Hello Families,

Thank you for your interest in Davison's Cardinal's Nest program. Due to the emergency shut down the registration process will look differently this year. Starting Monday, June 15th through Thursday, June 18th we will have registration packets available for pick up between 9:00 am and 3:00 pm.
There are two important steps to pre-registering for preschool.

Step 1
You will need to go to the Davison Website and click on the Early Childhood tab at the top of the page and choose the Cardinal's Nest. There is a link on the Cardinal's Nest to pre-register for either the 3 or 4 year old preschool program. There are a variety of choices ranging from ½ day to full day and 2, 3, or 5 days a week. You **MUST** complete this online pre-registration for the program you choose for your child. There is a $50 pre-registration cost that holds your spot in the program and covers other fees including online assessments for your child.

Step 2
After you pre-register online, you can print the required registration documents from the quick link on the Davison Schools Website for Cardinal's Nest Distance Registration. Quick links are located on the left of the main Davison Community Schools webpage. If you do not have access to print the documents from the website, you can pick up a Cardinal's Nest Distance registration packet. Please take one packet per child. The packet will have instructions on the documents that need to be filled out, what types of documentation you will need to copy and return, as well as the eligibility and prioritization guidelines. Once completed, you will return the packet to the Cardinal's Nest building during the week of June 15th-June 18th between 9:00 am and 3:00 pm. **DO NOT LEAVE COMPLETED PACKETS IN THE BIN OUTSIDE.** We will have a table set up inside the entrance for you to drop off your documentation to staff. If needed we can make copies for you. Only one person at a time will be allowed inside, you **MUST** wear a face mask and practice social distancing.

Thank you and we look forward to meeting all of you!
Davison Cardinal's Nest Staff

Davison's Cardinal's Nest Preschool Program Distance Registration Instructions!

Our teachers and staff are looking forward to meeting you and your child. This is an exciting time for your family and we are glad to be part of your child's educational journey!

It was Davison's hope to have started preschool intake appointments by now. Unfortunately, with the world-wide pandemic and the closure of schools state-wide, the registration process has been delayed. We are now ready to get your little Cardinals registered for preschool and the plan is as follows:

In order to register your child, please complete the following documents & directions below.

1. Child Information Record- This form is kept in the classroom with the teachers and contains important emergency contact information. Be sure to fill out both sides completely and sign and date.
2. Questionnaire- This form gives us valuable information about your child that helps with teacher placement, medical needs and helpful information regarding eligibility and prioritization.
3. Health Appraisal- This is a state required form that must be turned in for all students. A three/four year old physical is due on or before the first day of school. This must be filled out by both the parent/guardian and your child's physician. Be sure to have the physician sign and date.
4. Concussion Awareness form – This form also needs to be completed, signed and dated by one parent. We keep this form in your child's folder for record keeping of any head bumps. (You will be notified of any head bumps at school)

Once these documents are completed and signed, you will need to drop them off at the Cardinal's Nest **WITH A COPY OF THE FOLLOWING DOCUMENTS**:

1. **Your child's birth certificate**
2. **Your driver's license**
3. **Updated immunization record.**
4. **Student's IEP (if applicable)**
5. **Custody documents (if applicable)**
6. **Medical forms (if applicable)**

***PLEASE USE THIS ENVELOPE TO RETURN YOUR PAPERWORK!**

***If any of the required documentation is not provided, your child will be considered incomplete and their enrollment will be placed on hold.**

DROP OFF INFORMATION: Return completed packet and the above required documents to the Cardinal's Nest, 1490 N. Oak Road, Davison MI 48423, ***Monday, June 15 through Thursday, June 18 between 9:00 AM and 3:00 PM***. For security and confidentiality reasons, please ring the doorbell at the main entrance and we will meet you to collect your envelope. **DO NOT LEAVE COMPLETED PACKETS IN THE BIN OUTSIDE!**

If you have questions, please call our office at 810-591-0821.
Or email Early Learning Administrator, Susan Vamos- svamos@davisonschools.org

