ENROLLMENT CHECKLIST

QUICK CHILD INFO	
CHILD'S NAME:	*CLASSROOM:*
START DATE:	PLAN:

1. FILE

- ☐ Application Complete
- ☐ Food Program Income Statement form
- ☐ Health form (unless in school) within 30 days of start date
- ☐ If allergies complete physician CACFP form, put info in KT and post notice in room
- ☐ If GSRP – 2nd file started with only GSRP required docs
- ☐ Shot record (or print from MCIR if they get shots in Michigan)
- ☐ Parent Orientation form – keep copy in file and give copy to teacher
- ☐

2. KANGAROOTIME

- ☐ Enter family and child, put on plan, choose classroom
- ☐ Registration Paid in KT
- ☐ Deposit paid or entered into a deposit payment plan in KT
- ☐ Check that first week's charge is accurate in KT
- ☐ Upload application, health form, and food program sheet
- ☐ Assign food program category
- ☐
- ☐

OTHER

- ☐ Change status of child to started
- ☐ Add child to MCIR (if not in school)
- ☐ Get child's name, DOB, start date and schedule to teacher

Child Information Record

Emergency Contact

Release of Child

Emergency Treatment Release

Application & Contract

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

Parent/Legal Guardian's Name		Home Phone ( )	Parent/Legal Guardian's Name (Optional)		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		
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. 7-18) Previous edition 6-17 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 Initials:

________I give permission to The Children's Center, licensed by the Department of Licensing and Regulatory Affairs to secure emergency medical treatment for the above named minor child while in care.

I certify that I accurately completed this form and if anything changes, I will notify the provider by updating this form.

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. 7-18) Previous edition 6-17may be used.

Family Information

E-mail address:
____

Relationship to Child:_____________________________________

If divorced, who has legal custody?
____

May the non-custodial parent pick up the child? Yes No
(court documentation must be on file if answer is no)

Please list siblings and all other people that live in the home:
Name______________________Relationship to Child_______________Age_____
Name______________________Relationship to Child_______________Age_____
Name______________________Relationship to Child_______________Age_____
Name______________________Relationship to Child_______________Age____

Enrollment Session

Select session(s)
___ Summer Session (June - August) $35
___ Fall Session (September - May) $35
___ Full year (12 months) $50

___ By checking I authorize the above selected registration fees to be deducted from my tuition express account.

Child Care Schedule

Note Times Reserving:
M in:____ T in:____ W in:____ R in:____ F in:____
out:______ out:____ out:____ out:____ out:____

Start Date ________________ Please select classroom age group at start date:

___ School-Age (started K - 6th) School Attending ____________________
___ Preschool (3 years - 5 years)
___ Twos
___ Ones
___ Infant (under 1)

Food Program Information

Please circle all meals that your child will receive (if schedule varies throughout the week, circle every meal that may apply during the week)

Breakfast AM Snack Lunch PM Snack

Please circle the ethnicity of your child:

Hispanic or Latino Not Hispanic or Latino

Please circle one or more racial designations:

American Indian or Alaskan Native / Asian / Black or African American / Native Hawaiian or Pacific Islander / White

*you are not required to select ethnicity or racial designations for your child. If this information is not selected, we will report ethnicity and/or racial designation based on observation.

Emergency Authorization

- ☐ I hereby authorize the staff and director representing the center to give consent for any and all necessary emergency medical and First Aid care to include transportation, if needed, for my child while he/she is in the center's custody.
- ☐ I acknowledge that this center cannot be held liable in any way for accidents that occur on or off premises while my child is under this center's care.

School-Age Health Statement **(if in public school system)**

___ My child, ___________________________, is in good physical condition and has no health concerns which would limit normal participation in the regular program of the center.

___ My child, ___________________________, has a condition which would limit normal participation in the regular program of the center. (please submit explanation and relevant medical documentation

Additional Forms **(if not in public school system)**

___ I agree to provide a current Health Appraisal for my child who is not yet enrolled in public school.

___ I agree to provide an up-to-date immunization record at the time of enrollment (if child is not in the Michigan Immunization System.

Field Trips

I give my permission for my child to leave The Children's Center premises with The Children's Center staff for program activities within walking distance, as planned by the center staff. I understand that I will be notified by email and posted notice prior to field trips.

Pesticide Policy

If pesticide treatment becomes necessary, notification (written notice and posted notice) will be given to parents in advance of treatment including the reason for treatment, the location, date and type of treatment.

Licensing Rules

- This center maintains a licensing notebook of all licensing inspection reports, special investigation reports and all related corrective action plans, and it is available to parents for review.
- Licensing inspection and special investigation reports from at least the last two years are available at Michigan.gov/michildcare.

☐ I have read the above statement issued by The Children's Center.

