2021-2022 ENROLLMENT

GARFIELD
CO-OP PRE-SCHOOL

(313) 401-1576
www.garfieldpreschool.com
33901 Curtis Road, Livonia, MI

Contents of Enrollment Packet

- Registration Form (REQUIRED)
- Abuse and Neglect Statement (REQUIRED)
- Allergy Form (REQUIRED)
- Health Information Release Form (REQUIRED)
- Health Appraisal Form – Instructions
- Health Appraisal Form (REQUIRED)
- Medical Intervention Form (REQUIRED)
- Membership Commitment (REQUIRED)
- Photography and Observation Consent Form (REQUIRED)
- Parent Notification of the Licensing Notebook (REQUIRED)
- Child Information Record (REQUIRED)
- Screening Form (WORKING PARENTS ONLY)
- Central Registry Clearance Request (WORKING PARENTS ONLY- COPY OF DRIVER'S LICENSE REQUIRED)

PRINT ONE-SIDED PAGES ONLY

GARFIELD COOPERATIVE PRESCHOOL, INC.
REGISTRATION FORM

In addition to filling out this form, please visit: www.garfieldpreschool.com and fill out our enrollment form located under prospective families.

CONTACT INFORMATION: (Please print clearly.)
CHILD'S FULL NAME: _____ NICKNAME: _____
CHILD'S GENDER: _____M _____F CHILD'S BIRTHDATE _____
CHILD'S ADDRESS: _____ CITY: _____ ZIP CODE: _____
PHONE _____ CELL PHONE _____ EMAIL: _____
MOTHER'S NAME: _____ OCCUPATION: _____
FATHER'S NAME: _____ OCCUPATION: _____

RETURN THIS FORM AND THE $50 NON-REFUNDABLE REGISTRATION FEE, *PAYABLE TO GARFIELD COOPERATIVE PRESCHOOL*:
Garfield Cooperative Preschool
C/O Membership Chair
33901 Curtis Rd, Room 4
Livonia, MI 48152

Garfield Cooperative Preschool does not discriminate on the basis of race, color, ethnicity, or national origin

FOR ADMINISTRATIVE USE ONLY: Check #_____ Date _____ Registration # _____ Waitlist # _____

ABUSE AND NEGLECT STATEMENT

As a parent of a child attending Garfield Cooperative Preschool, I am aware that abuse and neglect is against the law. I have been informed of the school's policies on child abuse and neglect. Caregivers are required by law to immediately report suspected abuse and neglect to children's protective services.

Signature: _____ Date: _____

Print Name: _____ Class: _____

Child's Name: _____

GARFIELD COOPERATIVE PRESCHOOL, INC.
ALLERGY FORM

Garfield Cooperative Preschool recognizes the health risk posed by allergies, especially food allergies. In an effort to reduce the risk to children with severe allergies, we maintain a **PEANUT-FREE AND TREE NUT-FREE CLASSROOM.**

Creating a classroom environment that reduces the risk to severely allergic children requires the cooperation and understanding of all members of the Preschool. Members are asked to carefully monitor the foods brought in for snack to make sure that nuts are not part of the ingredient list. In addition to peanuts and tree nuts, members will be notified if there are any additional restricted foods for their class. Working/Snack Parents should review the Allergy List posted above the sink in the classroom at the beginning of each workday. Ultimately, however, it is the responsibility of the parent of the child with an allergy to check the snack each day and to keep an alternate "safe" snack on hand at the Preschool. We also recommend that the parent of a child with an allergy provide the Teacher with an Allergy Action Plan detailed by the child's physician.

Please complete this form **even if your child has no known allergies.** Please contact the **Health & Records Chairperson** to add any new allergies as soon as they are discovered.

Does your child have any known allergies? No _____ Yes _____ (please describe below)

Food Allergies:

Drug Allergies:

Any Other Allergies:

Does your child require an EpiPen to treat a reaction to allergies? No _____ Yes _____

All full-time teachers at Garfield Co-op are trained in the administration of emergency care, including the use of an EpiPen. Substitute teachers are not required to have EpiPen training, thus, if your child's allergy may require the use of an EpiPen, you may be required to stay at school with your child on days when an untrained substitute teacher is present.

