

- If you are unable to attend the paperwork drop off – email duncann@stthecla.com for other arrangements

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

SECTION I - HEALTH HISTORY

Yes	No	Resolved	# Is your child having any of the problems listed below?
☐	☐	☐	1 Allergies or Reactions (for example, food, medication or other)
☐	☐	☐	2 Hay Fever, Asthma, or Wheezing
☐	☐	☐	3 Eczema or Frequent Skin Rashes
☐	☐	☐	4 Convulsions/Seizures
☐	☐	☐	5 Heart Trouble
☐	☐	☐	6 Diabetes
☐	☐	☐	7 Frequent Colds, Sore Throats, Earaches (4 or more per year)
☐	☐	☐	8 Trouble with Passing Urine or Bowel Movements
☐	☐	☐	9 Shortness of Breath
☐	☐	☐	10 Speech Problems
☐	☐	☐	11 Menstrual Problems
☐	☐	☐	12 Dental Problems: Date of Last Exam / /
☐	☐	☐	Other (please describe): _____
☐	☐		Does your child take any medication(s) regularly?

Reason for Medication

_____ / /
Parent/Guardian Signature Date

Birth History:

Are there any current or past diagnosis(es) ☐ Yes ☐ No

If yes, please describe:

If yes, list medications:

Was the health history reviewed by a health professional?
☐ Yes ☐ No ***Examiner's Initials:*** _____

SECTION II - PHYSICAL EXAMINATION, INSPECTION, TESTS AND MEASUREMENTS

Required for Child Care and Head Start / Early Head Start

Tests and Measurements

No	Yes	Was child tested for:	Test results:	Normal	Referred	Under Care
☐	☐	VISION	Visual Acuity			
			Muscle Imbalance			
		Date: / /	Other:			
☐	☐	HEARING	Audiometer			
			Other:			
		Date: / /				
☐	☐	URINALYSIS	Sugar			
			Albumin			
		Date: / /	Microscopic			
☐	☐	BLOOD LEAD LEVEL	Level _____ ug/dl ⇨			
		Date: / /				

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

NOTE: Blood lead level required for all children enrolled in Medicaid must be tested at one and two years of age, or once between three and six years of age if not previously tested. All children under age six living in high-risk areas should be tested at the same intervals as listed above.

Examinations and/or Inspections

Essential Findings Deviating from Normal:

Exam Date: / /

"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."

SECTION III - IMMUNIZATIONS

Statements such as "UP-TO-DATE" or "COMPLETE" will not be accepted. Admission to school may be denied on the basis of this information.*

VACCINES (Circle Type)	DATE ADMINISTERED MM/DD/YYYY	
Hepatitis B (HepB)	1	3
	2	
DTaP/DTP/DT/Td	1	4
	2	5
	3	6
Tdap	1	
Haemophilus Influenzae type b (HIB)	1	3
	2	4
Polio (IPV/OPV)	1	3
	2	4
Pneumococcal Conjugate (PCV7/PCV13)	1	3
	2	4
Rotavirus (RV1/RV5)	1	3
	2	
Measles,Mumps, Rubella (MMR)	1	2
Varicella (Chickenpox)	1	2

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

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

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

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

Parent/Guardian refused immunizations: ☐

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

_____ *Health Professional's Signature* _____ Title _____ / / Date

SECTION IV - RECOMMENDATIONS

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

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

Other Recommendations

SECTION V - DENTAL EXAMINATION AND RECOMMENDATIONS (OPTIONAL)

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

_____ *Dentist's Signature* _____ / / Date

PHYSICIAN'S SIGNATURE

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

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

Information required for:

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

Child Care Licensing - Physical Exam, Restrictions, Immunizations

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

****

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.

"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."

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 faith, education, and love for one another as members of God's Family."

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? _____

_____

"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."

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.

"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."

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 St. Thecla
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

"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."

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 116COMPLETION: Required
PENALTY: Rule Violation Citation.

