Registration Requirements

2017-2018

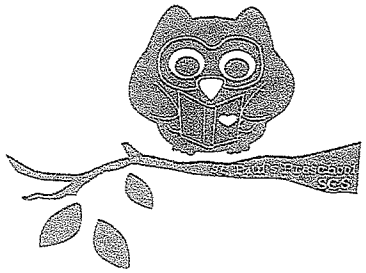
These Items are due before your child may start school.

- 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) Please do not use N/A or draw a line through or leave blank. Write none or unknown.
- Registration form
- **Health Appraisal Form (must be completely filled out and signed and dated by Dr.) Please see the attached form for rules set by licensing. Our center also requires that a health appraisal be updated every year.**
- Handbook Signature Form, photo release, prayer pal permission slip, field trip permission slips.
- Registration Fee $60 (must be paid to hold your child's spot)
- **Tuition for September and May is due September 11th**
- **Please circle if your child will be coming MWF or M-F**

You may send in registration with payment to:
Our First day of school is September 11th

St. Paul's Lutheran Church Early Childhood Center
22915 Greater Mack Avenue
St. Clair Shores, MI 48080
Attention: Heather Thomason/Director
(586) 202-4367



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_____

_____

_____

What is the best way to communicate with you?

_____

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. 4-16) Previous edition 6-15 & 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.	AUTHORITY: 1973 PA 116 COMPLETION: Required PENALTY: Rule Violation Citation.

BCAL-3731 (Rev. 4-16- Previous edition 6-15 and 7-12 only may be used.

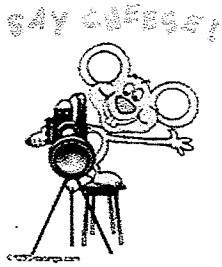


Photo Release

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, Church web-site, English District of the Lutheran Church, Preschool Facebook Page, wall displays, thank you notes, class books, and power point presentations on CD.

Child's Name _____

Parent's Signature _____

Date _____

Prayer Pal Permission

I give my child _____ permission to participate in the preschool pray pal program. A congregation member will be matched up with my child and they will pray for my child. The children will make cards for their prayer pal and may receive cards from them. Contact information will be limited to first names and cards will be sent from the preschool. We will not share your address.

Parent's Signature _____

Date _____

Information Packet Documentation

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 (Revised June 2017)

Parent Signature _____ Date _____

WRITTEN INFORMATION PACKET DOCUMENTATION

Michigan Department of Licensing and Regulatory Affairs
Bureau of Community and Health Systems

Child(ren)'s Name(s) (Last, First)	Center Name

A written information packet has been provided at the time of enrollment. The packet included all the following information:

- Criteria for admission and withdrawal.
- Schedule of operation, denoting hours, days, and holidays during which the center is open and services are provided.
- Fee policy.
- Discipline policy.
- Food service program.
- Program philosophy.
- Typical daily routine.
- Parent notification plan for accidents, injuries, incidents, illnesses.
- Exclusion policy for child illnesses.
- Notice of the availability of the center's licensing notebook.
  - The licensing notebook contains all the licensing inspection and special investigation reports and related corrective action plans since May 28, 2010.
  - The licensing notebook is available to parents during regular business hours.
  - Licensing inspection and special investigation reports from at least the past two years are available on the child care licensing website at **www.michigan.gov/michildcare.**
- Other _____

I certify that I received all of the above items.

_____ _____

Parent/Guardian Signature Date

Note: A single BCAL-4340 form may be used for all children in the same family.

MEDICATION PERMISSION AND INSTRUCTIONS
CHILD CARE HOMES AND CENTERS
Department of Licensing and Regulatory Affairs
Bureau of Community and Health Systems
Child Care Licensing Division

If you are giving or applying any medication to a child in care, the following must be completed by the parent for **each** medication. An interruption in medication will require a new permission form.

TO BE COMPLETED BY PARENT

I give my permission for _____ to give or apply the medication
(Caregiver, Facility)

_____, to my child _____, as follows:
(Specify, prescribed medication/over the counter product) (Child's Name)

DIRECTIONS:

1. Date to Begin Giving Medication	2. Date to Stop Medication
3. Times Medication is to be Given	4. Amount (dosage) of Medication Each Time Given
5. Storage of Medication	
6. Other Directions, if Any	
Signature of Parent	Date

TO BE COMPLETED BY THE CAREGIVER GIVING THE MEDICATION:

DATE	TIME	AMOUNT GIVEN	CAREGIVER'S NAME	CAREGIVER'S SIGNATURE

It is recommended this form be reviewed with the parent every 3 months if the medication is ongoing.

LARA is an equal opportunity employer/program.

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

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 _____ (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

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 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.