Parent Name(s): _____ Date: _____

Billing Address: _____

Father SSN: _____ Mother SSN: _____

Cell Phone: _____ Cell Phone: _____

E-Mail Address: _____ E-Mail Address _____

	PRESCHOOL (tuition pro-rated if child withdraws)		Total
	PS3 AM - $695	Name: _____	
	PS3 PM - $695	Name: _____	
	PS4 AM - $1,004	Name: _____	
	PS4 PM - $1,004	Name: _____	
	PS Full day - $ 1,500	Name: _____	
	Registration - $50	(Registration fee Non Refundable)	

	Tuition K-8 (pro-rated if child withdraws)			
	Member Rate: $1,288	Name: _____	Grade: _____	
	Child #2: $1,030	Name: _____	Grade: _____	
	Child #3: $ 773	Name: _____	Grade: _____	
	Child #4: $ 773	Name: _____	Grade: _____	
	Non-Member: $2,575	Name: _____	Grade: _____	
	Child #2: $2,318	Name: _____	Grade: _____	
	Child #3: $2,060	Name: _____	Grade: _____	
	Child #4: $2,060	Name: _____	Grade: _____	

	K-8 Fees (Non-Refundable)	
	Registration - $300	
	Technology - $100	
	Assembly Fee - $10	
	Payment Plan Fee - $50	
	Scholastic News (K) - $8.00	
	Scholastic News (1st, 2nd) - $7.00	
	All God's People (2nd) - $15.00	
	Recorder Books-4th $5.00	
	Band Books- 5th & 6th $10.00	
	Catechism (7/8) - $17.00	
	Athletic Fee - $50.00	

Notes and Comments:

Subtotal:	
Gifts:	
Payments:	
Grand Total:	

Payment Plans (initial preferred option)

☐ Option 1: Pay in full via any payment methods.

☐ Option 2: Pay over 10 months (August - May) - ACH or credit card on file
>> Requires monthly installments of $ _____ per month
>> We will charge your credit card or debit ACH bank draft on the 10th of each month regardless if the 10th falls on a weekend or holiday.
>> Late fees of 3% or bank fees of $25 apply if credit card declines or bank returns check

☐ Option 3: Pay over 6 months (August - January) - Manual pay (check, cash or credit card)
>> Requires monthly installments of $ _____ per month
>> Late fees of 3% or bank fees of $25 apply if credit card declines or bank returns check after the 10th of each month regardless if the 10th falls on a weekend or holiday.

Certification (initial each box)

☐ I understand and agree that I am responsible for all tuition and fees assessed per this schedule as indicated above.

☐ I understand and agree that I am responsible for all fees incurred due to declined credit cards or checks returned from the bank. Minimum charge is $25.00.

☐ I understand and agree that I am responsible for additional fees should this account go to collections due to non-payment of account.

Notice: accounts are forwarded to the collection agency on
January 11, 2021 (option 3) or May 11, 2021 (option 2) if not paid in full
****Accounts in PRIOR collections MUST use Option 1 upon registration****

Parent or Guardian-Signature

Parent or Guardian-Signature

Parent or Guardian-Printed Name

Parent or Guardian-Printed Name

eCheck Authorization Form

St Paul Evangelical Lutheran Congregation, Millington, Michigan

I authorize St Paul Evangelical Lutheran Congregation (aka St Paul Lutheran Church and School) to initiate either an electronic debit or to create and process a demand draft against my bank account according to the terms outlined below. I acknowledge that the origination of ACH transactions to my account must comply with the provisioning of United States law.

Terms of Billing

| Option 1 – Pay in full for the amount of _____.

| Option 2 - Starting on _____ and on the 10th day of each month through May 2020 in the amount of _____.

Bank Information

Routing Number: _____

Account Number: _____

Account Type: __ Checking __ Savings

This payment authorization is to remain in full force and effect until I, _____, notify St Paul Lutheran Church & School of its cancellation by sending written notice in such time and in such manner to allow both St Paul Lutheran Church & School and the receiving financial institution a reasonable opportunity to act on it.