Photography

Permission (is / is not) given for photography for publicity purposes to be used in print promotions, email, or use on the company's web site including social media sites.

Lotions / Baby Wipes

I give the center permission to apply the selected items to my child in accordance with the directions on the label of the container:

☐ Baby wipes
☐ Band-Aids
☐ Sunscreen
☐ Insect Repellant
☐ Non-prescription ointment (such as A&D, , Vaseline)
☐ Other (please specify) ___________________________

Enrollment & financial policies

I agree to electronic withdrawal of tuition fees.

I am aware that I will be charged a fee for unsuccessful tuition withdrawal.
I am aware that I will be charge a fee for late pick-ups.
I have received the Parent Handbook, containing additional policies and procedures

I understand that current rates are subject to change.

I am aware that a two week notice is required for withdrawals and failure to properly notify the center will result in being charged for the period of time that notice was not given.

I agree to pay a two-week deposit ($200 minimum deposit), which will be credited to my account and used when notice of two weeks prior to withdrawal has been given.

I am aware that the center is within it's rights to collect any unpaid tuition, fees and collection or court costs associated with collection of these charges.

I understand that that tuition is prorated and that there are no vacation credits issued.

I understand that a $10 fee may be charged for schedule changes and withdrawals prior to the end of a contract.

I have read this document and agree to abide by the statements within.

Full form Signature

Parent signature_______________________________ **Date** __________

The Children's Center

Kangarootime Payment Authorization Form

Note: 3% added to all charges using Credit or Debit CARD. Credit Card Authorization	I (we) hereby authorize The Children's Center to initiate recurring credit card charges to the below referenced credit card account. To properly affect the cancellation of the agreement, I (we) are required to give 14 days written notice. ☐ Visa ☐ Mastercard Cardholder Name_______________________________________ Phone _________________ Cardholder Address ____ ____ Account Number _________________________ Exp. Date _____ Cardholder Signature ___________________________________ CSV _______________ Date ___________________
Bank Authorization	I (we) hereby authorize The Children's Center to initiate debit entries to my (our) Checking or Savings Account indicated below.. To properly affect the cancellation of the agreement, I (we) are required to give 14 days written notice. (credit union members, please contact credit union to verify account and routing numbers for automatic payment) Your Name_______________________________________ Phone _________________ Cardholder Address ____ ____ Bank Name ____ Bank Address ____ Routing Transit # __________________ Account #_____________ ☐ Checking Account ☐ Savings Account Signature ______________________Date __________

Complete and return signed form by email to Jared@NilesKids.Com OR fax to 269-683-0411

Return this completed form to: ***(Insert institution's name, address & telephone number)***

Household Income Eligibility Statement – Child Care Institutions

Part 1 – Households Receiving Food Assistance Program (FAP), Family Independence Program (FIP), or Food Distribution Program on Indian Reservations (FDPIR)

If any member of your household receives FAP, FIP, or FDPIR, provide the name and case number for the person who receives the benefits.

Name:____**Case Number:** ________________________________

Part 2 – Household Information

First and Last Names of All Household Members, Related and Unrelated	Enrolled for Child Care (x)	Age	Birth Date	Foster Child (x)	Amount of Earnings from Work (before deductions)	How Often? (x) Annually	Monthly	2x Month	Bi Weekly	Weekly	Amount of Welfare, Child Support, or Alimony	How Often? (x) Annually	Monthly	2x Month	Bi Weekly	Weekly	Amount of All Other Income (Indicate source and amount)	How Often? (x) Annually	Monthly	2x Month	Bi Weekly	Weekly	Mark if No Income (x)

Part 3 – All Households: Signature and Last Four (4) Digits of Adult Social Security Number (Adult household member MUST sign and date)

I certify that all information on this form is true and that all income is reported. I understand that the center or day care home will receive federal funds based on the information I give. I understand that CACFP officials may verify the information. I understand that if I purposely give false information, the participant receiving meals may lose the meal benefits, and I may be prosecuted.

Signature:_______________________________________Print Name:____Date:____________________

Last four digits of Social Security Number: XXX-XX-_ _ _ _ ____I do not have a Social Security Number

For Institution Use Only:

For Institution Use Only		
Total Household Members:	Total Income: $ ____ Annually ____ Monthly ____ 2x Month ____ Bi-Weekly ____ Weekly	APPROVED CATEGORY Categorical Eligibility (A/Free): Foster FIP FAP FDPIR Other Household Children: A (Free) B (Reduced) C (Paid)
Institution Official Signature: ______________________ Approval Date: __________		

This form is valid for 12 months from the date of institution signature. Approval date and institution signature are required.