By signing this form, I acknowledge that I have read and fully understand the Preschool policy regarding allergies. I understand that I may be required to attend class with my child when a substitute teacher is present. I agree to keep the Preschool informed of any new or existing allergies affecting my child.

Signature: _____ Date: _____

Print Name: _____ Class: _____

Child's Name:

GARFIELD COOPERATIVE PRESCHOOL, INC.
HEALTH INFORMATION RELEASE FORM

I will inform Garfield Cooperative Preschool, Inc., of any communicable disease my child or children may have.

I give Garfield Cooperative Preschool, Inc., permission to notify our preschool families of any communicable disease my child or children may have.

Example: We have 2 cases of chicken pox or 3 cases of head lice.

I understand, as in any other public setting, that I may be exposed to an illness. Due to the age of the children, I may encounter any and all childhood illnesses.

Signature: _____ Date: _____

Print Name: _____ Class: _____

Child's Name: _____

Instructions for completing the: **HEALTH APPRAISAL FORM**

When completing your health appraisal form for Garfield Cooperative Preschool, please be sure that each of the following sections are **absolutely complete** with appropriate signatures, dates, addresses, phone numbers, etc.

1. Personal – every space needs to be completed; if not applicable, place N/A in the space.
2. Section I – Health History – complete and be sure to sign and date as parent and guardian.
3. Section II – Optional; not required for admission.
4. Section III – Immunizations – all dates have to be completed with month, day, and year. Be sure this area is signed by a doctor or nurse. They should supply and verify this information. Parent's signature will not be accepted here.
5. Section IV – has to be completed by the doctor and all information (date, degree, or license, name, address and phone number) must be completed.
6. Section V – Optional, not required for admission.

THANK YOU FOR HELPING THE CO-OP KEEP OUR RECORDS ACCURATE AND COMPLETE!

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			

Birth History:

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

If yes, please describe:

If yes, list medications:

_____ / / _____

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

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

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

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	
	Type of Vaccine(s)	Date of Vaccine(s)
OTHER Vaccines Specify Date & Type	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.

Parent/Guardian refused immunizations: ☐

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 _____ 's teeth. As a result of this examination, my recommendation for treatment is: _____
child's name

_____ ___/___/___

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.

GARFIELD COOPERATIVE PRESCHOOL, INC.
MEDICAL INTERVENTION FORM

Garfield Cooperative Preschool recognizes that some children may have medical conditions that may need to be addressed in the classroom (i.e. asthma attacks, seizures, etc.) We depend on our parents to make sure the required medications are on hand in the classroom and that written instructions are provided to ensure proper use. We thank you for your cooperation in this matter.

Please complete this form if your child may need medical intervention. If your child does not require medication please write "NA" (not applicable)

Reason for medical intervention (please describe below):

Medications required _____

Additional Medical Instructions (please describe below):

Signature: _____ Date: _____

Print Name: _____ Class: _____

Child's Name:

GARFIELD COOPERATIVE PRESCHOOL, INC.
MEMBERSHIP COMMITMENT

Parent input and involvement is what makes a cooperative preschool so very special. By enrolling your child at Garfield Cooperative Preschool, you have made a commitment to be actively involved in your child's early childhood education.

This Membership Commitment form highlights the Membership Agreement detailed in the Bylaws. Please read each statement and initial on the line to indicate your understanding. Your signature indicates your acceptance of these responsibilities.

	I will become a member of the Garfield Cooperative Preschool website to gain access to the Handbook, Bylaws, Calendar and any other information relative to the school. www.garfieldpreschool.com
	I will read the Garfield Cooperative Preschool Bylaws, Handbook, and Exposure Control Plan. All of which are contained at www.garfieldpreschool.com.
	I will complete and submit all required registration forms, health forms, and emergency contact information prior to the first day of class.
	I will attend each General Membership Meeting.
	I will attend the required number of Classroom Cleaning sessions during the school year or opt out for a $50 fee.
	I will pay tuition, fees, and fines on time.
	I will fulfill the fundraising requirement of $150 for 1 child or $200 for two or more enrolled children.
	I will perform my assigned co-op job or opt out by paying the non-participation fee.
	I will participate in the classroom as a working parent on my scheduled workdays or opt out by paying the non-working parent fee. I understand that I am responsible for providing a substitute if I am unable to participate on my scheduled workday.
	I will inform the Health and Records Chairperson of my child's absences and of any communicable diseases they may have. I understand that the Preschool will notify all members of any communicable diseases I report (Example: We have a case of chicken pox in the 3-yr AM class.)
	I will conduct myself in a courteous and professional manner at all times when I am on school grounds.
	I will contribute my time, talents, and ideas whenever possible to maintain and improve the Preschool.

