



Registration Requirements

These Items are due before your child may start school.

- Shot record (We must have proof of at least one dose of each immunization required by Health department) or a signed waiver
- **Immunization Waiver Update**
- Macomb County Health Department will provide education for parents/guardians/18 year old or older students that reside in Macomb County or attend a school/preschool/childcare center located in Macomb County. **To schedule an appointment, call 586-466-6840.** Education will include the benefits of immunization and the risks of vaccine-preventable illness, and allows the parent/guardian/adult student an opportunity to have questions addressed.
-
- Child Information Card (Must be completely filled out)
- Registration form
- Health Appraisal Form (must be completely filled out and signed and dated by Dr.)
- Handbook Signature Form and photo release
- Registration Fee \$60 (must be paid to hold your child's spot)
- Tuition for September and May is due September 14th

You may send in registration with payment to:

St. Paul's Lutheran Church Early Childhood Center
22915 Greater Mack Avenue
St. Clair Shores, MI 48080
Attention: Heather Thomason/Director

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)	TODAY'S DATE (mm/dd/yy)
		MI	/ /
PARENT/GUARDIAN (Last, First, Middle)			HOME TELEPHONE NUMBER ()
ADDRESS (Number & Street)	(City)	(ZIP Code)	WORK TELEPHONE NUMBER ()
		MI	

SECTION I - HEALTH HISTORY

Yes	No	Resolved	# Is your child having any of the problems listed below?	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	1 Allergies or Reactions (for example, food, medication or other)	Birth History: Are there any current or past diagnosis(es) <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, please describe: If yes, list medications: Was the health history reviewed by a health professional? <input type="checkbox"/> Yes <input type="checkbox"/> No Examiner's Initials: _____
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	2 Hay Fever, Asthma, or Wheezing	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	3 Eczema or Frequent Skin Rashes	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	4 Convulsions/Seizures	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	5 Heart Trouble	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	6 Diabetes	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	7 Frequent Colds, Sore Throats, Earaches (4 or more per year)	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	8 Trouble with Passing Urine or Bowel Movements	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	9 Shortness of Breath	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	10 Speech Problems	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	11 Menstrual Problems	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	12 Dental Problems: Date of Last Exam / /	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Other (please describe): _____	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Does your child take any medication(s) regularly?	
Reason for Medication				
_____ / / Parent/Guardian Signature Date				

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	No	Yes	Was child tested for:	Test results:	Normal	Referred	Under Care
<input type="checkbox"/>	<input type="checkbox"/>	VISION Date: / /	Visual Acuity				<input type="checkbox"/>	<input type="checkbox"/>	HEIGHT & WEIGHT	Height			
			Muscle Imbalance							Weight			
			Other:							Other:			
<input type="checkbox"/>	<input type="checkbox"/>	HEARING Date: / /	Audiometer				<input type="checkbox"/>	<input type="checkbox"/>	HEMOGLOBIN / HEMATOCRIT				
			Other:							BLOOD PRESSURE	Reading: _____		
<input type="checkbox"/>	<input type="checkbox"/>	URINALYSIS Date: / /	Sugar				<input type="checkbox"/>	<input type="checkbox"/>	TUBERCULIN	Type: _____			
			Albumin							Date: / /	Neg.: <input type="checkbox"/> Pos.: <input type="checkbox"/> _____ mm		
			Microscopic										
<input type="checkbox"/>	<input type="checkbox"/>	BLOOD LEAD LEVEL Date: / /	Level _____ ug/dl				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		VACCINES (Circle Type)	DATE ADMINISTERED MM/DD/YYYY		
Hepatitis B (HepB)	1	3	Hepatitis A (HepA)	1	2	
	2			1	3	
DTaP/DTP/DT/Td	1	4	Influenza (IIV/LAIV)	2	4	
	2	5		Meningococcal (MCV4 / MPSV4)	1	2
	3	6	Human Papillomavirus (HPV4/HPV2)	1	3	
Tdap	1		OTHER Vaccines Specify Date & Type	2		
Haemophilus Influenzae type b (HIB)	1	3		Type of Vaccine(s)		Date of Vaccine(s)
	2	4		1		
Polio (IPV/OPV)	1	3	2			
	2	4	3			
Pneumococcal Conjugate (PCV7/PCV13)	1	3	<i>Indicate and attach physician diagnosis or laboratory evidence of immunity as applicable</i>			
	2	4	*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 child's school or local health department.			
Rotavirus (RV1/RV5)	1	3				
Measles, Mumps, Rubella (MMR)	1	2	Parent/Guardian refused immunizations: <input type="checkbox"/>			
	2					
Varicella (Chickenpox)	1	2				

