Childhood is a journey, not a race.

Dear Families,

WELCOME TO DEVELOPMENTAL KINDERGARTEN! I am excited for your interest in DK. I am happy to be your child's teacher this upcoming year. Together, we will make your child's school year exciting, challenging, and most of all…FUN!!! My goal is to create a safe, comfortable, stimulating learning environment so that all children can succeed and grow to their potential.

I love that DK provides the gift of time to our youngest learners.

We are so fortunate to have a full-time aide in the classroom, Mrs. Hoffman. Having two adults provides a lower student to teacher ratio and ensures that we do most of our learning in small groups.

I can guarantee that every child will learn many new things at school this year socially and academically. So much of what our young children learn simply happens from being in school and participating in all of our activities. Therefore, not everything your child learns will come home to you on paper. We will be reading new stories every day. Research has shown that reading to your child and *talking* about those stories are key factors in your child's reading development. Please read stories, nursery rhymes, poems, or any other literature that your child is interested in every day for at least 15 minutes!

We are partners in your child's education. Feel free to contact me at any time (email: ginamaria@comcast.net or golson@petoskeysfx.org) with comments or concerns. Specific day-to-day information about Developmental Kindergarten will come home with your student on the first day of school. I can't wait to meet everyone! We will have a great year!

Sincerely,

Gina Olson ☺

St. Francis Xavier Developmental Kindergarten Program

Welcome to St. Francis Xavier Developmental Kindergarten Program. Enclosed you will find a welcome letter from Mrs. Olson, student supply list, registration form, financial support agreement, emergency contact form and required immunization schedule. To enroll your child for the 2026-2027 academic school year, the following documents are required:

__________ Registration Form

__________ Financial Support Agreement with $100.00 enrollment fee due by May 1st, 2026

I understand the enrollment fee is non-refundable and will not be credited towards tuition.

__________ Emergency Contact Form

__________ Birth Certificate-A copy of your child's birth certificate can be obtained from the county of his/her birth

__________ Immunization Record-The child who has an immunization record that is not up-to-date according to guidelines established by the Michigan Department of Health may not enter the classroom. If you need a waiver contact the health department.

__________ Proof of Residency-A copy of the parent's driver's license, property tax bill or utility bill can be accepted

We would be happy to assist you with any further questions you may have. Please contact the St. Francis Xavier School Office at (231) 348-2360 and ask for Melissa or Sierra.

Developmental Kindergarten (DK) Our Development Kindergarten program is designed for children that turn 5 years old in August through the end of November. DK is a half day program geared to develop kindergarten readiness skills. The class meets 5 days a week from 8:00 a.m. to 11:00 a.m. Students that complete DK in the spring, transition into full day kindergarten in the fall. The DK tuition rate for the 2026-2027 school year is $3,200 per child.

St. Francis Xavier School Developmental Kindergarten

Tuition Policy and Rate Statement

Financial Support Agreement

2026-2027 Academic Year

Father's Name:_____________________ Mother's Name:_________________________

Student's First and Last Name:____

Daytime Telephone# _________________Daytime Telephone#_____________________

Billing Address:_________________________City_________________Zip_____________

Total Tuition for the 2026-2027 school year: $3,200.00

1. Please initial which payment options you will be committing to for the 2026-2027 school year:

Full Payment at time of enrollment of $3,200.00_______________ ← Initial here

or

10 equal payments of $320.00 each, which will be charged monthly to your FACTS account ____________ ← Initial here

1. Every family will be responsible to sell 5 Grand Raffle tickets for the annual school fundraiser. ______________ ← Initial here

I have read, understand and agree to the current tuition rate and payment schedule that I have selected.

I understand and agree to my responsibilities and obligations as set forth in these policies.

I have included my $100.00 registration fee payable to St. Francis Xavier School.

Parent/Guardian Signature:______________________________________Date:_________

ST. FRANCIS XAVIER SCHOOL

STUDENT EMERGENCY CONTACT FORM

(one per student)

Child's Legal Name: ______________________ Birthdate:__________

Home Address:_____________________City:________Zip:_________

Home Phone:___________________ Email:_____________________

Father's Name:______________________Cell phone:______________

Father's employer:___________________Work phone:_____________

Mother's Name:______________________Cell phone:______________

Mother's employer:___________________Work phone:_____________

Sibling Information:

Name:____________________ Grade:_____________

Name:____________________ Grade:_____________

Name:____________________ Grade:_____________

Emergency Action Contact Plan:

Name & phone numbers in order of contact

1.Name_________________________Phone______________

2.Name_________________________Phone______________

3.Name_________________________Phone______________

4.Name_________________________Phone______________

In case of a school closing due to inclement weather or unexpected building emergency, send this child:

____home by usual route ____SFX CDC ____Parent will pick up

SPECIAL MEDICAL CONSIDERATIONS:

Family Physician:__________________________Phone__________

(Include allergies, etc.)

