ATA Pre-K (GSRP) Application

Please Read Carefully!

To ensure your application is processed, **all required documents must be submitted at the time of application.**

Applications will **NOT** be accepted without the following **REQUIRED DOCUMENTS:**

- Student's **Birth Certificate**
- Parent/Guardian **Driver's License, State ID, or Passport**
- Student's **Up-to-Date Michigan Immunization Record**
- Student's **Michigan Health Appraisal**
- Parent/Guardian must complete income verification. Applications will **NOT** be considered until **August 1st** per GSRP mandates if income verification is not completed.

IMPORTANT INFORMATION

- Incomplete applications will **NOT** be accepted.
- We do **NOT** hold spots for incomplete applications.
- Once your application is complete, you may:
  - Email it to Brooke Baker, *Early Childhood Development Center Director,* **bbaker@my.atafordpas.org**
  - Drop it off at the Main Office **(4801 Oakman Blvd., Dearborn, MI 48126)**

PRESCHOOL TOURS & APPLICATION PICK-UP/DROP-OFF

- An appointment is required to tour the preschool or to pick up/drop off an application
- Walk-ins are not available due to children in the building and shortened summer hours.

If you have any questions, please contact Brooke Baker, *Early Childhood Development Center Director*
bbaker@my.atafordpas.org or 313-625-4849

Advanced Technology Academy
A Michigan Public Charter School District

Chartered by LAKE SUPERIOR STATE UNIVERSITY

Managed by TECHNICAL ACADEMY GROUP

2026-2027 Wayne County GSRP Intake Application

These materials were developed under a grant awarded by the Michigan Department of Lifelong Education, Advancement and Potential (MiLEAP).

Child's Name: _____

Date of Birth: _____ Place of Birth: _____

Home Language: _____ Gender: _____

Parent/Guardian Name: _____

Parent/Guardian Name: _____

Licensed Site Name: _____

Teacher Name: _____

Staff MUST initial next to each document as it is received from the parent/guardian.*

Enrollment File		Family Engagement File
GSRP Forms required before enrollment:		ASQ-3 Summary Sheet: Date Entered into system: _____
	Birth Certificate or Alternative* Type: _____ Date Received: _____	COR or GOLD Report Dates: 1_____ 2_____ 3 _____
	Parent Identification Type: _____ Date Received: _____	Individualized Development Plan Dates: _____ _____ _____ _____
	Documentation Type: _____ Date Received: _____	Family Contact Form (Optional)
		Partnering on Child Development (Optional)
Licensing Forms required before enrollment:		Additional Documents used by program
	Child Information Record Date Received: _____	**By signing this application, I certify that I completed this form with the parent/guardian and the information is correct to the best of my knowledge**
	Immunizations Date Received: _____	Staff Name (Please Print) _____
	Written Information Packet Documentation Date Received: _____	Staff Signature _____
Licensing Form due within 30 calendar days of start date:		Date _____
	Health Appraisal Date Received: _____	

WAYNE RESA | SERVICE LEADERSHIP COLLABORATION EXCELLENCE

Great Start Readiness Program

Application

GSRP Child

Child's Name:

_____

Child's Address: _____ City: _____ Zip Code: _____

Which of the following is the student's race (if multi-racial, place a checkmark for each that applies):

American Indian or Alaska Native_____ Black or African American_____ White_____

Asian American_____ Native Hawaiian or other Pacific Islander_____ Hispanic or Latino_____

Parent/Guardian

Name: _____

Address (*if not child's address*):_____ City: _____ Zip Code: _____

Home Phone: _____ Cell: _____ Work: _____

E-mail address: _____

Marital Status: Married_____ Single_____ Divorced_____ Widowed_____ Separated_____

Employment Status: Unemployed_____ Part Time_____ Full Time_____ Seasonal_____

Parent/Guardian

Name:_____

Address (*if not child's address*):_____ City: _____ Zip Code: _____

Home Phone: _____ Cell: _____ Work: _____

E-mail address: _____

Marital Status: Married_____ Single_____ Divorced_____ Widowed_____ Separated_____

Employment Status: Unemployed_____ Part Time_____ Full Time_____ Seasonal_____

If parents are separated or the child is not with the parents, who has legal custody of the child?

Mother_____ Father_____ Foster Care_____ Legal Guardian_____ Grandparent_____

If guardian or foster parent (other than biological parent), please complete:

Legal Guardian's Name(s): _____ **Case Number:** _____

I understand that my child may be placed on a countywide waitlist, if the program that I am interested in has full enrollment. I also understand that there may be availability at other GSRP locations in Wayne County available to my family.

- ☐ I consent to receive text messages from Wayne RESA regarding my child's status on the waitlist.
- ☐ I consent to have my information shared with other GSRP locations that have current/immediate openings.
- ☐ I do not consent to have my information placed on a countywide waitlist.

WAYNE RESA | SERVICE LEADERSHIP COLLABORATION EXCELLENCE

Great Start Readiness Program

How did you hear of the Great Start Readiness Program?

