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
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. 4-16) Previous edition 6-15 & 7-12 only 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 must initial one of the following:

_____I give permission to _____, licensed by the Department of Licensing and Regulatory Affairs to secure emergency medical and/or emergency surgical treatment for the above named minor child while in care.

_____I do not give permission to _____, licensed by the Department of Licensing and Regulatory Affairs to secure emergency medical and/or emergency surgical treatment for the above named minor child while in care. I understand I assume responsibility for all emerency medical 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

LARA is an equal opportunity employer/program.	AUTHORITY: 1973 PA 116 COMPLETION: Required PENALTY: Rule Violation Citation.

BCAL-3731 (Rev. 4-16- Previous edition 6-15 and 7-12 only may 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
2017-2018

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.

Family's traditions and cultural heritage:

Warren Consolidated Schools

Creating Dynamic Futures through Student Achievement, High Expectations, and Strong Relationships

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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 2017-2018

- —— 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 may be charged a $5.00 late fee for every 5 minutes I am late. This fee will be added to my monthly invoice.

- —— I understand the year-end tax statement policy.

- —— I understand my child must be toilet-trained. I have reviewed the policy and procedure.

- —— I understand I will make my child's teacher aware of any changes with phone numbers, addresses, e-mail address and information pertaining to my child.

- —— I must provide local emergency contact information.

- —— 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 a field trip.

- —— 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 being made 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 D.H.S. Central Registry and through the Michigan State Police Criminal Clearance Program.

- —— 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 2017-2018 Preschool Program Parent Handbook and I agree to all policies described within it.

_____ _____ _____

Parent Name (Print) Parent Signature Date

WARREN CONSOLIDATED SCHOOLS HUMAN RESOURCES DEPARTMENT
BACKGROUND CHECK AUTHORIZATION FORM

View Full Screen

It is the policy of Warren Consolidated Schools to secure criminal conviction history information as mandated by Michigan state laws for **public school employees and volunteers**. **One form per year is required per volunteer.**

Background check forms must be submitted **two weeks prior to volunteering**. Volunteer coaches must complete Parts I and II only.

PART I – PLEASE PRINT:

Name: _____
Last First M.I.

Maiden Name/Names previously used: _____

Date of Birth: _____ Gender: _____ Race: ☐ White ☐ Black ☐ Asian/Pacific Islander ☐ American Indian/Alaskan Native ☐ Unknown/Other

Driver's License #: _____ State Issued: _____

Phone Number: _____ / _____
Home Cell

Address: _____ City, State, Zip: _____

PART II (volunteer coaches only) - PLEASE PRINT

I am volunteering for the following sports: _____ Level: _____

School where volunteering will take place: _____

I am volunteering in the following seasons: ☐ Fall ☐ Winter ☐ Spring

PART III (not applicable to volunteer coaches) – PLEASE PRINT

Name of School where volunteering will take place: _____

Date of Event /Trip (if ongoing, list beginning and end dates): _____

Student Name: _____ Teacher: _____

Please list all other children and the schools they attend.

Student Name	Building
1. _____	1. _____
2. _____	2. _____
3. _____	3. _____

YOU MUST ATTACH A PHOTO COPY OF YOUR DRIVER'S LICENSE OR STATE ID CARD.

I understand that as a volunteer for Warren Consolidated Schools, I will receive no remuneration whatsoever on behalf of the school district for my volunteered time. Furthermore, I am aware that I must follow all of the rules, regulations, and procedures of the District and that I may be required to view online videos pertaining to these rules and regulations.

I have viewed the following online videos as required by the District (*see the GCN Training Instruction Sheet*):

☐ **Concussion In Schools (All volunteers)** ☐ **FERPA (All volunteers)** ☐ **Bloodbourne Pathogens (Coaches only)** ☐ **Sexual Harassment (Coaches only)**

☐ **I have previously viewed the online videos that are listed above.**

I understand that the above information is required by the Central Records division of the Michigan State Police, Lansing, Michigan. I authorize Warren Consolidated Schools to utilize the above information for the sole purpose of obtaining a conviction only criminal history file search.

