



PCCN Preschool
 3600 W Milham Ave.
 Portage, MI 49024
 (269) 323-7855

tiffany.warren@pccnpreschool.org

Welcome to PCCN Preschool!



We are very excited that you have chosen our cooperative preschool experience for your child. We hope PCCN establishes a solid foundation of social and emotional development for your preschooler, while at the same time involving you as parents in the building of this foundation. Below is information on our class offerings and tuition. On the next page you'll find a list of necessary items in order to reserve your spot in the class as well as items needed prior to school starting.

Enrollment Dates

February 17th: Open enrollment for Returning/Alumni families *only*

February 24th: Open enrollment for *all*

2025-2026 Tuition

PCCN PRESCHOOL	<i>Option 1</i>	<i>Option 2</i>	<i>Option 3</i>
Days of the Week	Monday, Wednesday, Fridays	Monday-Friday	Monday-Friday
Time	8:45am-11:45am	8:45am-11:45am	8:45am-3:15pm
*Participating	\$300/Month	\$450/Month	\$800/Month
**Non-Participating	\$400/Month	\$550/Month	\$900/Month
KCReady 3s and 4s Funding	✘		

As a co-op preschool, parents work in a classroom on a semi-regular basis to provide a well-rounded experience in the classroom for students and families. We also offer a non-participating option for families who cannot commit to in-class working responsibilities. If you're interested in non-participating, please indicate on your enrollment form and it will be approved by the Director as enrollment allows. A balance of 3 and 4 year olds will be maintained and the Program Director reserves the right to make placement recommendations.

FEES
REGISTRATION: \$100 paid by check with complete enrollment packet and is non-refundable. Please include your child's name and class on the check memo.
ACTIVITY: This amount will be determined prior to the Parent Meeting in August and is meant to cover the cost of field trips and/or special events and activities throughout the year, as deemed appropriate by the Board of Directors.
FINGERPRINTING: Due at the time of the first tuition payment (July 15th). This fee is only required of families that have not already been fingerprinted at the school or if their fingerprinting is more than five years old. If you have been fingerprinted elsewhere within the last five years, please contact our Program Directors. Pricing will be determined closer to the date.

In order to save your spot in class, the following must be turned in (all paperwork listed below is in this packet):

- \$100 registration fee paid by check made out to PCCN Preschool (please list your child's name in the memo line)
- Student Enrollment Page
- Child Placement Contract (two pages)
- Child Information Record (please note specific instructions to complete)

*Health Appraisal/Immunization Records are not due at this time but must be received before August 1st.

The above must be turned in in person during school hours (Monday through Friday, 9 am to 3:30 pm). If you cannot meet during work hours, please email or call the contact information listed on the first page. Once your spot has been reserved in class, you will receive a confirmation letter welcoming your child and family into the PCCN family.

The summer welcome email (sent out June 1st) will include a copy of our current 2025-2026 Parent Handbook for your review. Please note, the handbook will be updated prior to the start of next school year and is subject to change. If you have any questions at any point, please email tiffany.warren@pccnpreschool.org.

Student Enrollment

Child Name: _____ DOB: _____ Option (circle one): 1 2 3

Circle one: Participating or Non-Participating

Parent Information

Parent/Legal Guardian 1: _____

Address: _____

City: _____ State: _____ Zip: _____ County: _____

Primary Phone: _____ Primary Email: _____

Parent/Legal Guardian 2: _____

Address (if different from above): _____

City: _____ State: _____ Zip: _____ County: _____

Primary Phone: _____ Primary Email: _____

Child Information

Intended elementary school your child will attend: _____

What name would you like the teachers to use for your child? _____

What is the primary language spoken in the home? _____

Does your child have a special need that the teachers should be aware of? YES or NO

If yes, circle if your child receives any services: Speech / PT / OT / Other

Additional Info: _____

Does your child have an open IEP? YES or NO

Does your child have an anaphylactic allergy? YES or NO

If Yes, please explain: _____

Please list family holidays and cultures celebrated in your home:

Share what you'd like us to know about your child: *Ex: likes, dislikes, concerns, etc.*

How did you hear about PCCN: Facebook ___ Kzoo Kids ___ Friend ___ Other _____

Child Placement Contract

This contract is required of all licensed childcare centers by R 400.8146 of the Michigan Administrative Code. The Michigan Department of Consumer and Industry Services is required to inspect the childcare center and enforce the contract based on the terms provided in this contract.