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

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:
<input type="checkbox"/>	<input type="checkbox"/>	_____
<input type="checkbox"/>	<input type="checkbox"/>	Should the child's activity be restricted because of any physical defect or illness? If yes, check and explain degree of restriction(s): <input type="checkbox"/> Classroom <input type="checkbox"/> Playground <input type="checkbox"/> Gymnasium <input type="checkbox"/> Swimming Pool <input type="checkbox"/> Competitive Sports <input type="checkbox"/> Other
<input type="checkbox"/>	<input type="checkbox"/>	_____
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: _____

_____ Date _____

Dentist's Signature

PHYSICIAN'S SIGNATURE

Examiner's Signature

Date

Examiner's Name (Print or Type)

Degree or License

Number & Street

City

MI

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.

Developed in Cooperation with the Departments of Human Services, Education, Community Health, 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.

CHILD INFORMATION RECORD

State of Michigan Department of Human Services - Bureau of Children and Adult 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. 7-12) Previous editions 9-09, 3-08, 10-07, & 1-06 may be used until 12/31/13.

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.	()		

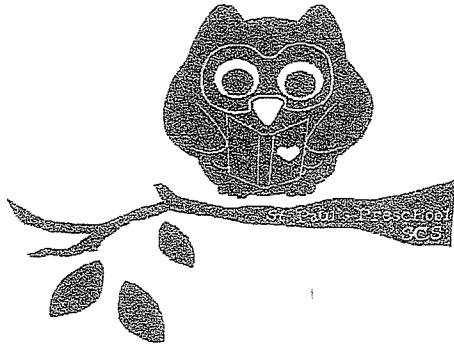
I give permission to _____, licensed by the Department of Human Services <div style="text-align: center; font-size: small;">(Provider's Name)</div>	
to secure emergency medical and/or emergency surgical treatment for the above named minor child while in care.	
Signature of Parent or Guardian	Date Signed

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

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.

AUTHORITY: 1973 PA 116
COMPLETION: Required
PENALTY: Rule Violation Citation.

BCAL-3731 (Rev. 7-12) Previous editions 9-09, 3-08, 10-07, & 1-06 may be used until 12/31/13.



St. Paul's Lutheran Church
Early Childhood Center
Child Information/Registration Form

Child's full name _____

Name child goes by _____

Date of birth _____ Sex _____

Child's home Address _____

Child's home phone number _____

Father's name _____ Phone _____

Father's Address _____

Father's Occupation and place of employment _____

_____ Phone _____

Mother's name _____ Phone _____

Mother's Address _____

Mother's Occupation and place of employment _____

_____ Phone _____

Siblings (please indicate names and ages and whether they live with the child) _____

Please list any other persons living with the child and their relationship (if any) to the child _____

Church Affiliation _____

Child's baptismal Date _____

Previous preschool experiences _____

Does your child have any allergies? _____

Do you have any family pets? _____

What does your child like to play with at home? _____

Are there any medical problems we should be aware of? _____

What languages are spoken in the home? _____

Does your child have any particular fears? _____

What experiences has your child had in Church or Sunday school? _____

Any additional information that you would like us to know about your child _____

PARENT NOTIFICATION OF THE LICENSING NOTEBOOK
Child Care Organizations Act, 1973 Public Act 116
Michigan Department of Human Services

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 Children and Adult Licensing website at www.michigan.gov/michildcare.

I have read the above statement issued by _____
Name of Child Care Center

Child(ren)'s Name(s) _____

Parent Name _____

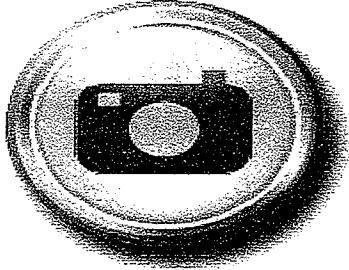
Parent Signature _____ Date _____

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.

Policies in this Information Packet may be revised as necessary. Updated policies will be provided to you.

I have read and agree to the policies in the St. Paul's Lutheran Church Early Childhood Center Information Packet :

Parent Signature _____ Date _____



I give my permission for my child and their family to have their picture taken during class, family events, and field trips. The pictures will be used for Memory Books, wall displays, class books, and power point presentations on CD.

Child's Name _____

Parent's Signature _____

Date _____

Walking Trip Permission Slip

St. Paul's Lutheran Church Early Childhood Center

I hereby give my permission for my child, _____
to participate in walking field trips with their teachers around the immediate neighborhood of
St. Paul's Lutheran Church.

Parent Signature _____

Date _____

I hereby give my permission for my child, _____
to take walking field trips over to the church to practice for a variety of school programs. These
trips will be once a week for not more than an hour.

Parent Signature _____

Date _____