WALDEN GREEN MONTESSORI
17339 Roosevelt Road
Spring Lake, MI 49456
p: 616.842.4523
f: 616.842.4522
K-8 • Tuition-free
waldengreen.org

OFFICE USE ONLY ▶ Date Received: Grade:

BC Attached: DL Attached: IEP Attached:

WALDEN GREEN MONTESSORI 2025-2026
APPLICATION FOR SIBLING ENROLLMENT

NOTE: Applications are DUE by 4:00 PM on March 27, 2025 (Driver's License, Birth Certificate, and IEP must be attached)

Student Information			
Child's Legal Name:		Applying for Grade: Y5 K 1 2 3 4 5 6 7 8	
Birthdate:	Sex:	Ethnicity:	Language:

Previous School Attendance		
School Name:	From 20____ to 20____	Grade(s):
School Name:	From 20____ to 20____	Grade(s):

Family Information	
Mother's Name:	Father's Name:
Address:	Address:
City, State, Zip:	City, State, Zip:
Employer:	Employer:
Home Phone:	Home Phone:
Work Phone:	Work Phone:
Cell Phone:	Cell Phone:
Email:	Email:

Marital status of parents:	Married	Remarried	Divorced	Single	Separated	Widowed
Child lives with:	Both parents	Mother	Father	Other:		

Sibling Name:	Age:	School:
Sibling Name:	Age:	School:
Sibling Name:	Age:	School:

Health-Related Paperwork (see additional attachments)			
☐ Immunizations (all grades)	☐ Physical Exam (Y5s/K)	☐ Hearing/Vision (Y5s/K)	Dental Exam Date (Y5s/K):_____

continue on ▶

Does your child have any medical conditions, medications, or allergies?			Yes No
If yes, please explain:			
Does your child have any behavioral challenges?			Yes No
If yes, please explain:			
Does your child have an active IEP (special education)?			Yes No
If yes, please explain:			
Emergency Contacts			
Name:	Relationship:	Home Phone:	Work Phone:
Name:	Relationship:	Home Phone:	Work Phone:
Doctor:		Phone 1:	Phone 2:
What do you expect your child to gain from his/her experience at Walden Green?			
Please describe your child in the following areas (both inside and outside of school)			
Socially:			
Talents:			
Strengths:			
Opportunities for Growth:			
Field Trip Permission			
I hereby give my permission to Walden Green to transport my child in a vehicle and participate in field trips.			
Printed Name:		Signature:	
Parent/Guardian Signatures			
Signature:		Signature:	
Relationship to Child:		Relationship to Child:	

Walden Green does not discriminate on the basis of race, color, gender, or ethnic origin in its educational and admissions policies.

WALDEN GREEN MONTESSORI

Young Fives/Kindergarten Waiver Request 2025-2026 School Year

According to Michigan Law, if a child is not five years of age on September 1, 2025 but will be five years of age not later than December 1, 2025, the parent or legal guardian of that child may enroll the child in young fives/kindergarten for the 2025-2026 school year if the parent or legal guardian notifies the school district in writing, using this waiver.

A school district that receives this written notification may make a recommendation to the parent or legal guardian as to whether the child is not ready to enroll in kindergarten due to the child's age or other factors. Regardless of the district recommendation, the parent or legal guardian retains the sole discretion to determine whether or not to enroll the child in kindergarten if the student is five years of age not later than December 1, 2025.

Student Name: _____ Date of Birth: _____

Verification of Age (Check one):

- ○ Birth Certificate
- ○ Government Record
- ○ Hospital Record
- ○ Court Record
- ○ Citizenship Paper
- ○ Other: _____

_____ _____ _____

Parent/Guardian's Printed Name | Parent/Guardian's Signature | Date

Walden Green Montessori Recommendation

☐ School Administration agrees with the recommendation of the parents to enroll in Young Fives/Kindergarten.

☐ School Administration recommends kindergarten begin in the 2026-2027 school year for the following reasons:

1) _____

2) _____

3) _____

4) _____

_____ _____

Administrator's Signature | Date

HEALTH APPRAISAL

Michigan Department of Health and Human Services

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, dentist, dental therapist, and dental hygienist.
(**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)	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 I – 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, please describe
☐	☐	☐	11	Shortness of Breath	
☐	☐	☐	12	Speech Problems	
☐	☐	☐	13	Menstrual Problems	
☐	☐	☐	14	Dental Problems Date of Last Exam_____ **OR** Date of Last Assessment_____	
☐	☐	☐		Other (please describe)_____	

Reason for Medication		
Concussion History		
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

Test and Measurements

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

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 III – IMMUNIZATIONS

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

Vaccines (Circle Type)	Date Administered		Vaccines (Circle Type)	Date Administered mm/dd/yy	
Hepatitis B (HepB)	1	3	Hepatitis A (HepA)	1	3
	2	4		2	
DTaP/DTP/DT/Td	1	4	Influenza (IIV/LAIV)	1	3
	2	5		2	4
	3	6	Meningococcal MenACWY (MCV4)	1	3
				2	
Tdap	1		Meningococcal B (Bexsero, Trumenba)	1	3
				2	
Haemophilus Influenzae type b (HIB)	1	3	Human Papillomavirus (9vHPV, 4vHPV, 2vHPV)	1	3
				2	
	2	4	Additional Vaccines Specify Date & Type	Type of Vaccine(s)	Date of Vaccine(s)
Polio (IPV/OPV)	1	4		1	
	2	5		2	
	3			3	
Pneumococcal Conjugate (PCV7/PCV13)	1	3	Indicate and attach physician diagnosis or laboratory evidence of immunity as applicable.		
	2	4			
Rotavirus (RV1/RV5)	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				
Measles, Mumps, Rubella (MMR/MMRV)	1	3			
	2				
Varicella (Chickenpox), (Var, MMRV)	1	2			
History of Chickenpox Disease? ☐ Yes ☐ No If yes, date _____			Parent/Guardian refused recommended immunizations at visit: ☐		
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)