I understand that my involvement in the above activities is critical to the operation of Garfield Cooperative Preschool. Further, I understand that failure to carry out my responsibilities could result in termination of membership.

Signature: _____ Date: _____

Print Name: _____ Class: _____

Child's Name:

GARFIELD COOPERATIVE PRESCHOOL, INC.
PHOTOGRAPHY AND OBSERVATION CONSENT FORM

As the parent/guardian of _____ , I agree to the following:

- I understand that my child may be videoed/photographed at Garfield Cooperative Preschool during normal preschool hours, activities, or events.
- I understand that these photographs may be used throughout the school, and on Garfield Cooperative Preschool website.
- I understand Garfield Cooperative Preschool will protect my child's identity and will not publish my child's name if a video/photograph of my child is used as described above.
- I understand that such photographs shall become the property of Garfield Cooperative Preschool, which has the right to duplicate, reproduce, and/or make other uses as Garfield Cooperative Preschool deems necessary.

Please check the appropriate statement(s):

____ Yes, I confirm that I have read and understood the above and thereby give consent for use of my child photograph/video as described above.

____ No, I do not wish to have my child photographed.

____ Yes, I give permission for a specialist from Livonia Public schools to observe my child in class.

____ No, I do not give permission for a specialist from Livonia Public schools to observe my child in class.

Signature: _____ Date: _____

Print Name: _____ Class: _____

Child's Name:

If you have any questions, please contact the Health and Records Chairperson at healthrecords@garfieldpreschool.com

GARFIELD COOPERATIVE PRESCHOOL, INC.
PARENT NOTIFICATION OF THE LICENSING NOTEBOOK

Child Care Organization Act, 1973 Public Act 116

Michigan Department of Licensing and Regulatory Affairs

All child care centers must maintain a licensing notebook which includes all licensing inspection reports, special investigation reports and all related corrective action plans (CAP). The notebook must include all reports issued and CAPs developed on and after May 27, 2010 until the license is closed.

- This center maintains a licensing notebook of all licensing inspection reports, special investigation reports and all related corrective action plans.

- The notebook will be available to parents for review during regular business hours.

- Licensing inspection and special investigation reports from at least the past two years are available on the Bureau of Community and Health Systems website at **www.michigan.gov/michildcare**.

I have read the above statement issued by Garfield Cooperative Preschool.

Child(ren)'s Name(s) _____

_____

Parent Name _____

Parent Signature _____ Date _____

LARA is an equal opportunity employer/program.

BCAL-5053 (10-16) MS Word

Enrollment Packet 2021-2022

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
Father/Legal Guardian's Name	Home Phone ( )	Mother/Legal Guardian's Name		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 (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 Special Instructions (Attach additional sheets, if necessary.)				

BCAL-3731 (Rev. 6-15) Previous edition 7-12 only 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 must initial one of the following:

_____I give permission to _____, licensed by the Department of Licensing and Regulatory Affairs to secure emergency medical and/or emergency surgical treatment for the above named minor child while in care.

_____I do not give permission to _____, licensed by the Department of Licensing and Regulatory Affairs to secure emergency medical and/or emergency surgical treatment for the above named minor child while in care. I understand I assume responsibility for all emerency medical care.

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. Auxiliary aids, services and other reasonable accommodations are available upon request to individuals with disabilities.	AUTHORITY: 1973 PA 116 COMPLETION: Required PENALTY: Rule Violation Citation.

BCAL-3731 (Rev. 6-15) Previous edition 7-12 only may be used.

GARFIELD COOPERATIVE PRESCHOOL, INC.
SCREENING FORM

In accordance with the licensing requirements outlined by the Department of Human Services, and in an effort to ensure the safety and security of all children attending the preschool, Garfield Cooperative Preschool, Inc. requires all persons who will have contact with the children in the classroom to complete this screening form. Failure to complete and sign this form will result in the member forfeiting their eligibility as a working parent. This form and the results of the criminal background check will be kept confidential.