_____ _____
Signature of Applicant **Date**

GCN TRAINING
GLOBAL COMPLIANCE NETWORK
YOUR SITE FOR INTERNET-BASED TRAINING

Need help? Email us at help@gcntraining.com

Please be sure to have your speakers turned on.
TYPE **www.gcntraining.com** into your browser's address bar and **Press Enter**

CLICKING LOGIN TO VIEW TRAINING will take you to the **PRE-LOGIN CHECKLIST**
(ROLLOVER why? next to the icon to learn what the icons mean).

If you have **not** created an account with GCN, select: *I have NOT yet created an account*
Press Next >>

If you have already created an account with GCN, select: *I already have an account*
Press Next >>

Enter your Organization ID:
warren
Press Submit

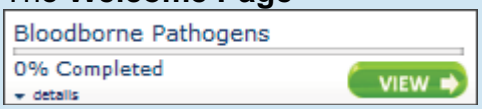
Enter your Preferred Personal ID
Press Submit

Enter your Personal ID
Press Submit

Complete the Personal Information.
(* indicates Required Fields)
Press Submit

If you've forgotten your PID,
Press I Don't Know My Personal ID

The **Welcome Page**



The tutorials available to you are listed to the left.
Choose a tutorial by pressing **VIEW**

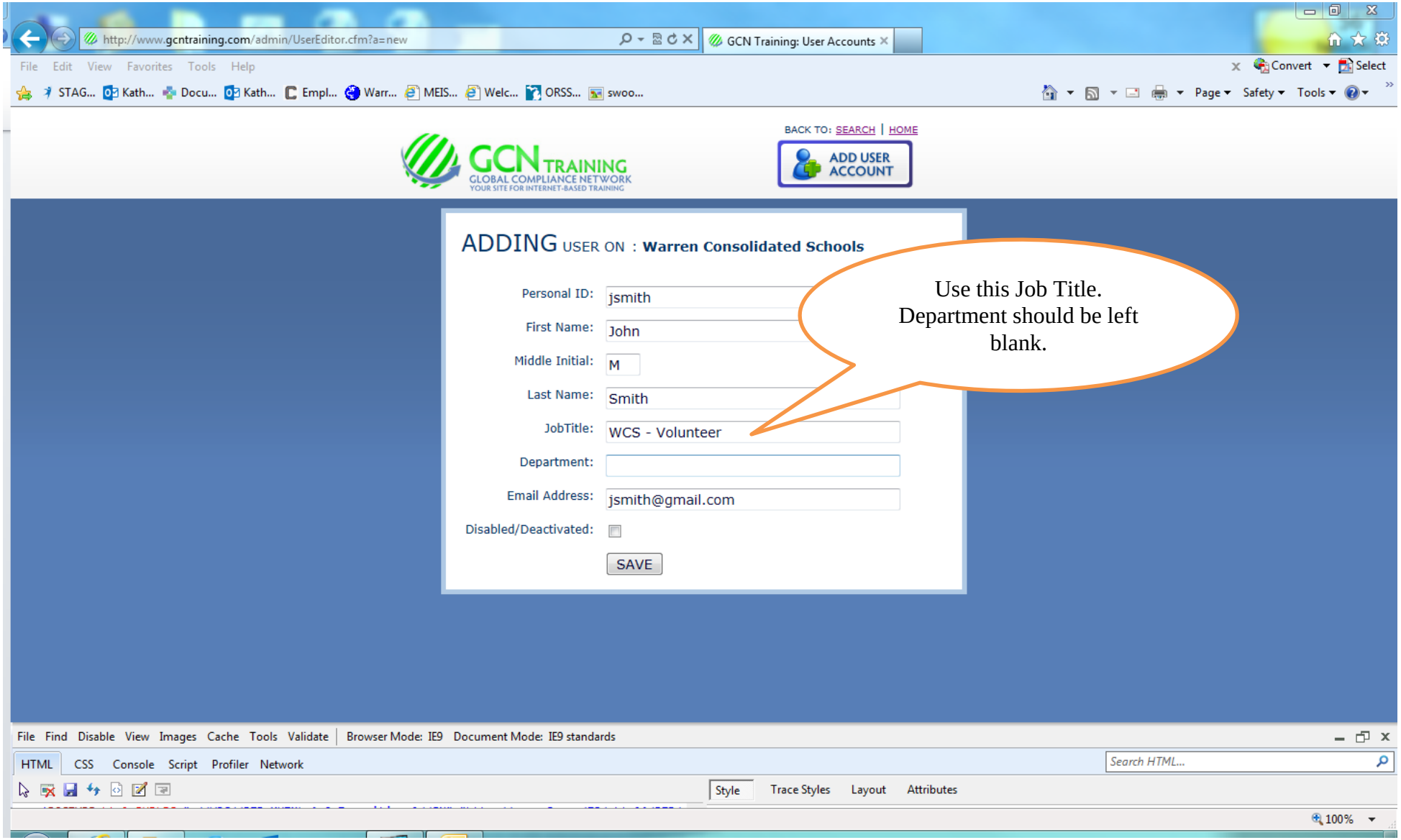
Verify your information. Press START TUTORIAL or CONTINUE TUTORIAL (if available)

