PRESCHOOL DOCUMENT CHECKLIST 19-20

Please plan to provide all required documentation to the preschool teacher at Meet the Teacher Night (1st Week in September). The teacher will contact you in late August to provide the date/time for Meet the Teacher Night. You must have all information listed below completed prior to the student attending class

	REQUIRED DOCUMENTS
☐	Original Birth Certificate
☐	Driver's License OR State of Michigan ID for parent/legal guardian. Parent or legal guardian must be present during Meet the Teacher.
☐	Child Information Record
☐	Immunizations
☐	Health Appraisal
☐	Preschool Enrollment Questionnaire
☐	Parent Notification of Licensing Notebook
☐	Written Information Packet Documentation Form
☐	Early Childhood Program Policies
☐	Early Childhood Early Dismissal/ Emergency Release
☐	Statement of Varicella Form
Parent Volunteer Only	WCS Background Authorization Form
Parent Volunteer Only	Central Registry Clearance Request

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 _____, 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.

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			

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?

Parent/Guardian Signature Date ☐ 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 Date: / /	Visual Acuity			
			Muscle Imbalance			
			Other:			
☐	☐	HEARING Date: / /	Audiometer			
			Other:			
☐	☐	URINALYSIS Date: / /	Sugar			
			Albumin			
			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	
	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 _____ 's teeth. As a result of this examination, my recommendation for treatment is: _____

child's name

_____ ___/___/___

Dentist's Signature Date

PHYSICIAN'S SIGNATURE

_____ ___/___/___ _____ _____

Examiner's Signature Date ***Examiner's Name (Print or Type)*** Degree or License

_____ _____ MI _____ (___) _____

Number & Street City 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.

PRESCHOOL ENROLLMENT QUESTIONAIRE
2019-2020

Please complete and return to your child's teacher on the first day of class

Name of Child: _____ Nickname To Be Used In Class:_____

Child's Birthdate:_____

Does your child have any allergies to foods?_____ If so, please list:_____

Does your child have any other allergies?_____ If so, please list:_____

With whom does your child live: _____

Are there other adults living in the home?_____ Who?_____

Are there any other children in the family?_____ If so, what are their ages?_____

What is the main language spoken in the home?_____

Are there any other languages spoken in the home?___ If so, what are they?_____

Does your child suck his/her thumb?_____ Does your child have "temper tantrums"?_____

What form of discipline do you find works best with your child?_____

What other school-type experience has your child had?_____

Has your child ever used: Scissors?_____ Glue?_____ Crayons?_____ Paint?_____ Pencil?_____

Is your child right handed, left handed, or not established yet? _____

Approximately how many hours does your child spend daily watching TV?_____

Approximately how many hours does your child spend daily playing video games?_____

Approximately how many hours does your child spend daily on the computer?_____

What school will your child attend for Kindergarten?_____

Does your child have any special needs? _____ If so, please describe_____

Describe your family traditions and cultural heritage on the back side of this form.

Warren Consolidated Schools

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ADMINISTRATION BUILDING
31300 Anita
Warren, MI 48093
586.825.2400

1.888.4WCS.KIDS
www.wcskids.net

Parent Notification of the Licensing Notebook

Child Care Organizations Act, 1973 Public Act 116
Michigan Department of Licensing and Regulatory Affairs

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 the past two years are available on the Bureau of Children and Health Systems at:*

www.michigan.gov/michildcare.

I have read the above statement issued by Warren Consolidated Schools

Name of School: _____

Child Name(s): _____

Parent Name (Printed): _____

Parent Signature: _____

Date: _____

Reference: State of Michigan Licensing Rules for Child Care Centers/ BCAL-5053

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.

LARA is an equal opportunity employer/program.

Student Name:_____ Building:_____

Early Childhood Program Policies 2019-2020

- —— I understand that tuition is due on the 10th of each a month. Failure to make payments in a timely manner may result in my child being dropped from the program.
- —— I understand that all tuition payments are processed on-line. Please use the weblink provided on your monthly billing statement.
- —— I understand I am responsible for the entire tuition amount upon enrollment regardless of the child's attendance.
- —— I understand that I may be charged a $1.00 late fee for every 1 minute that I am late picking up my child. This fee will be added to my monthly invoice.
- —— I understand the year-end tax statement policy.
- —— I have reviewed the policy and procedures and understand my child must be toilet-trained.
- —— I understand that I am responsible to provide my child's teacher with any changes in parent/student information including: phone numbers, address, email addresses, and any other pertinent information pertaining to the child.
- —— I understand I am required to provide local emergency contact information and immediately notify staff in writing of any changes.
- —— I understand that I must complete the entire Child Information Record and include all parent information, local emergency contact information, physician and hospital information, as well as allergies, special needs, and special instructions.
- —— I have made my child's teacher aware of any allergies, medications and special needs that my child may have.
- —— I understand the parents provide transportation to and from school and all field trips.
- —— I understand that my child may be photographed or videotaped during their time in the program. These photos or tapes may be used in newsletters, WCS website or WCS TV channel.
- —— I am aware that a Licensing Notebook of all licensing inspection reports, special investigation reports, and all related corrective action plans are available for review at each preschool location. I understand that this notebook will be available for parents to review during regular business hours.
- —— I understand that all employees of the Warren Consolidated Early Childhood Programs have been cleared through LARA (Licensing and Regulatory Affairs) via a Comprehensive Background Check.
- —— I understand that I must complete the WCS Background Check Authorization Form and the DHS Central Registry Clearance Request Form and send in a copy of a current driver license and be cleared before I can volunteer in my child's classroom.
- —— I have read the entire 2019-2020 Preschool Program Parent Handbook and I agree to all policies described within it.

Parent/Guardian Name (Print):_____

Parent/Guardian Signature (Sign):_____

Date:_____

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EARLY CHILDHOOD EARLY DISMISSAL/EMERGENCY RELEASE FORM

Student Name: _____ School:_____

In the event of an emergency dismissal, I, the parent/guardian, will be responsible for picking my child up from school.

_____ _____
Mother/Guardian Name Father/Guardian Name

_____ _____
Address Address

_____ _____
Daytime Phone Number Daytime Phone Number

In the event that I am unable to pick up my child from school, I give the school permission to release my child to the following individuals:

1. _____ - _____
Name Relationship To Child

_____ _____
Address(Appears on Driver's License) City, State, Zip

_____ _____
Cell Phone Number Alternate Phone Number

2. _____ - _____
Name Relationship To Child

_____ _____
Address(Appears on Driver's License) City, State, Zip

_____ _____
Cell Phone Number Alternate Phone Number

_____ _____ _____
Parent Name (Print) Parent Signature Date

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STATEMENT OF VARICELLA DISEASE
(CHICKEN POX)

Macomb County Immunization Regulations require all children admitted to any public, private, or parochial elementary or secondary school, day care center, camp, or any other organized care or educational facility operating in Macomb County to present a certificate indicating dates of all required immunizations.

Complete the portion below **only** if your child has had varicella (chickenpox) disease.

This must be signed and witnessed at your child's school/child care program.

I certify that my child:

_____	_____	_____
Last Name	**First Name**	**Middle Initial**
_____	_____	_____
Birth Date	**Grade**	**Date of School Enrollment**

has had varicella disease on_____
(When did Varicella occur – age or date)

_____	_____
Parent/Guardian Signature	**Date**
_____	_____
Name of Witness from School or Child Care Program	**Date**

PLACE IN STUDENT PERMANENT RECORD