"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 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. ☺

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

"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 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: _____

"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
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:	Daytime Phone:	After Hours Phone:
Children's Protective Services	877-412-6109	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 assist 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 13-15 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	1st Time	2nd Time	3rd Time	4th 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

"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:_____

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 select one:

_____ Yes

_____ No

St. Thecla has permission to use my child's picture in the yearbook.

Please select one:

_____ Yes

_____ No, do not put my child's picture in the yearbook (you child's picture will not appear on the class page or on other pages of the yearbook.)

(Please clearly print child's 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."

UNDERSTANDING Information for parents and students (Content meets MDCH requirements)

CONCUSSION

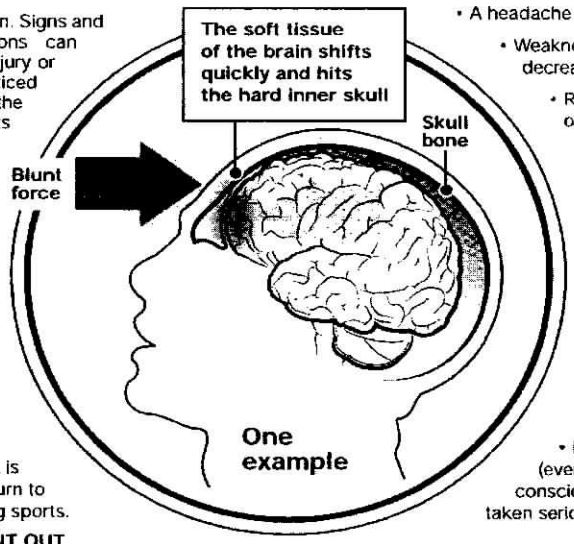
Some common symptoms

- Headache
- Pressure in the head
- Nausea/ vomiting
- Dizziness
- Balance problems
- Double vision
- Blurry vision
- Sensitivity to light
- Sensitivity to noise
- Sluggishness
- Haziness
- Fogginess
- Grogginess
- Poor concentration
- Memory problems
- Confusion
- "Feeling down"
- Not "feeling right"
- Feeling irritable
- Slow reaction time
- Sleep problems
- Appears dazed and stunned
- Disoriented or confused
- Forgets an instruction

What is a concussion?

A concussion is a type of traumatic brain injury that changes the way the brain normally works. A concussion is caused by a bump, blow, or jolt to the head or body that causes the head and brain to move quickly back and forth. It can also be caused by the shaking or spinning of the head or body. 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 concussions can show up right after the injury or may not appear or be noticed until days or weeks after the injury. If the student reports any symptoms of a concussion, or if you notice symptoms yourself, seek medical attention right away.



If you suspect 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 the student to return to regular activities, including sports.

2. KEEP YOUR STUDENT OUT OF PLAY

Concussions take time to heal. Don't let the student return to play the day of the injury and until a health care professional says it's OK. Students who return to play too soon-while the brain is still healing-risk a greater chance of having a second concussion. Repeat or second concussions can be very serious. They can cause permanent brain damage, affecting the student for a lifetime.

3. TELL THE SCHOOL ABOUT ANY PREVIOUS CONCUSSION

Schools should know if a student had a previous concussion. A students school may not know about a concussion received in another sport or activity unless you notify them.

Concussion danger signs

In rare cases, a dangerous blood clot may form on the brain in a person with a concussion and crowd the brain against the skull. A student should receive immediate medical attention if after a bump, blow, or jolt to the head or body s/he exhibits any of the following danger signs:

- One pupil larger than the other
- Is drowsy or cannot be awakened
- A headache that gets worse
- Weakness, numbness, or decreased coordination
- Repeated vomiting or nausea
- Slurred speech
- Convulsions or seizures
- Cannot recognize people or places
- Becomes increasingly confused, restless, or agitated
- Has unusual behavior
- Loses consciousness (even a brief loss of consciousness should be taken seriously)

How to respond to a report of a concussion

If a student reports one or more symptoms of a concussion after a bump, blow, or jolt to the head or body, s/he should be kept out of athletic play the day of the injury. The student should only return to play with permission from a health care professional experienced in evaluating for concussion.

