MADISON
DISTRICT PUBLIC SCHOOLS

School Age Child Care Program Registration Checklist

Child's Last Name _____ Child's First Name _____

- ☐ Enrollment Application
- ☐ Registration Payment
- ☐ Written Information Packet Documentation
- ☐ Child Information Record (completely filled out)
- ☐ Parent Notification of the Licensing Notebook
- ☐ Child/Parent Behavior Contract
- ☐ Payment Agreement
- ☐ Policy Agreement
- ☐ Program Permissions
- ☐ Health Appraisal (**Toddler and Preschool age only)**

This section will be completed by Child Care staff.

- ☐ Registration Payment Received
- ☐ All Registration Documents Completed and Received

Child Care Staff Signature _____ Date _____

MADISON
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School Age Child Care Enrollment Application

PLEASE PRINT CLEARLY. The information you provide on this form remains in effect throughout your child's enrollment unless a parent/guardian requests an update.

CHILD INFORMATION

Date of application _____ Requested start date _____

Child's Last Name _____

Child's First Name _____

Date of Birth _____ Age _____ Gender _____ Grade _____

Home Address _____ City/Zip _____

Circle Days to Attend A.M. MON TUES WED THUR FRI Arrival Time: _____

P.M. MON TUES WED THUR FRI Departure Time: _____

MOTHER/GUARDIAN INFORMATION

Mother/Guardian Name _____

Cell Phone _____ Work Phone _____

Email Address _____

Home Address _____ City/Zip _____

FATHER/GUARDIAN INFORMATION

Father/Guardian Name _____

Cell Phone _____ Work Phone _____

Email Address _____

Home Address _____ City/Zip _____

ADDITIONAL INDIVIDUALS AUTHORIZED TO PICK UP CHILD

Name _____ Cell Phone _____

Name _____ Cell Phone _____

Name _____ Cell Phone _____

ALLERGIES, HEALTH, OR MEDICAL CONDITIONS

Does your child have any food, medication, or environmental allergies? *(check all that apply)*

- ☐ NO
- ☐ YES – check all that apply
  - ☐ Food *(list and explain)* _____
  - ☐ Medication *(list and explain)* _____
  - ☐ Environmental *(list and explain)* _____

Does your child have a health or medical condition?

- ☐ NO
- ☐ YES *(please explain)* _____

Is your child currently using any medication, food supplement, or medical food (such as electrolyte solution)?

- ☐ NO
- ☐ YES *(please explain)* _____

Does your child have any dietary restrictions, including those for medical, religious, or cultural reasons?

- ☐ NO
- ☐ YES *(please explain)* _____

I have reviewed and received a copy of the Madison Elementary School Age Child Care Parent Handbook and understand all program policies and procedures.

_____ _____

Parent Signature Date

WRITTEN INFORMATION PACKET DOCUMENTATION

Michigan Department of Licensing and Regulatory Affairs
Child Care Licensing Bureau

Child(ren)'s Name(s) (Last, First)	**Facility's Name and License Number** Madison Early Childhood Center License Number: DC630383502

A written information packet has been provided at the time of enrollment. The packet included all the following information *(R 400.8146 (1-2)):*

- 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, and illnesses.
- Transportation policy, if applicable.
- Medication policy.
- Exclusion policy for child illnesses.
- Notice of the availability of the center's licensing notebook. (CENTER MUST CHECK ONE)

  ☒ The center keeps a licensing notebook containing a summary sheet, all licensing inspections and special investigation reports, and related corrective action plans for the last 5 years. The licensing notebook is available to parents/guardians during regular business hours. Reports from at least the past three years are available at www.michigan.gov/michildcare.

  ☐ The center does not keep a licensing notebook, but internet is available onsite. Reports from at least the last three years are available at www.michigan.gov/michildcare.

- Other _____

I certify that I received all of the above items.

_____ _____

Parent/Guardian Signature **Date**

Note: A single CCL-4340 form may be used for all children in the same family.

LARA is an equal opportunity employer/program.

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.)	

