

ALANSON PUBLIC SCHOOL

3 & 4 YEAR CHILD CARE CONTRACTED AGREEMENT

Parent/Guardian: _____

Street Address _____

City, State and Zip _____ Phone Number _____

The following child will be attending the A.P.S. 3 & 4 Year Old Child Care Program during the times and days listed below at a cost of \$25.00 per day paid bi-weekly in advance (before child first start date). Hours of service are 8:00 a.m. to 3 p.m. Monday thru Friday. You will be charged whether your child attends or not per contracted hours.

Child's Name: _____ Date of Birth: _____

Days & Hours: M _____ T _____ W _____ TH _____ F _____

Total hours contracted _____ Total Cost \$ _____

I _____, the parent/guardian of the above named child understand that to participate in the A.P.S. 3 & 4 Year Old Child Care Program, I must pay bi-weekly for contracted time for my child. If at any time, I do not make a scheduled payment, the above named child will not be allowed to attend the program until such time as I am able to pay in advance. In the event I need to change the hours contracted for service I am to contact the Child Care to prepare a new contract to be resigned prior to the next billing cycle. *I understand that it is my responsibly for payment of contracted time regardless if my child attends or not. **I understand I am responsible for any and all debts that occur from the use of this program (including any amount not covered by DHS if applicable).*** Please feel free to call with any questions you may have. 548-2261 ext. 3

A.P.S. 3 & 4 Year Old Child Care Program reserves the right to terminate this contract for any reason. Two weeks' notice will be given under usual circumstances. However we reserve the right to immediately terminate services under certain circumstances. (i.e. children who are a threat to others, non-payment etc..) This agreement may be terminated by the Parent/Guardian at any time provided that the school has written notification and two weeks prior notice.

Signature of parent/guardian

Date

Anita Ginop Program Director

Date

Tonia Keller Child Care Coordinator

Date

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 (Provider's Name)	
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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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?	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	1 Allergies or Reactions (for example, food, medication or other)	Birth History: <div style="border: 1px solid black; height: 40px; margin-bottom: 5px;"></div> <div style="border: 1px solid black; height: 40px; margin-bottom: 5px;"></div> <div style="border: 1px solid black; height: 40px; margin-bottom: 5px;"></div> <div style="border: 1px solid black; height: 40px; margin-bottom: 5px;"></div> <div style="border: 1px solid black; height: 40px; margin-bottom: 5px;"></div> <div style="border: 1px solid black; height: 40px; margin-bottom: 5px;"></div> <div style="border: 1px solid black; height: 40px; margin-bottom: 5px;"></div> <div style="border: 1px solid black; height: 40px; margin-bottom: 5px;"></div> <div style="border: 1px solid black; height: 40px; margin-bottom: 5px;"></div> <div style="border: 1px solid black; height: 40px; margin-bottom: 5px;"></div> <div style="border: 1px solid black; height: 40px; margin-bottom: 5px;"></div> <div style="border: 1px solid black; height: 40px; margin-bottom: 5px;"></div>
<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)	
<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): _____	Are there any current or past diagnosis(es) <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, please describe: <div style="border: 1px solid black; height: 40px; margin-bottom: 5px;"></div> <div style="border: 1px solid black; height: 40px; margin-bottom: 5px;"></div> <div style="border: 1px solid black; height: 40px; margin-bottom: 5px;"></div> <div style="border: 1px solid black; height: 40px; margin-bottom: 5px;"></div> <div style="border: 1px solid black; height: 40px; margin-bottom: 5px;"></div> <div style="border: 1px solid black; height: 40px; margin-bottom: 5px;"></div> <div style="border: 1px solid black; height: 40px; margin-bottom: 5px;"></div> <div style="border: 1px solid black; height: 40px; margin-bottom: 5px;"></div> <div style="border: 1px solid black; height: 40px; margin-bottom: 5px;"></div> <div style="border: 1px solid black; height: 40px; margin-bottom: 5px;"></div> <div style="border: 1px solid black; height: 40px; margin-bottom: 5px;"></div> <div style="border: 1px solid black; height: 40px; margin-bottom: 5px;"></div>
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Does your child take any medication(s) regularly?	
			Reason for Medication	
			_____ / /	Was the health history reviewed by a health professional? <input type="checkbox"/> Yes <input type="checkbox"/> No Examiner's Initials: _____
			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 Muscle Imbalance Other:				<input type="checkbox"/>	<input type="checkbox"/>	HEIGHT & WEIGHT Other:	Height Weight Other:			
<input type="checkbox"/>	<input type="checkbox"/>	HEARING Date: / /	Audiometer Other:				<input type="checkbox"/>	<input type="checkbox"/>	HEMOGLOBIN / HEMATOCRIT BLOOD PRESSURE	 Reading: _____ Type: _____ Neg.: <input type="checkbox"/> Pos.: <input type="checkbox"/> mm			
<input type="checkbox"/>	<input type="checkbox"/>	URINALYSIS Date: / /	Sugar Albumin Microscopic				<input type="checkbox"/>	<input type="checkbox"/>	TUBERCULIN Date: / /				
<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		
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.

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:	Grant 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)

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.