Cardinal's Nest Additional Child Information

1. Child's full name: _____ DOB_____

2. Does your child have a nickname they would like to be called by at school: _____

3. How did you hear about our program?_____

4. Has your child attended a previous daycare or preschool?____ If so, where?_____

5. Biological Parents listed on birth certificate:_____
_____

6. Step-Parents, Foster Parents, Legal Guardians:_____
7. Who does the child live with?_____
8. Primary contacts email address _____
9. Do either of the child's parents attend college/school? If so, where?_____

10. Does this student have any immediate family members that are connected with the military? If yes, provide the name(s) and relationship to the student. Is the immediate family member active, retired, or in the reserve?_____

11. Do you live in the Davison School District? _____
If out of district, what school district do you reside in? _____

12. Does your child take any medication on a regular basis? If so, dosage and time of day:
_____

13. Will they need medication at school?_____

14. Does your child have any diagnosed allergies including food allergies? _____
Does your child have any food intolerances? _____

15. By September 1st 3 yrs. old 4 yrs. old
Are you interested in ½ or full day? _____ a.m. p.m.
What days are you interested in your child attending? _____

16. Is there anything you would like us to know about your child? Additional concerns?
_____
_____
_____
_____
_____

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.)					

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

See Reverse Side

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 individuals, 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 Davison Community Schools, licensed by the Department of Licensing and Regulatory Affairs to secure emergency medical treatment 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 6-17may be used.

HEALTH APPRAISAL

Dear Parent or Guardian: The following information is requested so that the school can work with the parent to meet the physical, intellectual and emotional needs of the child. Fill out the information requested in Section I. Section III may be certified by the transcription of information from the certificate of immunization. The remaining sections are to be completed by a doctor, nurse and dentist. **(BE SURE TO BRING YOUR CHILD'S IMMUNIZATION RECORDS TO THE EXAMINATION.)**

PERSONAL

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

SECTION I - HEALTH HISTORY

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

☐ ☐ Does your child take any medication(s) regularly?

Reason for Medication ⇨

_____ / /
Parent/Guardian Signature Date

Birth History:

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

If yes, please describe:

If yes, list medications:

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

SECTION II - PHYSICAL EXAMINATION, INSPECTION, TESTS AND MEASUREMENTS

Required for Child Care and Head Start / Early Head Start

Tests and Measurements

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

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

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

Examinations and/or Inspections

Essential Findings Deviating from Normal:

Exam Date: / /

SECTION III - IMMUNIZATIONS

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

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

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

VACCINES (Circle Type)	DATE ADMINISTERED MM/DD/YYYY	
Hepatitis A (HepA)	1	2
Influenza (IIV/LAIV)	1	3
	2	4
Meningococcal (MCV4 / MPSV4)	1	2
Human Papillomavirus (HPV9/HPV4/HPV2)	1	3
	2	

OTHER Vaccines Specify Date & Type	Type of Vaccine(s)	Date of Vaccine(s)
	1	
	2	
	3	

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

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

Parent/Guardian refused immunizations: ☐

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

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

SECTION IV - RECOMMENDATIONS

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

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

Other Recommendations

SECTION V - DENTAL EXAMINATION AND RECOMMENDATIONS (OPTIONAL)

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

Dentist's Signature _____ Date ___/___/___

PHYSICIAN'S SIGNATURE

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

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

Information required for:

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

Child Care Licensing - Physical Exam, Restrictions, Immunizations

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

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.

Davison Community Schools

Where Kids Come First and Futures Begin

Administrative Offices 1490 N. Oak Road Davison, Michigan 48423

August 2018

Dear Parents or Guardians:

Michigan recently became the 39th state to enact a law requiring all school districts and sports-related organizations to provide educational materials about concussion awareness and the risks of concussions to each student. **The law also required parents or guardians to sign a form acknowledging that they have received Concussion Awareness information from the school district.** This signed form must be kept on file with the district until the student turns 18.

Attached to this letter, please find educational material about concussion awareness and a Concussion Awareness Educational Material Acknowledgement Form. Please take a few minutes to read and sign the attached materials so that they may be returned to school and placed in your child's file in order to comply with the law.

Concussions are a very serious brain injury caused by a blow, bump or jolt to the head. According to the Centers for Disease Control, U.S. emergency rooms annually treat an estimated 173,285 sports and recreation-related concussions among children and adolescents, with the highest number of injuries occurring in boys' football and girls' soccer.