During recovery, exercising or activities that involve a lot of concentration (such as studying, working on the computer, or playing video games) may cause concussion symptoms to reappear or get worse.

Sources: Michigan Department of Community Health and the National Operating Committee on Standards for Athletic Equipment (NOCSAE)

!!! WHEN IN DOUBT...SIT OUT !!!

"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."

CYO
catholic youth organization

CATHOLIC LEAGUE ATHLETICS
MESSAGE COMMUNITY SERVICE

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.

"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."

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)

ST. THECLA CATHOLIC SCHOOL

Annual Parent/Teacher Asbestos Notification

TO: Parents and Staff of St. Thecla Catholic School

DATE: August 30, 2022

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 (Jeanette Markiewicz, Asbestos Coordinator), our designated person for asbestos activities.

ST. THECLA CATHOLIC SCHOOL

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 answers)

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

Please select one.

_____Yes

_____ No

St. Thecla has permission to use my child's picture in the yearbook.

_____ Yes

_____ No, Do not put my child's picture in the yearbook (your child's picture will not appear on the class page or on other pages of the yearbook.)

_____

(Please clearly print the names of all your children)

_____

(Parent signature) (Date)

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

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.

WRITTEN INFORMATION PACKET DOCUMENTATION

Michigan Department of Licensing and Regulatory Affairs
Child Care Licensing Bureau

Child(ren)'s Name(s) (Last, First)	Facility's Name and License Number

A written information packet has been provided at the time of enrollment. The packet included all the following information *(R 400.8146 (1-2)):*

- 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, and illnesses.
- Transportation policy, if applicable.
- Medication policy.
- 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 for the last 5 years.
  - The licensing notebook is available to parents during regular business hours.
  - Licensing inspection and special investigation reports, and corrective action plans from at least the past 3 years are available on the department's website at **www.michigan.gov/michildcare**.
- Other _____

I certify that I received all of the above items.

_____ _____

Parent/Guardian Signature **Date**

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

HEALTH APPRAISAL

Michigan Department of Health and Human Services

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, dentist, dental therapist, and dental hygienist.

(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/Cell Phone Number
Address (Number, Street, City, Zip Code)	Work Phone Number

SECTION I – HEALTH HISTORY

Yes	No	Resolved	#	Is your child having any of the problems listed below?
☐	☐	☐	1	Allergies or Reactions (for example, food, medication or other)
☐	☐	☐	2	Anaphylaxis
☐	☐	☐	3	Does your child take any medication(s) regularly?
☐	☐	☐	4	Hay Fever, Asthma, or Wheezing
☐	☐	☐	5	Eczema or Frequent Skin Rashes
☐	☐	☐	6	Convulsions/Seizures
☐	☐	☐	7	Heart Trouble
☐	☐	☐	8	Diabetes
☐	☐	☐	9	Frequent Colds, Sore Throats, Earaches (4 or more per year)
☐	☐	☐	10	Trouble with Passing Urine or Bowel Movements
☐	☐	☐	11	Shortness of Breath
☐	☐	☐	12	Speech Problems
☐	☐	☐	13	Menstrual Problems
☐	☐	☐	14	Dental Problems Date of Last Exam _____ **OR** Date of Last Assessment _____
☐	☐	☐		Other (please describe) _____

Birth History
If yes, list medications
Are there any current or past diagnosis(es) ☐ Yes ☐ No
If yes, please describe

Reason for Medication		
Concussion History		
Parent/Guardian Signature	Date	Was the health history reviewed by a health professional? ☐ Yes ☐ No **Examiner's Initials** ____

SECTION II – PHYSICAL EXAMINATION, INSPECTION, TESTS AND MEASUREMENTS
Required for Child Care and Head Start / Early Head Start

