CHILD INFORMATION RECORD

State of Michigan - Department of Licensing and Regulatory Affairs - Child Care Licensing Bureau

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		Primary Phone ( )	Parent/Legal Guardian's Name (Optional)		Primary Phone ( )
Home Address (if not child's address)		2nd Phone (if applicable) ( )	Home Address (if not child's address)		2nd Phone (if applicable) ( )
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/or Special Instructions? Yes ☐ No ☐ If yes, explain: (Attach additional sheets, if necessary.)	

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 ______________________________, 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.

Child Name: ____

Child Start Date: ____

Family Information Record

All information contained within shall be kept confidential. The sole purpose of this information is to help staff better understand your family/child situation so that we can better meet your needs.

Parent #1 Name: ____

Parent #2 Name: ____

Marital Status: ___ Single ___ Married ___ Divorced ___ Other

Other Children in the Family (Names and Ages)

______________________________ ________________________________

______________________________ ________________________________

______________________________ ________________________________

Child Lives With? ____

Does your child have any allergies? NO YES

If YES, what are they? ____

____

Some of your child's favorite things: ____

____

Child's Pets: (Kind and Name) ____

Any Child Custody Info we need to know? ____

____

If a court ordered custody agreement exists, Precious Angels <u>must</u> have a copy on file

Completed By: ____

Date: ________/________/________

Child Name: ____________________________

Precious Angels Christian Academy

Permission Slips

Food Agreement *(Check only one please)*

___ **YES,** my child can eat/drink the food and drink provided by Precious Angels Christian Academy.

___ **YES,** my child can eat/drink the food and drink provided by Precious Angels Christian Academy **except for the following (doctors note provided) due to allergies:**

___ **NO,** my child cannot eat/drink the food and drink provided by Precious Angels Christian Academy due to medical reasons (**doctors not provided).** I will provide all snacks/drinks and will check with staff regarding approved food items.

Photography/Video

I give permission for my child to be photographed or filmed and understand that the images may be used in or on Precious Angels Christian Academy publications, buildings, websites, or social media sites. I understand that as a precaution my child's name will not be published or linked, by Precious Angels Christian Academy, with the photographs.

Do you give consent for Precious Angels Christian Academy to photograph or film your child?

__ YES ___ NO

Permission to Transport (Field Trip)

I give permission for my child to be transported by Precious Angels Christian Academy staff via bus for the purpose of field trips.

Do you give consent for Precious Angels Christian Academy to transport your child?

___ YES ___ NO

Permission to Apply Sunscreen/Bug Spray/Lotion/Diaper Cream/Lip Balm

I give permission/ my consent for Precious Angels Christian Academy staff to apply sunscreen, bug spray, lotion, diaper cream and lip balm. (These will be supplied by parent) to my child as needed.

___ YES ___ NO

Parent Handbook and Policy Agreement

I have received a copy of the Precious Angels Christian Academy Parent Handbook and have read the policies and procedures explained within it. *I understand that I am expected to comply with all policies and procedures in the handbook. *I understand that continual disrespect of policies/procedures/staff members will result in removal from program. * I understand by my enrollment in the program, I am consenting to the care and educational standards and procedures as described in the Parent Handbook.

Parent/Guardian Name: ___________________________________ Date: _________________

Parent/Guardian Name: ___________________________________ Date: _________________

Child Name: ____ Start Date: ___/___/___

Contract Agreement

1. **Overtime Rates**

   Pick-up after 5:30pm will result in a late fee being charged of $5.00 per minute. This fee is due **IN CASH, BEFORE** your child can return to care.

2. **Rates regarding Holidays, Vacations and Other Absences**

   The following are paid holidays (tuition charged) when they fall on a day regularly scheduled for care:

   Martin Luther King Jr Day, Good Friday, Easter, Monday after Easter, Memorial Day, Independence Day (4th of July), Labor Day, the day before Thanksgiving, Thanksgiving Day and the day after, Christmas-New Year's Break, and Professional Development days.