Parent Signature:___________________________Date:_________

Registration Form

St. Francis Xavier School
414 Michigan St., Petoskey, MI 49770

Student I.D. # ________________
Date of Registration____________

Student Information

Last Name________________________________ First Name_____________________ MI_____________

Name preferred____________________________ Gender: Male/Female Grade__________

SSN______________________________________ Birth date_______ Birthplace(city)______________

Home Phone (____)______________________ Unlisted? Yes/No

Home Address____

City/State/Zip____

County of Residence____________________________

Siblings

Name______________________________________ Birthdate_______ S.F.X. student? Yes/No Grade_____

Name______________________________________ Birthdate_______ S.F.X. student? Yes/No Grade_____

Name______________________________________ Birthdate_______ S.F.X. student? Yes/No Grade_____

Ethnic category: (Please circle one)

Caucasian Hispanic African American Native American Asian Multi-Racial Native Hawaiian Pacific Islander

Do we have your permission to have your family name, address, phone number and child/children's names listed in the school directory? Yes/No

Family Information

Father/Guardian

Dr./Mr. Please circle one: Married Single Widowed Divorced

Name____ Home Phone_____________________________

Address____

City/State/Zip____

Employer________________________________ Position____

Work phone______________________________ Cell Phone____

E-mail ____________________________________

Responsible for bill? Yes/No

Mother/Guardian

Dr./Mrs./Miss/Ms. Please circle one: Married Single Widowed Divorced

Name____ Home Phone_____________________________

Address____

City/State/Zip____

Employer________________________________ Position____

Work phone______________________________ Cell Phone____

E-mail____________________________________

Responsible for bill? Yes/No

Family Information (continued)
**Legal Guardian/Joint Custody (if divorced)
Name____ Home Phone____________________________
Address____
City/State/Zip____

Employer_________________________________ Position_______________________________________
Work phone_______________________________ Cell phone_____________________________________
E-mail____________________________________
Responsible for Bill? Yes/No Does student reside with you? Yes/No Relationship_________________

Parish Information
Religion____
Parish or Church____
Dates: Baptism________________ First Eucharist________________ Confirmation_________________

Health Information
Doctor_______________________________________ Phone____________________________________
Dentist_______________________________________ Phone____________________________________
List any medical conditions/allergies the school should be aware of:________________________________
First DTP Immunization (required for enrollment) ____

School History
Last school attended______________________________________ Date left_________________________
Address____ School Phone____________________
Principal____________________ Has the student repeated a grade? Yes/No If yes, which grade?_____
Has your child ever received any special education services or speech language classes? Yes/No
If yes, what type of services?____
Counselor/Teacher:___________________________________ Phone_______________________________

Referral Program
How did you hear of our school?____
If one of our parents referred you, please state his/her name?____________________________________

Photo Permission

I understand that during the course of school and school sponsored events, students will occasionally be photographed and/or videotaped for various S.F.X. & Catholic Communities of L'Arbre Croche (CCLC parish media), the Diocese of Gaylord, advertising, website, newspaper articles, Auction advertisements, etc. I hereby authorize such activities to take place.

Signature:____

MDHHS-3305, HEALTH APPRAISAL

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

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 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

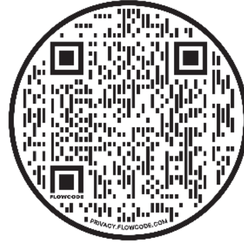
Test and Measurements

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

Findings (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 **MI** | Zip Code

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.

The Michigan Department of Health and Human Services (MDHHS) does not discriminate against any individual or group on the basis of race, national origin, color, sex, disability, religion, age, height, weight, familial status, partisan considerations, or genetic information. Sex-based discrimination includes, but is not limited to, discrimination based on sexual orientation, gender identity, gender expression, sex characteristics, and pregnancy.