For the school year of 2024-2025, PCCN Preschool agrees to provide services for the following child:

Child's Name _____ DOB: _____ Class _____

CONTRACT PROVISIONS SPECIFIC TO PCCN PRESCHOOL

Please initial each section below showing that you have read and agreed.

_____ **Return completed paperwork:** All necessary paperwork must be completed and turned in by the due dates. PCCN Requires two business days to process paperwork before any child may start school. You understand that if you fail to provide PCCN with required documentation, your child will be unable to start school.

_____ **Assist teachers/Directors in the classroom:** In a cooperative preschool, a parent or designated person (grandparent, relative, or friend) is required to work scheduled sessions in the classroom. All workers in the preschool classroom will need to have signed a Bureau of Regulatory Services form stating that they have no prior criminal convictions. Your required number of working days is dependent upon the total enrollment of your child's class.

- A. If you are unable to work a scheduled day, it is **your** responsibility to find someone with which to **exchange** your workday.
- B. Parents who fail to show up for their scheduled day of work will be charged penalties, payable to PCCN Preschool, of \$50 for first day missed, \$75 for second day missed, and may be asked to leave PCCN for any subsequent day missed.
- C. Working parents must be in the classroom and ready to begin the day 15 minutes prior to the start of class to receive the day's instructions and stay after to prepare for the next class. Failure to do so will result in a \$25 penalty.
- D. If more than one child from a family attends PCCN Preschool, the workdays are increased as the workdays are assigned per child.

_____ **Volunteer and Clean:** You will be expected to volunteer at at least one school event (family event, fundraising event, etc.) **AND** complete a School Clean for the preschool to ensure quality cleanliness of our cooperative program. This is based on full enrollment and subject to change if necessary. There will be a \$100 fine charged for failure to complete the clean and/or participation in a school event. It is not an option to pay the fee rather than participate.

_____ **Pay tuition promptly:** Tuition must be paid by the due date or there will be a \$35 late fee and expulsion will be considered if payment is not received within fourteen days of the due date.

_____ **Provide nutritious snacks:** When scheduled to do so, you will provide snacks for all students in the class and follow PCCN Preschool's snack policy, as outlined in the handbook.

_____ **Participate in fundraising:** As a non-profit, PCCN operates largely off of fundraising. We ask that all families participate in fundraising throughout the school year as is possible for their families.

_____ **Provide transportation during field trips:** Field trips occur on average every 4-6 weeks. Parents must provide transportation as well as participate during this time. Siblings are welcome on most field trips. Carpooling is always an option.

_____ **Take an active role:** As a cooperative school, all parents are a part of the Parent Teacher Organization (PTO). You are expected to attend necessary PTO meetings and take an active role in voting, surveys, etc.

_____ **Attend required Parent Meetings:** It is required that each family attend the Mandatory Parent Orientation held prior to the start of the school year in August and any mandatory parent meetings during the school year.

_____ **Toilet Training:** PCCN Preschool is not licensed to change children's diapers/pull-ups. It is required that your child be toilet trained prior to the start of school. If an accident occurs during school hours, you will receive a phone call and must come and change your child.

_____ **Follow PCCN health guidelines:** You will keep your child home and follow the PCCN Health Screening Protocols if your student is ill and report any confirmed cases of communicable diseases to the preschool.

_____ **Photo/Video Release- select all that apply (please read carefully):**

_____ I authorize that PCCN, KCRReady4s and PCCN parents may take or post photographs/video footage of my child in class to the **PCCN website or PUBLIC PCCN social media** of my child while he/she is attending preschool classes.

_____ I authorize PCCN and PCCN parents may take or post photographs or video footage of my child in class to the **PRIVATE PCCN class Facebook page** (viewed only by approved parents/guardians of students).

_____ I do not authorize the use of any photos or video footage of my child.

_____ **PCCN does not discriminate:** I understand that PCCN admits students of any race, color, national and ethnic origin, and gender identity to all rights, privileges, programs and activities generally accorded or made available to students at the school. It does not discriminate on the basis of race, color, national and ethnic origin, and gender identity in administration of its educational policies, admission policies, scholarship and other school-administered programs.

