St. John Lutheran School

2022 Summer Splash Only

These forms need to be completed by families, who are not enrolled in St. John Lutheran School.

St. John Lutheran's Summer Childcare Program offers children a safe, friendly, Christ-centered environment of fun, learning, and inspiration. We're glad you're here!

Please use the following checklist to make sure everything gets filled out and returned to the school. Thanks!

- ☐ School Application
- ☐ Child Information Record
- ☐ Health Appraisal
- ☐ Permission for Use of SJLS Computers and Internet
- ☐ Summer Splash Photo Release
- ☐ Concussion Awareness Acknowledgment
- ☐ Immunization Record
- ☐ Written Information Packet Documentation (Preschool-Age)

St. John Lutheran School

145 North Fifth Street • Rogers City, Michigan 49779
sjlsrogerscity@gmail.com
StJohnSoars.com
989.734.3580

...but those who hope in the Lord will renew their strength. They will soar on wings like eagles; they will run and not grow weary, they will walk and not be faint. ~Isaiah 40:31

2022-23 Application for Enrollment

Family Name _____

Street Address	_____	
City, State, Zip	_____	
Home Phone	_____	
Family Email	_____	
Church Membership	_____	

Please check if this information may be included in a school family directory

Student Information

First	Middle	Grade Fall 2021	Birthdate	Place of Birth	Date of Baptism	Baptism Location	Ethnicity

Family Information

	Father	Mother
Name		
Address (If Different From Above)		
Cell Number		
Work Number		

Other Children Living At Home (Please list names & birthdates)

_____

_____

_____

Preferred Method of Contact:

____Phone call (____ Home ____ Mom cell ____ Dad cell)
____Text (____ Mom cell ____ Dad cell)
____Email listed above

Preschool parents: please indicate sessions desired for your child.

	M	T	W	Th	F
AM					
PM					

NONDISCRIMINATION POLICY: St. John Lutheran School admits students of any race, color, national and ethnic origin to all the rights and privileges, programs and activities accorded or made available to students at the school. It does not discriminate on the basis of race, color, or national or ethnic origin in administration of its educational policies, admissions policies, scholarships programs, and athletic and other school administered programs.

CHILD INFORMATION RECORD

State of Michigan - Department of Licensing and Regulatory Affairs - Child Care Licensing Bureau

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	Primary Phone ( )	Parent/Legal Guardian's Name (Optional)	Primary Phone ( )
Home Address (if not child's address)	2nd Phone (if applicable) ( )	Home Address (if not child's address)	2nd Phone (if applicable) ( )
City / State	Zip Code	City / State	Zip Code
Email Address (optional)		Email Address (optional)	
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/or Special Instructions? Yes ☐ No ☐ If yes, explain: (Attach additional sheets, if necessary.)			

CCL-3731 (Rev. 3/17/2022) Previous editions 7-18 & 4-21 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 _____, 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.

CCL-3731 (Rev. 3/17/2022) Previous editions 7-18 & 4-21 may 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			

Birth History:

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

If yes, please describe:

If yes, list medications:

_____ / /

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

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	
	Type of Vaccine(s)	Date of Vaccine(s)
OTHER Vaccines Specify Date & Type	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.

Acceptable Use Policy of SJLS Computers and Internet

Dear Parent/Guardian and Student:

During the school year, students will be allowed access to the school computer network and the internet through
the school's connection. The school has the following Acceptable Use Policy in place concerning such resources:

- Access to technology is a gift from God and should only be used in a God pleasing manner. In order to clarify and explain that use, this policy is provided to students, parents, and staff. ***Violations of this policy will be treated with normal school disciplinary procedures and may result in loss of privileges.***
- Students are responsible for good behavior on school computer networks just as they are in a classroom or school hallway. Communications on the network are often public in nature. General school rules for behavior and communications apply.
- The internet is provided for students to conduct research and communicate with others. Access to internet service is given to students who agree to act in a considerate and responsible manner. Parent permission is required. Access is a privilege – not a right. Access entails responsibility.
- Individual users of the computers are responsible for their behavior and communications over those networks.
- File storage areas may be treated like school lockers. Administrators may review files and communications to maintain system integrity and insure that users are using the system responsibly. Users should not expect that files stored on provided storage will always be private.
- Within reason, freedom of speech and access to information will be honored. During school, teachers will guide students toward appropriate materials. Outside of school, families bear the same responsibility for such guidance as they exercise with information sources such as television, telephones, movies, radio, and other potentially offensive media.
  Individual users of the internet are expected to abide by the generally-accepted rules of network etiquette. The following are NOT permitted:

- Sending or displaying offensive messages or pictures
- Using obscene language
- Harassing, insulting or attacking others
- Damaging computers, computer systems, software, or computer networks
- Violating copyright laws
- Using another's id/password
- Illegal use of data in folders or work files
- Intentionally wasting limited resources
- Employing the network for commercial purpose

Approved/Advised Board of Christian Education 8/7/17

Permission for Use of SJLS Computers and Internet

As a user of the St. John Lutheran School Computer Network and Internet, I hereby agree to follow the Acceptable Use Policy of SJLS Computers and Internet and use the network in a responsible and God pleasing manner for as long as I am a student at St. John Lutheran School of Rogers City, MI.

Student Signature _____

Printed Name of Student _____ Grade _____

As the parent or legal guardian of the above student, I grant permission for my child to access the SJLS computers and internet for school related purposes. I understand that under the Acceptable Use Policy of SJLS Computers and Internet my student may be held responsible for violations.

Parent Signature _____

Printed Name of Parent _____ Grade _____

Approved/Advised Board of Christian Education 8/7/17

Photo Release

Website

____ I give my permission for my child's photos (taken during school functions) to be published on the church and school website.

____ I do not wish to have my child's picture on the church/school website.

Newspaper

____ I give my permission for my child's photos (taken during school functions) to be published in the local newspapers.

____ I do not wish to have my child's picture in the local newspapers.

_____ _____

Parent Signature Date

Student(s) _____

Parent Comments _____

St. John Lutheran School

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

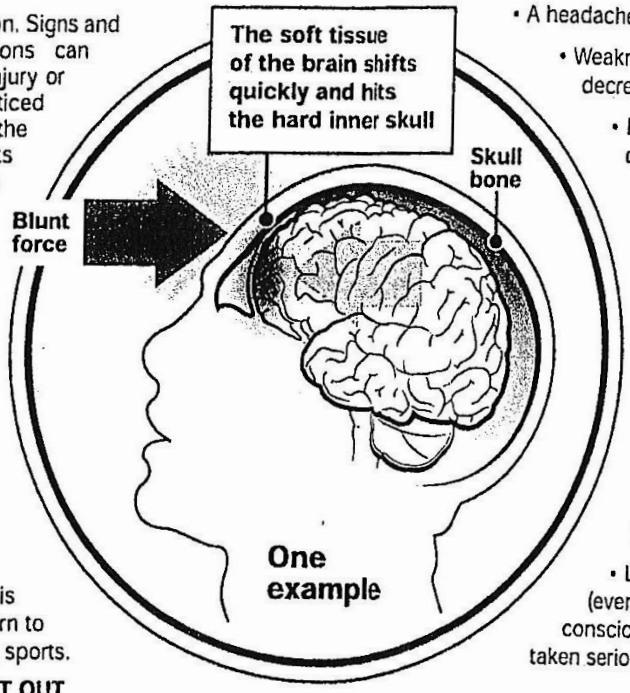
UNDERSTANDING Information for parents and students (Content meets MDCH requirements)

CONCUSSION

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 !!!

Michigan District, LCMS

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 St. John Lutheran School of Rogers City, Michigan.

_____	_____
Student Name Printed	Parent or Guardian name Printed
_____	_____
Student Signature	Parent or Guardian Signature
_____	_____
Date	Date
_____	_____
Student's Date of Birth	Date when student will turn 25 years old

Report any known previous incident(s) of concussion (use back of form if necessary)

_____

Return this signed form to St. John Lutheran School. St. John Lutheran School 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 for future reference.

2022-23

St. John Lutheran School

Preschool Packet

The following form needs to be filled out if you have a preschool-age child in Summer Splash.

☐ Written Information Packet Documentation

St. John Lutheran School

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sjlsrogerscity@gmail.com
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...but those who hope in the Lord will renew their strength. They will soar on wings like eagles; they will run and not grow weary, they will walk and not be faint. ~Isaiah 40:31

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.

LARA is an equal opportunity employer/program.