Some common symptoms

- Headache
- Pressure in the head
- Nausea/ vomiting
- Dizziness
- Balance problems
- Double vision
- Blurry vision
- Sensitivity to light
- Sensitivity to noise
- Sluggishness
- Haziness
- Fogginess
- Grogginess
- Poor concentration
- Memory problems
- Confusion
- "Feeling down"
- Not "feeling right"
- Feeling irritable
- Slow reaction time
- Sleep problems
- Appears dazed and stunned
- Disoriented or confused
- Forgets an instruction

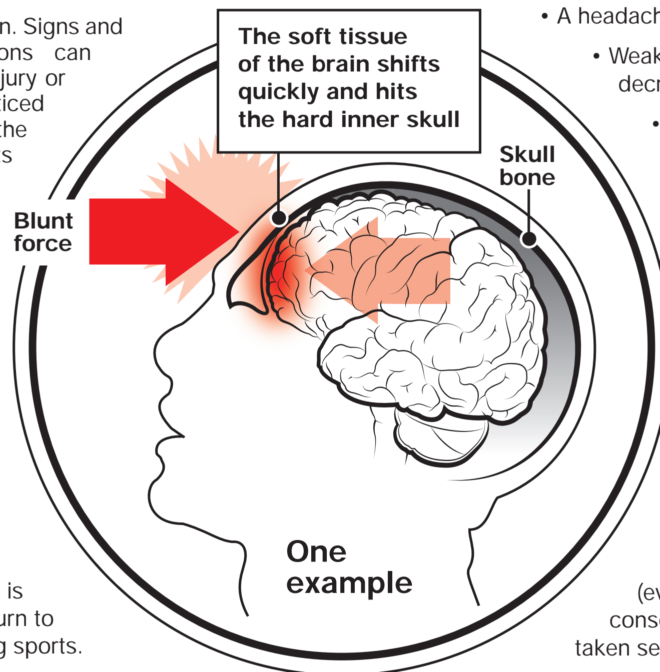
UNDERSTANDING Information for parents and students (Content meets MDCH requirements)

CONCUSSION

What is a concussion?

A concussion is a type of traumatic brain injury that changes the way the brain normally works. A concussion is caused by a bump, blow, or jolt to the head or body that causes the head and brain to move quickly back and forth. It can also be caused by the shaking or spinning of the head or body. Even a "ding,""getting your bell rung," or what seems to be a mild bump or blow to the head can be serious.

You can't see a concussion. Signs and symptoms of concussions can show up right after the injury or may not appear or be noticed until days or weeks after the injury. If the student reports any symptoms of a concussion, or if you notice symptoms yourself, seek medical attention right away.



If you suspect a concussion

1. SEEK MEDICAL ATTENTION RIGHT AWAY A health care professional will be able to decide how serious the concussion is and when it is safe for the student to return to regular activities, including sports.

2. KEEP YOUR STUDENT OUT OF PLAY

Concussions take time to heal. Don't let the student return to play the day of the injury and until a health care professional says it's OK. Students who return to play too soon-while the brain is still healing-risk a greater chance of having a second concussion. Repeat or second concussions can be very serious. They can cause permanent brain damage, affecting the student for a lifetime.

3. TELL THE SCHOOL ABOUT ANY PREVIOUS CONCUSSION

Schools should know if a student had a previous concussion. A students school may not know about a concussion received in another sport or activity unless you notify them.

Concussion danger signs

In rare cases, a dangerous blood clot may form on the brain in a person with a concussion and crowd the brain against the skull. A student should receive immediate medical attention if after a bump, blow, or jolt to the head or body s/he exhibits any of the following danger signs:

- One pupil larger than the other
- Is drowsy or cannot be awakened
- A headache that gets worse
- Weakness, numbness, or decreased coordination
- Repeated vomiting or nausea
- Slurred speech
- Convulsions or seizures
- Cannot recognize people or places
- Becomes increasingly confused, restless, or agitated
- Has unusual behavior
- Loses consciousness (even a brief loss of consciousness should be taken seriously)

How to respond to a report of a concussion

If a student reports one or more symptoms of a concussion after a bump, blow, or jolt to the head or body, s/he should be kept out of athletic play the day of the injury. The student should only return to play with permission from a health care professional experienced in evaluating for concussion.

During recovery, exercising or activities that involve a lot of concentration (such as studying, working on the computer, or playing video games) may cause concussion symptoms to reappear or get worse.

Sources: Michigan Department of Community Health and the National Operating Committee on Standards for Athletic Equipment (NOCSAE)

!!! WHEN IN DOUBT...SIT OUT !!!

CONCUSSION AWARENESS

EDUCATIONAL MATERIAL ACKNOWLEDGEMENT

By my name and signature below, I acknowledge in accordance with Public Acts 342 and 343 of 2012 that I have received and reviewed the Concussion Fact Sheet for Parents and Students provided by

____
School/Parish

________________________ Student Name Printed	________________________ Parent or Guardian Name Printed
________________________ Student Name Signature	________________________ Parent or Guardian Signature
________________________ Date	________________________ Date

Return this signed form to the School/Parish. The School/Parish must keep this on file for the duration of enrollment/participation and until age 25.

Students and parents should review and keep the educational materials available for future reference.