Information Provided for Licensing Purposes

R 400.8146 Information Provided to Parents:

Rule 146: 1. A center shall provide a written information packet to each parent enrolling a child. I have read the Child Placement Contract as stated above and agree to the terms and conditions.

Parent Signature: _____

Printed Name: _____

Relationship to Child: _____ Date: _____

Child Information Record

The following page is the Child Information Record. Please complete this page as part of the enrollment packet. This page must be filled out very specifically. **All boxes must be filled in. If something is not applicable, you may only write "unknown" or "none".** N/A is not an appropriate response.

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 _____, 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 6-17 may be used.

Health Appraisal Form- Instructions for Completing

Instructions for completing the attached Health Appraisal Form are listed below. An updated physical examination is required before your child may start school each year. If your child's annual visit falls after the start of school, you may have your pediatrician's office complete the paperwork without a visit. However, we would then need an up-to-date Health Appraisal Form following your child's annual visit.

Please note: Your child may not attend classes until the Health Appraisal form has been fully completed and is handed in to PCCN Directors. If you have any questions or need further explanation regarding this policy please contact either Director or a Board member. You may also email the enrollment email listed above.

***Please note, we must have an updated Health Appraisal form on file signed within the past year to date. You must turn in a new form if your child has their yearly wellness check up during the school year to replace the previous Health Appraisal.**

***What is highlighted in yellow is to be signed/completed by parents and blue is to be signed/completed by the provider.**

Personal and Section I:

These sections must be completed, **SIGNED AND DATED** by the parent. **EXAMINERS INITIALS** and a **Yes or No response must be noted by the physician.** The question regarding the Physicians' review of the child's Health History must be completed and initials provided.

Section II:

This section is to be completed and dated when the physical examination is given.

Section III:

This section on immunizations must be filled out, **SIGNED AND DATED** by a health care provider or you must provide a immunization waiver. The form will be valid for one year if dated within the year attending school. **If a separate form is provided, that form must be signed and dated.**

Section IV:

Your health care provider must complete this section.

Section V:

This section is optional.

Physician Signature:

Your health care provider must **SIGN AND DATE** this section when the physical exam is given.

Medication Authorization Instructions

Please contact the Directors if your child has routine or emergency medications that must be administered or kept on hand during school hours. There will be two additional forms that must be completed before your child can start school.

Health Appraisal Document can be accessed here or you may print the example below. This form is not due until August 1st, 2023.

https://www.michigan.gov/documents/dhs/BCAL-3305_09_10_336837_7.pdf

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

<table style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 5%; text-align: center;">Yes</td> <td style="width: 5%; text-align: center;">No</td> <td style="width: 5%; text-align: center;">Resolved</td> <td style="width: 85%;"># Is your child having any of the problems listed below?</td> </tr> <tr> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> <td>1 Allergies or Reactions (for example, food, medication or other)</td> </tr> <tr> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> <td>2 Hay Fever, Asthma, or Wheezing</td> </tr> <tr> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> <td>3 Eczema or Frequent Skin Rashes</td> </tr> <tr> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> <td>4 Convulsions/Seizures</td> </tr> <tr> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> <td>5 Heart Trouble</td> </tr> <tr> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> <td>6 Diabetes</td> </tr> <tr> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> <td>7 Frequent Colds, Sore Throats, Earaches (4 or more per year)</td> </tr> <tr> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> <td>8 Trouble with Passing Urine or Bowel Movements</td> </tr> <tr> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> <td>9 Shortness of Breath</td> </tr> <tr> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> <td>10 Speech Problems</td> </tr> <tr> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> <td>11 Menstrual Problems</td> </tr> <tr> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> <td>12 Dental Problems: Date of Last Exam / /</td> </tr> <tr> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> <td>Other (please describe): _____</td> </tr> <tr> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> <td>Does your child take any medication(s) regularly?</td> </tr> <tr> <td colspan="3"></td> <td>Reason for Medication _____</td> </tr> <tr> <td colspan="3"></td> <td>_____ / /</td> </tr> <tr> <td colspan="3"></td> <td style="text-align: right;">Parent/Guardian Signature _____</td> </tr> <tr> <td colspan="3"></td> <td style="text-align: right;">Date _____</td> </tr> </table>	Yes	No	Resolved	# Is your child having any of the problems listed below?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	1 Allergies or Reactions (for example, food, medication or other)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	2 Hay Fever, Asthma, or Wheezing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	3 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	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	9 Shortness of Breath	<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?				Reason for Medication _____				_____ / /				Parent/Guardian Signature _____				Date _____	<p>Birth History:</p> <p>Are there any current or past diagnosis(es) <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>If yes, please describe:</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>If yes, list medications:</p> <p>_____</p> <p>_____</p> <p>Was the health history reviewed by a health professional? <input type="checkbox"/> Yes <input type="checkbox"/> No Examiner's Initials: _____</p>
Yes	No	Resolved	# Is your child having any of the problems listed below?																																																																										
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			Date _____																																																																										