I further acknowledge in the event of non-sufficient funds (NSF), I will be liable for resulting NSF fees and billed appropriately.

Member Signature: _____

Member Printed Name: _____

Date: _____

Note: once information is entered into your electronic PCI-Compliant account, this form is destroyed. Account information is truncated within your account and cannot be read by anyone within our church or school.

Credit Card Authorization Form

St Paul Evangelical Lutheran Congregation, Millington, Michigan

I authorize St Paul Evangelical Lutheran Congregation (aka St Paul Lutheran Church and School) to initiate either an electronic debit or to create and process a demand draft against my credit card account according to the terms outlined below. I acknowledge that the origination of credit transactions to my account must comply with the provisioning of United States law.

Terms of Billing

☐ Option 1 – Pay in full for the amount of _____.

☐ Option 2 - Starting on _____ and on the 10th day of each month through May 2020 in the amount of _____.

Credit Card Information (**Credit** cards only – no debit cards)

Card Number: _____

Exp Date: _____

CVC code: _____ Billing zip code: _____

This payment authorization is to remain in full force and effect until I, _____, notify St Paul Lutheran Church & School of its cancellation by sending written notice in such time and in such manner to allow both St Paul Lutheran Church & School and the receiving financial institution a reasonable opportunity to act on it.

I further acknowledge in the event of credit card declination, I will be liable for resulting declination fees and billed appropriately.

Member Signature: _____

Member Printed Name: _____

Date: _____

Note: once information is entered into your electronic PCI-Compliant account, this form is destroyed. Account information is truncated within your account and cannot be read by anyone within our church or school.

PHOTO PERMISSION FORM PRESCHOOL

Dear Parent:

From time to time we would like to take photos of students participating in a variety of activities. We would like to feel free to publish them in the school or church newsletter or display them around school. For us to do that, we need to have your permission in writing. If you would be willing to allow us to do this, please sign the permission slip below. If you do not give your child permission, they will need to be lelt out of photographs.

I hereby give permission to St. Paul Lutheran School to photograph my child(ren) and to use that photograph in school or church publications or in local or area newspapers or in school promotional projects as deemed appropriate by the St. Paul staff. This includes still photography as well as video.

Child(ren)'s Name

Parent Signature

Date

PRESCHOOL SUPPLY LIST

Supply List:

1 rolls of paper towel 1 box of Kleenex

1 container Clorox Disinfectant Wipes

1 box Ziploc snack or sandwich sized bags 1 package of washable markers

1 package glue sticks

**Please keep an extra set of clothes in your child's backpack (shirt, underwear, socks, pants, or shorts) in a Ziploc bag labeled with your child's name. Please remember to change clothing with the seasons.

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 ⇨

_____ / / _____
Parent/Guardian Signature Date

Birth History:

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

If yes, please describe:

If yes, list medications:

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	Visual Acuity			
			Muscle Imbalance			
		Date: / /	Other:			
☐	☐	HEARING	Audiometer			
			Other:			
		Date: / /				
☐	☐	URINALYSIS	Sugar			
			Albumin			
		Date: / /	Microscopic			
☐	☐	BLOOD LEAD LEVEL	Level _____ ug/dl ⇨			
		Date: / /				

No	Yes	Was child tested for:	Test results:	Normal	Referred	Under Care
☐	☐	HEIGHT & WEIGHT	Height			
			Weight			
		Other: _____	Other			
☐	☐	HEMOGLOBIN / HEMATOCRIT	⇨			
☐	☐	BLOOD PRESSURE	Reading: _____			
☐	☐	TUBERCULIN	Type: _____			
		Date: / /	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

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	
OTHER Vaccines Specify Date & Type	Type of Vaccine(s)	Date of Vaccine(s)
	1	
	2	
	3	

History of Chickenpox Disease? ☐ Yes ☐ No If yes, date:

Indicate and attach physician diagnosis or laboratory evidence of immunity as applicable

Parent/Guardian refused immunizations: ☐

*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.

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

_____ _____ MI _____ (____) _____

Number & Street City 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.

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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.