

STRETCH CHILD CARE CENTER\
CONTRACTED SERVICES SUMMER AGREEMENT

Parent/Guardian _____ Date _____

Street Address _____

City, State and Zip _____

Phone numbers: (day) _____ (night) _____

The following children will be attending the Summer Child Care Program during the times and days listed below at a cost of \$3.50 per hr. per child for each, paid weekly in advance. Any time after 1 hour will be billed on a ½ hour basis. Hours of service are 7a.m. to 6p.m. Monday thru Friday. You will be charged for all days your child is contracted to attend, even if they do not actually attend.

Childs Name	Monday	Tuesday	Wednesday	Thursday	Friday
	Hours	Hours	Hours	Hours	Hours
1 _____	____: ____	____: ____	____: ____	____: ____	____: ____
2 _____	____: ____	____: ____	____: ____	____: ____	____: ____
3 _____	____: ____	____: ____	____: ____	____: ____	____: ____

Total hours contracted _____ Total Cost (hours X \$3.50) _____

I _____, the parent/guardian of the above named student understand that to participate in the Summer STRETCH Child Care program I must pay weekly for contracted time for each child listed. If at any time I do not make a scheduled payment the above named children will not be allowed to attend the program until such time as I again repay the amount of any outstanding debt in full. **I understand I am responsible for any and all debts that occur from the use of this program.**

Signature of parent/guardian

Date

Tonia Keller Coordinator

Date

******By signing this contract, parents/guardians and provider agree to abide by the written policies as stated above.**

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.	

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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 _____

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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?	Birth History:
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	1	Allergies or Reactions (for example, food, medication or other)	
<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	Exzema 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)	Are there any current or past diagnosis(es) <input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	8	Trouble with Passing Urine or Bowel Movements	If yes, please describe:
<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?		If yes, list medications:
Reason for Medication					
_____ / /					Was the health history reviewed by a health professional?
Parent/Guardian Signature				Date	<input type="checkbox"/> Yes <input type="checkbox"/> 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	No	Yes	Was child tested for:	Test results:	Normal	Referred	Under Care
<input type="checkbox"/>	<input type="checkbox"/>	VISION	Visual Acuity				<input type="checkbox"/>	<input type="checkbox"/>	HEIGHT & WEIGHT	Height			
		Date: / /	Muscle Imbalance						Weight				
			Other:				<input type="checkbox"/>	<input type="checkbox"/>	Other: _____	Other			
<input type="checkbox"/>	<input type="checkbox"/>	HEARING	Audiometer				<input type="checkbox"/>	<input type="checkbox"/>	HEMOGLOBIN / HEMATOCRIT				
		Date: / /	Other:				<input type="checkbox"/>	<input type="checkbox"/>	BLOOD PRESSURE	Reading: _____			
<input type="checkbox"/>	<input type="checkbox"/>	URINALYSIS	Sugar				<input type="checkbox"/>	<input type="checkbox"/>	TUBERCULIN	Type: _____			
		Date: / /	Albumin						Date: / /	Neg.: <input type="checkbox"/> Pos.: <input type="checkbox"/> _____ mm			
			Microscopic										
<input type="checkbox"/>	<input type="checkbox"/>	BLOOD LEAD LEVEL	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		
Hepatitis B	1	3	
(Hep B)	2		
DTaP/DTP/DT/Td	1	4	
	2	5	
	3	6	
Tdap	1		
<i>Haemophilus Influenzae</i>	1	3	
type b (HIB)	2	4	
Polio - IPV / OPV	1	3	
	2	4	
Pneumococcal Conjugate	1	3	
(PCV7/PCV13)	2	4	
Rotavirus (RV1/RV5)	1	3	
	2		
Measles, Mumps, Rubella (MMR)	1	2	
Varicella (Chickenpox)	1	2	
History of Chickenpox Disease? <input type="checkbox"/> Yes <input type="checkbox"/> 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	
<input type="checkbox"/>	<input type="checkbox"/>	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"/>	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
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: _____

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 schedule of well-child care 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 and 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.

Alanson Public Schools Child Care Program

**ADMINISTRATION OF NON-PRESCRIPTION TOPICAL MEDICATION
PARENTAL WRITTEN CONSENT FORM**

As per state regulations nonprescription topical medications include but are not limited to:

Sunscreen, insect repellents, diaper ointments, antifungal ointment, powders

Child's Full Name: _____ Date of Birth: _____

Parent/Guardian Names: _____

List Specific Name of Nonprescription Topical Medication to be administered:

- 1.
- 2.
- 3.

List Schedule of Administration & Location (i.e. "as needed" or be specific). DEET Insect Repellent will only be applied once per day.

I give my permission for A.P.S. Child Care program staff members to administer the above nonprescription topical medication to my child. My child has had this nonprescription topical medication administered previously without adverse effects.

Parent /Guardian Signature

Date

Field Trip Permission

Date: _____

I/We hereby give A.P.S Child Care Center STRETCH permission to take my/our children _____

Off the premises and on excursions that will take place during regular childcare hours. I understand that I will be notified of any such trips beforehand, that trips will be supervised and that all precautions will be made for the safety and well-being of all the children. I/We also understand that A.P.S. Child Care Center STRETCH will not be liable for any accident or injury.

Consent is for normal activities unless indicated below- the following activities may occur during the course of the day at the Center.

These are the activities we anticipate but are not limited to.

____ Go for walks

____ Ride a bike

____ Play in water

____ Go to the Park downtown

____ Visit our local library downtown

____ Visit neighbors

____ Visit local businesses (walking distance)

____ Farmers Market Sale (downtown)

Are there any activities that your child should not participate in?

Mother/Father/Guardian's

Signature _____

Permission to Photograph

I,

(Parent's or guardian's name)

give permission for

(Name of child care provider or facility)

to photograph my child,

(Child's Name)

For the following purposes:

Type of Use:	Grand Permission	Decline Permission
Still Photographs:		
Display in provider's personal scrapbook		
Give photographs to current clients		
Display in facilities scrapbook or bulletin boards, shown to current and prospective clients		
Display still photos on facilities website *		
Use still photos in promotional materials		
Videos		
Give video to current parents		
Display video on facility website		
Use videos in promotional materials		
Other (Please List):		

*Only first names and possibly last initials (in the event of two or more children with the same first name) will be displayed on the facility website.

I understand that it is my responsibility to update this form in the event that I no longer wish to authorize one or more of the above uses. I agree that this form will remain in effect during the term of my child's enrollment.

Signed:

(Parent or Guardian's Signature and date)