3. **There will be no charge for one week (5 consecutive days) a year for family vacation time, with a 2-week notice given.**

4. **Tuition** will be ___________ a week and will be paid: ___ **Weekly** ___ **Bi-Weekly**

   My Child will attend: ___ Mon ___ Tues ___ Wed ___ Thurs ___ Fri

   ___ **My child will be attending Half Days (within the hours of 7am-12pm)**

   ___ **My child will be attending Full-Time (within the hours of 7am-5:30pm)**

5. **Other Charges**

   A registration fee in the amount of ________________ is due at the time of registration.

6. **Termination Procedure**

   This contract may be terminated by either the parent/guardian or provider by two-week written notice in advance of the last day that care will be provided. Tuition is still due for the two-week notice period, regardless of if the child is brought to the provider for care. The provider may terminate the contract without giving any notice if the parent/guardian does not make payments when due.

7. **Signature**

   By signing this contract, parent/guardian agree to abide by the written policies and procedures of Precious Angels Christian Academy, as defined in this handbook. The provider may amend these policies and procedures by giving the parent/guardian a copy of the changed policies and procedures at least 2 weeks before they go into effect.

Mother/Legal Guardian ____ Date ________________________________

Father/Legal Guardian ____ Date _______________________________

Provider Signature ____ Date _______________________________

Parent Handbook Agreement

- I have a child that will be attending Precious Angels Christian Academy.
- I have received and ***read each section*** of the Parent Handbook.
- I fully understand and agree to all the policies and procedures outlined in it.
- I understand that I will receive a written copy of any changes made to the handbook.

Child/ren Name/s (PRINT):

____

Parent/Guardian Name (PRINT):

____

Parent/Guardian (SIGNATURE):

____

DATE: ________/_________/__________

Child Schedule Form

My child's/children's name/s:

____

Schedule is starting the week of: ___________________

My child/children will attend:

We need accurate times in order to properly schedule our staff so that we can meet your needs.

<u>Half day schedules are 7am-12pm.</u>

___ Monday Arrive at _______________ Pick-up at ________________

___ Tuesday Arrive at _______________ Pick-up at _______________

___ Wednesday Arrive at _______________ Pick-up at _______________

___ Thursday Arrive at _______________ Pick-up at _______________

___ Friday Arrive at _______________ Pick-up at _______________

I understand that I am to adhere to this schedule. I understand that my drop-off and pick-up times need to remain consistent. I understand that staff will be scheduled according to the schedule I was given.

Parent Name: ____

Date: ____________________________

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 (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	
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 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.

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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.

Return this completed form to:

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

						How Often? (x)						How Often? (x)						How Often? (x)					
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)	Annually	Monthly	2x Month	Bi-Weekly	Weekly	Amount of Welfare, Child Support, or Alimony	Annually	Monthly	2x Month	Bi-Weekly	Weekly	Amount of All Other Income (Indicate source and amount)	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.

Return this completed form to:

Participant Enrollment Form

Instructions:

1. List full name of participant enrolled in care
2. Circle the typical days each participant is in care
3. List times each participant is in care
4. Circle the meals and snacks each participant typically receives while in care
5. Select the ethnicity of each participant using the following codes: H = Hispanic or Latino, N = Not Hispanic or Latino*
6. Select one or more racial designations of each participant using the following codes: A/I = American Indian or Alaskan Native, A = Asian, B = Black or African American, H/PI = Native Hawaiian or Pacific Islander, W = White*
7. Sign and date the form and return to your care center

Participant's First and Last Name	Typical Days in Care (circle all that apply)	List Times in Care	Meals/Snacks Received (circle all that apply)	Ethnicity	Race
	Mon Tues Wed Thu Fri Sat Sun		Breakfast AM Snack Lunch PM Snack Supper Evening Snack		
	Mon Tues Wed Thu Fri Sat Sun		Breakfast AM Snack Lunch PM Snack Supper Evening Snack		
	Mon Tues Wed Thu Fri Sat Sun		Breakfast AM Snack Lunch PM Snack Supper Evening Snack		
	Mon Tues Wed Thu Fri Sat Sun		Breakfast AM Snack Lunch PM Snack Supper Evening Snack		

* This information is voluntary. This will assist us in assuring the Child and Adult Care Food Program is administered in a nondiscriminatory manner.

Adult/Parent/Guardian's Address

Adult/Parent/Guardian's Phone Number

Signature of Adult/Parent/Guardian

Date Signed

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.