Radio Ad_____ TV Ad_____ Billboard_____ Flyer_____ Family/Friend_____

Other_____ please explain_____

Income Verification

- To calculate the Federal Poverty Level use the Federal Poverty Level Calculator.
- **To determine the enrollment prioritization, use the GSRP Timeline and Enrollment Plan Document.**

List ***ALL*** household members for which you are financially responsible (include self, other adults, and children).					
Name	**Relationship to Child**	**Age**	**Name**	**Relationship to Child**	**Age**
	GSRP Child				

Self-Reported Income

Income Type*:		Frequency:		Amount:	
Income Type:		Frequency:		Amount:	
Income Type:		Frequency:		Amount:	
Income Type:		Frequency:		Amount:	
				Total income from all sources:	

Total Number Supported: _____ Federal Poverty Level (FPL): _____

Undisclosed Income*(Complete only if parent refuses to disclose household income)*

___ I am declining to disclose my household income and I understand my child will not be eligible to receive placement in a GSRP Program until after August 1, 2026.

Income-eligible for: _____ Head Start (<100% FPL) _____ GSRP (0-400%FPL) _____ GSRP(400%+ FPL)

___ **I understand that my family qualifies for Head Start and acknowledge that I have been given information regarding Head Start services and locations and that my name and phone number can be shared with local Head Start agencies.**

By signing this application, you certify that the information given is true and accurate to the best of your knowledge.

Parent/Guardian's Name (please print): _____

Parent/Guardian's Signature: _____ **Date:** _____

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 6-17may be used.

MDHHS-3305, HEALTH APPRAISAL

Michigan Department of Health and Human Services (MDHHS)
(Revised 7-24)

ear 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 1. Section 4 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).

SECTION 1 – 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 2 – HEALTH HISTORY

Yes	No	Resolved	Is your child having any of the problems listed below?	Birth History
☐	☐	☐	1. Allergies or Reactions (for example, food, medication or other)	
☐	☐	☐	2. Anaphylaxis	
☐	☐	☐	3. Does your child take any medication(s) regularly?	If yes, list medications
☐	☐	☐	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)	Are there any current or past diagnosis(es) ☐ Yes ☐ No
☐	☐	☐	10. Trouble with Passing Urine or Bowel Movements	If yes, describe

☐	☐	☐	11. Shortness of Breath	
☐	☐	☐	12. Speech Problems	
☐	☐	☐	13. Menstrual Problems	
☐	☐	☐	14. Dental Problems Date of Last Exam OR Date of Last Assessment	
☐	☐	☐	15. Other (describe)	

Reason for Medication

Concussion History

Parent/Guardian Signature Date

Was the health history reviewed by a health professional? Examiner's Initials

☐ Yes ☐ No

SECTION 3 - PHYSICAL EXAMINATION, INSPECTION, TESTS AND MEASUREMENTS

Required for Child Care and Head Start / Early Head Start

Test and Measurements

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

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 4 – IMMUNIZATIONS

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

Vaccines (Select Type)	Date Administered (mm/dd/yy)			
Hepatitis B (HepB)	1.	2.	3.	
	4.			
DTaP/DTP/DT/Td	1.	2.	3.	
	4.	5.	6.	
Tdap	1.			
Haemophilus Influenzae type b (HIB)	1.	2.	3.	
	4.			
Polio (IPV/OPV)	1.	2.	3.	
	4.	5.		
Pneumococcal Conjugate (PCV)	1.	2.	3.	
	4.			
Rotavirus (RV1/RV5)	1.	2.	3.	
Measles, Mumps, Rubella (MMR/MMRV)	1.	2.	3.	
Varicella (Chickenpox), (Var, MMRV)	1.	2.		
Hepatitis A (HepA)	1.	2.	3.	

Influenza (IIV/LAIV)	1.	2.	3.
	4.		
Meningococcal (MCV4, MenABCWY)	1.	2.	3.
Meningococcal B (Bexsero, Trumenba, MenABCWY)	1.	2.	3.
Human Papillomavirus (HPV)	1.	2.	3.

Additional 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.

History of Chickenpox Disease? If yes, date

☐ Yes ☐ No

☐ Parent/Guardian refused recommended immunizations at visit.

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

Health Professional Signature Title Date

SECTION 5 - RECOMMENDATIONS (Required for Child Care and Head Start/Early Head Start)

Is there any defect of vision, hearing, or other condition for which the school could help by seating or other actions?

☐ Yes ☐ No

If yes, explain

Should the child's activity be restricted because of any physical defect or illness?

☐ Yes ☐ No

Check all that apply

☐ Classroom ☐ Playground ☐ Gymnasium

☐ Swimming Pool ☐ Competitive Sports ☐ Other

If yes, explain degree of restriction(s)

Other Recommendations

SECTION 6 - DENTAL EXAM OR ASSESSMENT RECOMMENDATIONS

Child's Name

Type of Service
☐ Dental Exam ☐ Dental Assessment

ndings (Check all that apply)
☐ No findings ☐ Treated Decay ☐ Untreated Decay

Recommendations (Check one)
☐ Routine Care
☐ Referral for dental treatment
☐ Referral for urgent dental care

Provider Signature Date

Check one
☐ Dentist ☐ Dental Therapist ☐ Dental Hygienist

SECTION 7 - PHYSICIAN'S SIGNATURE

Examiner's Name (Print) Degree or License Telephone Number

Examiner's Signature Date

Address City State Zip Code
MI

Information required for:
arly 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.

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. (CENTER MUST CHECK ONE)

  ☐ The center keeps a licensing notebook containing a summary sheet, all licensing inspections and special investigation reports, and related corrective action plans for the last 5 years. The licensing notebook is available to parents/guardians during regular business hours. Reports from at least the past three years are available at www.michigan.gov/michildcare.

  ☐ The center does not keep a licensing notebook, but internet is available onsite. Reports from at least the last three years are available 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.

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