WORKING PARENT INFORMATION – PLEASE PRINT ***(one form for each working parent/guardian)***

Last Name_____ First Name_____ Middle Initial_____

Race_____ Sex_____

Date of Birth (mm/dd/yyyy)_____

All Prior Names (maiden name, previous marriage, alias)_____

Driver's License Number_____

Have you ever been convicted of any offense other than a minor traffic violation?	_____Yes	_____No
Have you ever been involved in the abuse or neglect of children?	_____Yes	_____No
I am aware that abuse and neglect of children is against the law	_____Yes	_____No
I know that caregivers are mandated by law to report abuse and neglect.	_____Yes	_____No

The information contained in this statement is correct to the best of my knowledge. I understand that this information is required by Garfield Cooperative Preschool, Inc. as part of the screening process for working parents. I agree that the Preschool may use the information included on this form to conduct a criminal background check on me using the Michigan State Police ICHAT system and the Michigan Public Sex Offender Registry. I understand and acknowledge that any criminal convictions may result in me not being eligible to work in the classroom.

Signature: _____ Date: _____

Print Name: _____

Please circle your relationship to the child: Parent/Guardian Grandparent Other_____

Child's Name:_____ Class:_____

Office Use Only

Approved_____ Denied_____

Screened by:_____ Date_____

CENTRAL REGISTRY CLEARANCE REQUEST
Michigan Department of Human Services

INSTRUCTIONS:

- An enlarged and clear copy of individual's photo identification must be attached.
- For Michigan employers, individuals and volunteer agencies, submit this request to the local County Department of Human Services. To obtain the address and fax number of **your local county DHS, access www.michigan.gov/dhs->Inside DHS.**
- For individuals seeking clearance on themselves, the results will be sent to the address on the picture identification provided.
- Outstate Children's Protective Services workers, law-enforcement, and court officials fax request to 517-241-7047 (Outstate only) on agency letterhead with cover sheet.
- All fields must be completed for processing.

COPY PHOTO ID HERE AND RETAIN A COPY FOR YOUR RECORDS

OR ATTACH A CLEAR COPY OF YOUR ID ON A SEPARATE PAGE

SECTION 1
INFORMATION ON PERSON BEING CLEARED

1. Name First, Middle, Last	2. AKA (Also Known As) (Maiden Name)	3. Social Security Number	7. Signature Required for individual being cleared
4. Address	**5. Phone Number**	**6. Date Of Birth**	

SECTION 2
REQUESTOR INFORMATION

Please Check Appropriate Box

- ☐ Child Welfare Agency
- ☐ Individual ☐ I would like to pick up my results in _____ county
- ☐ Law-Enforcement/Dept of Corrections
- ☐ Prosecuting Attorney/Court (please provide docket number if available) _____ MI
- ☐ Employer
- ☐ Volunteer Agency
- ☐ Out-of-State Adoption and Foster Home Screening
- ☒ Other Cooperative Preschool

Name of Employer/Volunteer Agency/Individual	Name of CPS/Law-Enforcement or Court
Name: Garfield Co-op Preschool	Title:
Address: 33901 Curtis Rd.	City: Livonia State: MI Zip Code: 48152
Phone: 313 401-1576	Fax: ~ E-mail: Date:

Employers/volunteer agencies – will ONLY receive responses of NO central registry if the name being cleared has approved this request with their signature. Employers/volunteer agencies will NOT receive notification if the name submitted has any central registry history hits per CPL 722.627.

For questions about completing this form, please contact the local Michigan Department of Human Services, Children's Protective Services or CPS Program office at 517-373-6028. Mail questions to PO Box 30037, 235 S. Grand Avenue, Suite 510, Lansing, Michigan 48909

This clearance does not identify individuals who may have child abuse/neglect history in other states, territories or tribal trust land.

The confidentiality of central registry information is protected by Sections 7 through 7j of the Michigan Child Protection Law (MCL 722.627-722.627j). Anyone who violates this protection is guilty of a misdemeanor and is civilly liable for damages.

Department of Human Services (DHS) will not discriminate against any individual or group because of race, religion, age, national origin, color, height, weight, marital status, sex, sexual orientation, gender identity or expression, political beliefs or disability. If you need help with reading, writing, hearing, etc., under the Americans with Disabilities Act, you are invited to make your needs known to a DHS office in your area.

Enrollment Packet 2019-20