Livonia Public Schools
Great Start Readiness Program
Department of Student Services

PLEASE CALL AS SOON AS POSSIBLE TO SCHEDULE AN APPOINTMENT!

Dear GSRP Applicant:

Thank you for your interest in Livonia Public Schools' **Great Start Readiness Program (GSRP).** Specific information and documentation is necessary to determine your child's eligibility for the 2017-2018 school year. Application to the preschool program includes parent interview, home visit and developmental screening, to provide initial information for teachers to facilitate individual planning and children's learning.

*****Your child CANNOT start school until each item is received. *****

Your child's file must include the information described below. If you are unable to make copies, please bring original documents to be copied.

To start your child's file you will need:

______ **Completed Application Form**

______ **Original Birth Certificate with Seal or Other Official Record of Birth**

______ **Completed Physical Form, signed by Physician AND** ______ **Immunization Record**

PROOF OF RESIDENCY (MUST HAVE ALL THREE, PLEASE)

_______ **Driver's License or other Government-Issued Photo ID**

_______ **Current Lease, Rental Agreement or Property Tax Statement**

_______ **Current Utility Bill or Business Mail with Name and Current Address**

_______ **Employment or School Information** (Business or school name and phone number)

_______ **Household Income Information** (1040 Tax Form, W-2, SSI, etc., or proof of loss of income)

_______ **Emergency Contact Information**

** Please supply information for TWO contacts who **DO NOT RESIDE WITH YOU**:

Contact #1 ______________________ ______________________ ______________________
Name Address Phone

Contact #2 ______________________ ______________________ ______________________
Name Address Phone

Please contact Sally Roque (sroque@livoniapublicschools) or call (734) 744-2715, ext. 17990, with questions concerning eligibility, application and selection into Livonia Public Schools GSRP.

***** PLEASE NOTE: YOUR APPLICATION IS INCOMPLETE WITHOUT ALL ITEMS LISTED. *****

GSRP OFFICE @ GARFIELD. 10218 ARTHUR, LIVONIA, MI 48150 (734) 744-2715, ext. 17900

Livonia Public Schools
GREAT START READINESS PROGRAM
"KIDS FIRST"
Enrollment Application

Student # ____________

Teacher ______________

A.M. **P.M.**

Student's Name: ____
Last First Middle

Birth Date: ___/___/___ **Place of Birth:** ____________________ ◯ **Male** ◯ **Female**

Address: __________________________ **Apt. #** ______ **Complex:** ______________

City and Zip: __________________________ **Home Telephone:** (____) ______________

E-Mail Address: __________________________ **Cell Telephone:** (_____) ______________

Neighborhood Elementary School: ______________________________

Racial/Ethnic Background: Is this student Hispanic/Latino?______Yes ______No

____American Indian/Alaska Native _______ White/Caucasian _______ Hispanic/Latino

____Black/African American _______ Asian _______Native Hawaiian / Pacific Islander

Language spoken in your home: ______________ **Is student an immigrant?** ______

Student's primary language: ______________ **Is student a refugee?** _______

Family Information

Mother's Name: ____
Last First Middle Initial

Education (highest grade completed or degree): ______________________

Occupation: ______________________ ◯ Full time ◯ Part time

Father's Name: ____
Last First Middle Initial

Education (highest grade completed or degree): ______________________

Occupation: ______________________ ◯ Full time ◯ Part time

Child lives with: ◯ Both Parents ◯ Mother ◯ Father

◯ Legal Guardian ◯ Other ______________________

Years at current address: _ _______ **Years at Previous Address:** __________

List all *other* children in the home:

NAME	BIRTHDATE	RELATIONSHIP TO CHILD	SCHOOL ATTENDING

List all *other* adults in the home:

NAME	RELATIONSHIP TO CHILD

Briefly state any concerns you have in the following areas:

Child Health/Development: ____

____

Housing/Community/Financial Factors: ______________________________

____

Parenting/Family: ____

____

Certification: I certify that I have provided information which is true and accurate to the best of my knowledge. I agree to notify the school of address and/or telephone number changes. I understand that all information contained in this application is confidential. If my child is eligible for Head Start, I will be referred to the program for enrollment information.