SECTION II - PHYSICAL EXAMINATION, INSPECTION, TESTS AND MEASUREMENTS

Required for Child Care and Head Start / Early Head Start

Tests and Measurements

No	Yes	Was child tested for:	Test results:	Normal	Referred	Under Care	No	Yes	Was child tested for:	Test results:	Normal	Referred	Under Care
<input type="checkbox"/>	<input type="checkbox"/>	VISION Date: / /	Visual Acuity Muscle Imbalance Other: _____				<input type="checkbox"/>	<input type="checkbox"/>	HEIGHT & WEIGHT Other: _____	Height Weight Other: _____			
<input type="checkbox"/>	<input type="checkbox"/>	HEARING Date: / /	Audiometer Other: _____				<input type="checkbox"/>	<input type="checkbox"/>	HEMOGLOBIN / HEMATOCRIT BLOOD PRESSURE	_____			
<input type="checkbox"/>	<input type="checkbox"/>	URINALYSIS Date: / /	Sugar Albumin Microscopic				<input type="checkbox"/>	<input type="checkbox"/>	TUBERCULIN	Type: _____ Neg.: <input type="checkbox"/> Pos.: <input type="checkbox"/> _____ mm			
<input type="checkbox"/>	<input type="checkbox"/>	BLOOD LEAD LEVEL Date: / /	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.						

Examinations and/or Inspections

Essential Findings Deviating from Normal:
Exam Date: / /

SECTION III - IMMUNIZATIONS

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

VACCINES (Circle Type)	DATE ADMINISTERED MM/DD/YYYY		VACCINES (Circle Type)	DATE ADMINISTERED MM/DD/YYYY	
Hepatitis B (HepB)	1	3	Hepatitis A (HepA)	1	2
	2		Influenza (IV/LAV)	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)
<i>Haemophilus Influenzae</i> type b (HIB)	1	3	1		
	2	4	2		
Polio (IPV/OPV)	1	3	3		
	2	4	<i>Indicate and attach physician diagnosis or laboratory evidence of immunity as applicable</i>		
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.

Parent Teacher Organization

The Board of Directors is the governing body of our preschool. It is made up of at least four members. These members include the PCCN director and the rest are volunteers who facilitate the overall operation of the school. All Board members are required to attend at least one monthly Board meeting. The following is a list of Board positions and parent volunteer opportunities. **Please reach out to PCCN Directors or current Board members if you are interested in any of the opportunities below.**

Board of Directors (At least three of the four positions must be filled at all times)

President: This position is head officer and oversees the smooth functioning of PCCN. This position also facilitates all Board and PTO meetings.

Vice President: This position will organize School Pictures, CPR Trainings, and is the head of personnel.

Treasurer: This position oversees the school budget and spending and works closely with the Directors in utilizing Quickbooks software.

Secretary: This position will take minutes at all Board and PTO meetings and share minutes with members and families. This position may also create monthly newsletters.

Parent Volunteer Opportunities

Fundraising: This volunteer opportunity coordinates fundraising events throughout the year that may include PCCN T-shirt sale, Motion Marathon, Butter Braids, Parents Night Out, and book sales. PCCN welcomes parents volunteering and working together in this opportunity.

Field Trips: This volunteer opportunity coordinates with PCCN Director to schedule field trips and look into field trip opportunities that correspond with classroom studies.