Yes	No	
☐	☐	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 EXAM OR ASSESSMENT RECOMMENDATIONS

Child's Name	Type of Service ☐ Dental Exam ☐ Dental Assessment
Findings (check all that apply) ☐ No findings ☐ Treated decay ☐ Untreated decay	Recommendations (check <u>one</u>) ☐ Routine care ☐ Referral for dental treatment ☐ Referral for urgent dental care
Provider Signature	Date
Provider Type (Check **one)** ☐ Dentist ☐ Dental Therapist ☐ Dental Hygienist	

PHYSICIAN'S SIGNATURE

Examiner's Signature	Date	Examiner's Name (Print)		Degree or License
Number & Street	City	MI	Zip Code	Telephone Number

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 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.

MICHIGAN KINDERGARTEN
ORAL HEALTH ASSESSMENT PROGRAM

KINDERGARTEN ORAL HEALTH ASSESSMENT FORM

The Kindergarten Oral Health Assessment law [*Public Health Code Act 368 Section 333.9316*] was passed to ensure that children entering their first year of school are able to receive an oral health assessment (dental screening) prior to starting school. Good oral health is important to help children stay healthy and ready to learn. This optional assessment will let you know if your child has any dental problems that require attention by a dentist. The assessment must be done by a Registered Dental Hygienist, Dentist, or Dental Therapist.

STUDENT INFORMATION	
Child's Name (Last, First, Middle)	Date of Birth (mm/dd/yy)
Address (Number, Street, City, Zip Code)	Home/Cell Phone Number
Parent/Guardian Name (Last, First, Middle)	Parent/Guardian Email
School Name	

DENTAL EXAM OR ASSESSMENT RECOMMENDATIONS (Licensed dental professional must complete this section)

Date of Service

Type of service
☐ Dental Exam ☐ Dental Assessment

Findings (check all that apply)	Recommendations (check ONE)
☐ No urgent needs	☐ Routine care
☐ Treated decay	☐ Referral for urgent needs/restorative care or specialist
☐ Untreated decay	

Screening Provider (check one)
☐ Dentist ☐ Dental Therapist ☐ Dental Hygienist

Provider Signature	Agency/Local Health Department
Provider Name (print)	Phone

Additional Comments: _____

_____

_____

_____

The date of service must be between March and August (within six months of the first day of school).

Walden Green Montessori

Consent for Disclosure of Immunization Information to Local and State Health Departments

Immunizations are an important part of keeping our children healthy. Schools, State and Local health departments must monitor immunization levels to ensure that all communities are protected from potentially life-threatening diseases and, if necessary, respond promptly to an emerging public health threat. It is important that disease threats be minimized through the monitoring of students being immunized.

Sharing immunization and personally identifiable information including the students name, Date of Birth, gender, and address with local and state health departments will help to keep your child safe from vaccine preventable diseases. The Family Educational Rights and Privacy Act (FERPA), 20 U.S.C. § 1232g, requires written parental consent before personally identifiable information from your child's education records is disclosed to the health department.

You may withdraw your consent to share this information in writing at any time.

Please detach the bottom half of this form and submit to the school office.

_____ *I authorize* ***Walden Green Montessori*** *to release my child's immunization record to the Michigan Department of Health and Human Services and Local Health Department. I understand this information will be used to improve the quality and timeliness of immunization services and to help schools comply with Michigan Law. This includes any immunization information and limited personally identifiable information from the school.*

Student's Name: _____ Date of Birth: ___/___/____

Signature of Parent /Guardian _____ Date: ___/___/____

Printed Parent/Guardian Name: _____

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 **Walden Green Montessori**, 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

STATE BOARD OF EDUCATION APPROVED HOME LANGUAGE SURVEY*

Walden Green Montessori is collecting information regarding the language background of each of its students. This information will be used by the school to determine the number of children who should be provided bilingual instruction according to Sections 380.1151 – 380.1158 of the School Code of 1976, Michigan's Bilingual Education Law. Would you please help by providing the following information?

Thank you very much for your cooperation.

Name of Student _____ Grade _____ Age _____

1. Is your child's native tongue a language other than English?

☐ Yes What is that language? _____

☐ No

2. Is the primary language[1] used in your child's home or environment a language other than English?

☐ Yes What is that language? _____

☐ No

_____ _____

Signature of Parent/Guardian Date

_____

Home Address

[1]"Primary language" means "dominant language used by a person for communication."

*Translation of this survey form in Spanish, Arabic, French, Italian, and Ojibwa is available at the Office of Field Services at 517-373-6066.

Photo/Video Consent Form

Walden Green Montessori is proud of our students and wishes to keep our families and community well informed of daily activities and successes. We showcase our students and faculty in newsletters, brochures, school websites, social media and the local newspapers.

Your child's name will not be shared on our website, brochures or local newspapers unless we have your expressed approval. Staff members are prohibited from posting any student images on any form of social or personal media outlet without the approval of the administrative staff at Walden Green.

Please check the box next to the desired agreement.

☐ I GRANT permission for my child's image to appear in school related publications.

☐ I DO NOT GRANT permission for my child's image to be used in ANY publication for any reason.

Student's Name: (please print)_____Student's Grade:_____

Student's Name: (please print)_____Student's Grade:_____

Student's Name: (please print)_____Student's Grade:_____

Student's Name: (please print)_____Student's Grade:_____

Print name of Parent/Guardian: (print)_____

Relation to Student:_____

Signature of Parent/Guardian: (sign)_____ Date:_____