For more information about concussions or the new Concussion Awareness law, please contact your child's building principal or my office at 591-0913. The Michigan Department of Community Health has also launched a very helpful website with resources for coaches, parents and athletes at www.michigan.gov/sportsconcussions.

Sincerely,

Holly Halabicky

Holly Halabicky
Executive Director of Student Services

JD\Letters\Concussion Letter to Parents 2018

Eric Lieske
Superintendent
(810) 591-0801
Fax (810) 591-7813

Kevin Brown
Assistant Superintendent
(810) 591-0808
Fax (810) 591-0082

Holly Halabicky
Executive Director of Student Services
(810) 591-0913
Fax (810) 591-2674

www.davisonschools.org

Educational Material for Parents and Students (Content Meets MDCH Requirements)
Sources: Michigan Department of Community Health, CDC and the National Operating Committee on Standards for Athletic Equipment (NOCSAE)

UNDERSTANDING CONCUSSION

Some Common Symptoms

Headache	Balance Problems	Sensitive to Noise	Poor Concentration	Not "Feeling Right"
Pressure in the Head	Double Vision	Sluggishness	Memory Problems	Feeling Irritable
Nausea/Vomiting	Blurry Vision	Haziness	Confusion	Slow Reaction Time
Dizziness	Sensitive to Light	Fogginess	"Feeling Down"	Sleep Problems
		Grogginess		

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 fall, bump, blow, or jolt to the head or body that causes the head and brain to move quickly back and forth. A concussion can be caused by a shaking, spinning or a sudden stopping and starting of 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. A concussion can happen even if you haven't been knocked out.

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. A student who may have had a concussion should not return to play on the day of the injury and until a health care professional says they are okay to return to play.

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. Don't hide it, report it. Ignoring symptoms and trying to "tough it out" often makes it worse.

2. **KEEP YOUR STUDENT OUT OF PLAY** – Concussions take time to heal. Don't let the student return to play the day of injury and until a heath care professional says it's okay. A student who returns to play too soon, while the brain is still healing, risks a greater chance of having a second concussion. Young children and teens are more likely to get a concussion and take longer to recover than adults. Repeat or second concussions increase the time it takes to recover and can be very serious. They can cause permanent brain damage, affecting the student for a lifetime. They can be fatal. It is better to miss one game than the whole season.

3. **TELL THE SCHOOL ABOUT ANY PREVIOUS CONCUSSION** – Schools should know if a student had a previous concussion. A student's school may not know about a concussion received in another sport or activity unless you notify them.

SIGNS OBSERVED BY PARENTS:

- Appears dazed or stunned
- Is confused about assignment or position
- Forgets an instruction
- Can't recall events prior to or after a hit or fall
- Is unsure of game, score, or opponent
- Moves clumsily
- Answers questions slowly
- Loses consciousness (even briefly)
- Shows mood, behavior, or personality changes

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/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, rest is key. 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. Students who return to school after a concussion may need to spend fewer hours at school, take rests breaks, be given extra help and time, spend less time reading, writing or on a computer. After a concussion, returning to sports and school is a gradual process that should be monitored by a health care professional.

Remember: Concussion affects people differently. While most students with a concussion recover quickly and fully, some will have symptoms that last for days, or even weeks. A more serious concussion can last for months or longer.

To learn more, go to www.cdc.gov/concussion.

Parents and Students Must Sign and Return the Educational Material Acknowledgement Form

CONCUSSION AWARENESS

EDUCATIONAL MATERIAL ACKNOWLEDGEMENT FORM

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/or the Concussion Fact Sheet for Students provided by Davison Community Schools.

Student Name Printed	Parent or Guardian Name Printed
Student Name Signature	Parent or Guardian Name Signature
Date	Date

Return this signed form to the school in which your student attends. The district will keep this form on file for the duration of participation or age 18.

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

Parent Notification Record of Incident at School

Date: _____ Notification made to: _____ Notification made by: _____

Date: _____ Notification made to: _____ Notification made by: _____

Date: _____ Notification made to: _____ Notification made by: _____

Date: _____ Notification made to: _____ Notification made by: _____