The tutorial will begin with an Instructions slide that will explain the many buttons on this page.

Once the Next button appears you may move on to the next slide.

After you complete a tutorial, return to the **Main Menu** to Print your Certificate of Completion*
*SAVE SOME PAPER -- Wait until you complete the last of your tutorials before printing your Certificate. They're all printed on a single page.

GCN instructions for a volunteer.



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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

CENTRAL REGISTRY CLEARANCE REQUEST
Michigan Department of Human Services

INSTRUCTIONS:

- An enlarged and clear copy of individual's photo identification must be attached.
- For Michigan employers, individuals and volunteer agencies, submit this request to the local County Department of Human Services. To obtain the address and fax number of **your local county DHS, access www.michigan.gov/dhs->Inside DHS.**
- For individuals seeking clearance on themselves, the results will be sent to the address on the picture identification provided.
- Outstate Children's Protective Services workers, law-enforcement, and court officials fax request to 517-241-7047 (Outstate only) on agency letterhead with cover sheet.
- All fields must be completed for processing.

COPY PHOTO ID HERE AND RETAIN A COPY FOR YOUR RECORDS

OR ATTACH A CLEAR COPY OF YOUR ID ON A SEPARATE PAGE

SECTION 1
INFORMATION ON PERSON BEING CLEARED

Name First, Middle, Last	AKA (Also Known As) (Maiden Name)	Social Security Number	Signature Required for individual being cleared
Address	**Phone Number**	**Date Of Birth**	

SECTION 2
REQUESTOR INFORMATION

Please Check Appropriate Box

- ☐ Child Welfare Agency
- ☐ Individual ☐ I would like to pick up my results in _____ county
- ☐ Law-Enforcement/Dept of Corrections
- ☐ Prosecuting Attorney/Court (please provide docket number if available) _____ MI
- ☐ Employer
- ☐ Volunteer Agency
- ☐ Out-of-State Adoption and Foster Home Screening
- ☒ Other **Preschool Volunteer**

Name of Employer/Volunteer Agency/Individual	Name of CPS/Law-Enforcement or Court		
WARREN CONSOLIDATED SCHOOLS			
Name	Title		
THERESA CALLAHAN	**ADMINISTRATOR OF ASSESSMENTS, LATCHKEY AND PRESCHOOL**		
Address	City	State	Zip Code
31300 ANITA DRIVE WARREN, MI 48093			
Phone	Fax	E-mail	Date
586-698-4046	**586-698-4060**	**CALLAHAN@WCSKIDS.NET**	

Employers/volunteer agencies – will ONLY receive responses of NO central registry if the name being cleared has approved this request with their signature. Employers/volunteer agencies will NOT receive notification if the name submitted has any central registry history hits per CPL 722.627.

For questions about completing this form, please contact the local Michigan Department of Human Services, Children's Protective Services or CPS Program office at 517-373-6028. Mail questions to PO Box 30037, 235 S. Grand Avenue, Suite 510, Lansing, Michigan 48909

This clearance does not identify individuals who may have child abuse/neglect history in other states, territories or tribal trust land.

The confidentiality of central registry information is protected by Sections 7 through 7j of the Michigan Child Protection Law (MCL 722.627-722.627j). Anyone who violates this protection is guilty of a misdemeanor and is civilly liable for damages.

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.