Parent/Guardian Signature:______________________________________**Date:** ____________

FOR SCHOOL/OFFICE USE ONLY

REQUIRED INFORMATION COLLECTED:

○ **Birth Certificate** ○ **Immunization** ○ **Recent Physical**

○ **Residency** ○ **Income Verification**

Income Eligible: **YES** __________ **NO** __________ **FAMILY SIZE:** __________

Risk Factors: #________#_________ #________ # _________

IEP? NO _______ **YES** ______ **LAST IEPT** __________

Eligibility area(s):_______________________ **Family services received:** ____________________

Program Staff Signature: ____________________________________

Parent or Guardian: Please fill out all sections

SECTION I. MEDICAL HISTORY

Has your child ever had the condition or disease listed below? (U = Unknown)

	Yes	No	U		Yes	No	U		Yes	No	U
Asthma				Chicken Pox				Ear Infections			
Cancer				Frequent Colds				Eye Infections			
Pneumonia				Sickle Cell Trait				Heart Disease			
Seizures				Sickle Cell Disease				Liver Disease			
Diabetes				Strep Infections				Kidney Disease			

*If you checked "Yes" to any of the conditions listed above, please explain:

	YES	NO		YES	NO
Has child been hospitalized, had an operation, or have a serious illness? If yes, please explain:			Have there been any recent changes in your child's life (death, divorce, illness, separation)? If yes, please explain:		
Does Child Have:			Does child have allergies? ◯ Yes ◯ No Please list them: What happens during an allergy attack?		
Frequent sore throats					
Frequent cough					
Urinary infections					
Stomach Pain					
Vomiting			Is child taking medicine now? ◯ Yes ◯ No Name of medicine(s): Reason: 1. 1. 2. 2. 3. 3.		
Diarrhea					
Constipation					
Does child have difficulty seeing?					
Does child wear glasses?					
Does child have problems with ears or hearing? Please explain:			Does your child go to the doctor more than five times a year?		
Do you have any additional concerns or worries about your child? Please explain:					

SECTION II. PREGNANCY/BIRTH HISTORY

What was the child's weight at birth?_______________ What was mother's age at *first* pregnancy? _____________

	Yes	No		Yes	No
Did mother have a health problem affecting the baby during the pregnancy or delivery? Please Explain:			Did mother take medication during pregnancy? Medicine/reason:		
			Drugs?		
			Alcohol?		
Was the child born more than three weeks: ◯ Early? ◯ Late?			Were there any health problems at birth? Please Explain:		

SECTION III. DENTAL HISTORY

	Yes	No	
Does the child have any trouble with teeth, gums or mouth?			If yes, please explain:
Has child seen a dentist?			Dentist's Name?

SECTION IV. DEVELOPMENTAL HISTORY

At what age did your child talk?			At what age did your child walk?		
	Yes	No		Yes	No
Does your child put three words together in a sentence?			Which hand does your child use most often? ◯ Left ◯ Right		
Are you able to understand your child at least half of the time?			Does your child tell you in words what he wants and needs?		
Has your child ever had trouble walking, climbing, reaching, holding on to things? Please Explain:			Does your child play with blocks, boxes, cups, or other construction toys without help?		
Can your child: Run?______ Jump?______ Toss/catch?____			Does your child have any pets? What kind of pets?		
Does your child use crayons and/or markers to scribble or draw?			How many hours a day does your child spend watching TV?		
Does your child turn pages of a book and look at pictures?			Do you have any concerns about your child's play or social experiences? Please explain:		
Does your child listen to stories being read?			Does your child eat or chew on non•food things? Please explain:		
Does your child recall stories or events?			Does your child have any food restrictions for medical or religious reason? Please explain:		
Does your child talk with your friends/relatives who come to visit?			Does your child drink from a bottle? ◯ anytime ◯ bedtime		
Does your child enjoy playing alone or with imaginary friends?			Has your child had any recent changes in appetite?		
Does your child follow simple, Age-appropriate directions?			Does your child have any foods he dislikes? Please list:		
Has your child participated in any group experiences? (i.e., preschool, daycare) Please explain:			Does your child have favorite foods? Please list:		
What are your child's favorite toys, activities, books?			Is your child able to feed himself?		
Does your child worry a lot or is afraid of anything? Please explain:			Does your child have special dietary needs? Please explain:		
Do you give your child vitamins? What kind?			Does your child have trouble chewing or swallowing?		
Does your child sleep less than eight hours a day or have trouble sleeping (such as a nightmare, fretful, wants to stay up late)?			Is your child trained for: Bowel?________ Bladder?________		
Does your child take a nap?			How does your child let you know he needs to use the bathroom?		
What time does your child go to bed at night?					