Privacy Act Statement
The Richard B. Russell National School Lunch Act requires the information on this application. You do not have to give the information, but if you do not, we cannot approve the participant for free or reduced price meals. You must include the last four digits of the Social Security Number of the adult household member who signs the application. The Social Security Number is not required when you apply on behalf of a foster child or you list a Food Assistance Program (FAP), Family Independence Program (FIP), or Food Distribution Program on Indian Reservations (FDPIR) case number for the participant or other FDPIR identifier or when you indicate that the adult household member signing the application does not have a Social Security Number. We will use your information to determine if the participant is eligible for free or reduced price meals, and for administration and enforcement of the Program.

Non-Discrimination Statement
In accordance with Federal civil rights law and U.S. Department of Agriculture (USDA) civil rights regulations and policies, the USDA, its Agencies, offices, and employees, and institutions participating in or administering USDA programs are prohibited from discriminating based on race, color, national origin, sex, disability, age, or reprisal or retaliation for prior civil rights activity in any program or activity conducted or funded by USDA.

Persons with disabilities who require alternative means of communication for program information (e.g. Braille, large print, audiotape, American Sign Language, etc.), should contact the Agency (State or local) where they applied for benefits. Individuals who are deaf, hard of hearing or have speech disabilities may contact USDA through the Federal Relay Service at 800-877-8339. Additionally, program information may be made available in languages other than English.

To file a program complaint of discrimination, complete the USDA Program Discrimination Complaint Form, (AD-3027) (http://www.ascr.usda.gov/complaint_filing_cust.html) online, and at any USDA office, or write a letter addressed to USDA and provide in the letter all of the information requested in the form. To request a copy of the complaint form, call 866-632-9992. Submit your completed form or letter to USDA by: (1) mail: U.S. Department of Agriculture, Office of the Assistant Secretary for Civil Rights, 1400 Independence Avenue, SW, Washington, D.C. 20250-9410; (2) fax: 202-690-7442; or (3) email: program.intake@usda.gov. This institution is an equal opportunity provider.

MICHIGAN Department of Education
Rev 6/2020

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 Date: / /	Level ____ ug/dl ⇨			

No	Yes	Was child tested for:	Test results:	Normal	Referred	Under Care
☐	☐	HEIGHT & WEIGHT	Height			
			Weight			
☐	☐	Other: ____	Other			
☐	☐	HEMOGLOBIN / HEMATOCRIT	⇨			
☐	☐	BLOOD PRESSURE	Reading: ____			
☐	☐	TUBERCULIN Date: / /	Type: ____ 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 (Hep B)	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 (Hep A)	1	2
Influenza (TIV/LAIV)	1	3
	2	4
Meningococcal (MCV4 / MPSV4)	1	2
Human Papillomavirus (HPV4/HPV2)	1	3
	2	
OTHER 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 child's school or local health department.

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.

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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.

The Children's Center, Inc.

210 Main Street, Niles, MI 49120 (269) 683-0405

Dear Parents,
Please complete these questions so we can help your child through the orientation process and begin making adjustments to our class curriculum to reflect things that are important to your child and special about your family. If you are uncomfortable with any of the questions you do not have to answer them, but the questions on this form are asked solely for the purpose of improving your child's experience with us. Feel free to use the back of the form if you need more room to write. Thank you for allowing us to share in helping your child grow in every area!

Name of child ______________________________________Male _____Female _____
What does your child prefer to be called? ___________________Date of birth ______________
What email address would you like us to use for daily updates? ___________________________
Mother's name ________________________Father's name ________________________
Child resides with: Mother _______ Father _______ Both _______ Other _______

Siblings Names Ages (Please list in birth order)
1. ____
2. ____
3. ____
4. ____
5. ____

Language(s) spoken at home: English _______ Other _________________________

Child's Preferences

Please list your child's favorite:
Foods:____
Songs: ____
Books: ____
Videos: ____
Toy: ____
Inside Activity: ____
Outdoor Activity: ____

If my child has trouble falling asleep I usually
____
____
My child is afraid of
____

Child’s Personality

1. How would you describe your child’s personality? ___________________________
____
____
____

2. What are some of the things your child likes to do in his/her spare time? ________
____
____
____

Family History

1. What family activities or hobbies does your child particularly enjoy? _________
____
____
____
____

2. Which family member(s) is your child particularly close to? Please describe: ___
____
____
____

3. What responsibilities does your child have now? ____________________________
____
____
____

4. Have there been any major changes in your child’s life that may be affecting or have affected your child’s growth or development? (death, divorce, serious illness, etc.) ____
____
____
____
____

3. Please list a brief history of care/school arrangements for your child from birth to present: (babysitting, family care, nursery school, preschool, day care, day camp, etc.)

Age ________ arrangement ____
Age ________ arrangement ____
Age ________ arrangement ____
Age ________ arrangement ____
Age ________ arrangement ____