Test and Measurements

Yes	No	Was child tested for	Tests and results		Normal	Referred	Under care
☐	☐	Vision Date _____	Visual Acuity				
			Muscle Imbalance				
			Other				
☐	☐	Hearing Date _____	☐ Audiometer	(R= Right, L=Left)	R/L	R/L	
			☐ OAE	(R= Right, L=Left)	R/L	R/L	
			☐ Other	(R= Right, L=Left)	R/L	R/L	
☐	☐	Urinalysis	Sugar				
			Albumin				
			Microscopic				
☐	☐	Blood Lead Level Date _____	Level _____ ug/dl				

Note: All children in Medicaid need to be tested at 1 and 2 years of age, or once between 3 and 6 years of age if not previously tested. All children, regardless of Medicaid status, should be tested at those same ages if they live in an area where lead risk is high.

☐	☐	Height & Weight	Height				
			Weight				
		Other _____	Other _____				
☐	☐	Hemoglobin/Hematocrit	⇨				
☐	☐	Blood Pressure	Reading _____				

Complete pediatric tuberculosis risk assessment available at:
https://www.michigan.gov/documents/mdhhs/4._MI_Pediatric_TB_Risk_Assessment_661537_7.pdf **OR** feel free to use the attached QR code instead of the full link text.

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 based on this information.*

Vaccines (Circle Type)	Date Administered mm/dd/yy		Vaccines (Circle Type)	Date Administered mm/dd/yy	
Hepatitis B (HepB)	1	3	Hepatitis A (HepA)	1	3
	2	4		2	
DTaP/DTP/DT/Td	1	4	Influenza (IIV/LAIV)	1	3
	2	5		2	4
	3	6	Meningococcal MenACWY (MCV4)	1	3
Tdap	1			2	
Haemophilus Influenzae type b (HIB)	1	3	Meningococcal B (Bexsero, Trumenba)	1	3
	2	4		2	
Polio (IPV/OPV)	1	4	Human Papillomavirus (9vHPV, 4vHPV, 2vHPV)	1	3
	2	5		2	
	3		Additional Vaccines Specify Date & Type	Type of Vaccine(s)	Date of Vaccine(s)
Pneumococcal Conjugate (PCV7/PCV13)	1	3		1	
	2	4		2	
Rotavirus (RV1/RV5)	1	3		3	
	2				
Measles, Mumps, Rubella (MMR/MMRV)	1	3			
	2				
Varicella (Chickenpox), (Var, MMRV)	1	2			

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.

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

Parent/Guardian refused recommended immunizations at visit: ☐

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	
☐	☐	Is there any defect of vision, hearing, or other condition for which the school could help by seating or other actions? If yes, please explain: _____

☐ ☐ Should the child's activity be restricted because of any physical defect or illness?
If yes, check and explain degree of restriction(s):

☐ Classroom ☐ Playground ☐ Gymnasium
☐ Swimming Pool ☐ Competitive Sports ☐ Other

Other Recommendations

SECTION V – DENTAL EXAM OR ASSESSMENT RECOMMENDATIONS (OPTIONAL)

Child's Name	Has received ☐ Dental Exam ☐ Dental Assessment

Findings and Recommendation (Check all that apply)

☐ No Urgent Needs ☐ Routine Care Needed ☐ Treated Decay
☐ Restorative/Urgent Needs for Dental Care ☐ Untreated Decay ☐ Further Referral for Specialist

Signature	Date

Check One

☐ Dentist ☐ Dental Therapist ☐ Dental Hygienist

PHYSICIAN'S SIGNATURE

Examiner's Signature	Date	Examiner's Name (Print)		Degree or License
Number & Street	City	MI	Zip Code	Telephone Number

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 preventative and primary health care, including medical, dental, and mental health. The schedule must incorporate the well-childcare 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.

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: Jeanette Markiewicz
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)