CCL-3731 (Rev. 3/17/2022) Previous editions 7-18 & 4-21 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.

CCL-3731 (Rev. 3/17/2022) Previous editions 7-18 & 4-21 may be used

PARENT NOTIFICATION OF THE LICENSING NOTEBOOK

Child Care Organizations Act, 1973 Public Act 116

Michigan Department of Licensing and Regulatory Affairs

Child Care Licensing Bureau

CENTER MUST CHECK ONE

☒ The center keeps a licensing notebook containing a summary sheet, all licensing inspections and special investigations, and related corrective action plans for the last 5 years. The licensing notebook is available to parents/guardians during regular business hours. Reports from at least the past three years are available at **www.michigan.gov/michildcare**.

☐ The center does not keep a licensing notebook, but internet is available onsite. Reports from at least the last three years are available at **www.michigan.gov/michildcare**.

I have read the above statement issued by Madison Early Childhood Center

Name of Child Care Center

Child(ren)'s Name(s):	

Parent Name _____

Parent Signature _____ Date _____

LARA is an equal opportunity employer/program.

MADISON
DISTRICT PUBLIC SCHOOLS

MDPS School Age Child Care Program

Child/Parent Behavior Contract

(One form per child)

Child's Last Name: _____ Child's First Name: _____

- I will report directly to School Age Child Care room/staff immediately after school is dismissed and follow specific check-in procedures.
- I will listen to staff and follow instructions when they are given.
- I will respect other people's belongings by not touching/using their belongings without permission.
- I will respect School Age Child Care property and help clean up personal messes and assist in leaving an area better than I found it.
- I will be responsible for all my actions.
- I will respect other personal space by keeping my hands and feet to myself
- I will not have any physical contact with other people.
- I will not raise my voice while inside the building and will use my inside voice when speaking.
- I will use appropriate language and not use negative remarks
- I will ask staff for permission when leaving the room/area.
- I will respect others feelings by having a positive attitude when talking to them.
- I agree to keep a respectful and calm tone when speaking to ALL School Age Child Care staff members.

School Age Child Care operates with a "**ZERO TOLERANCE**" policy towards bullying.

Not abiding by these rules will result in suspension and/or termination from School Age Child Care. All incidents will be handled on a Three Incident System, except physical contact. If physical contact occurs, it will be an Immediate One Day Suspension from the School Age Child Care program.

All other incidents will be handled as follows:

1st Incident	Verbal Warning
2nd Incident	Write Up/Parent Meeting/Child Coaching Plan
3rd Incident	1-Day Suspension from School Age Child Care Program

Student Signature: _____ Date: _____

Parent/Guardian Signature: _____ Date: _____

MADISON
DISTRICT PUBLIC SCHOOLS

MDPS School Age Child Care Program

Payment Agreement

(One form per child)

Child's Last Name _____ Child's First Name _____

School Age Child Care Program is a Prepay Program

Registration fee and one week's payment is due before enrollment can begin. *You MUST be APPROVED and SHOWING on our billing site before enrollment can begin.*

Your Tuition Payment is due weekly on the Monday OF the week of care.

A Receipt of Payment will be sent out every TUESDAY.

1. I understand that the School Age Child Care Program is a non-profit, self-supporting program.
2. I understand that my child's School Age Child Care Program account from summer and the previous school year must be at a zero balance or I cannot enroll/register my child for the program.
3. I understand that if my child's account is not at a zero balance or in a credit status, my child will be denied entry to the School Age Child Care program.
4. I agree to pay the Registration Fee: $35 per child (non-refundable).
5. I understand my Payment Options are: cash, check, debit or credit card.
6. I understand the parent that is listed on the School Age Child Care Program registration form is considered to be the person responsible for full payment.
7. I understand that I will be given my Receipt of Payment statement every Tuesday. If I fail to receive a statement, I will contact the Program Director IMMEDIATELY.
8. I understand that any unpaid fees or tuition will be sent to a collection agency.
9. I understand payment is expected weekly, NOT in advance.
10. I understand that if I have joint custody of my child and if I share financial responsibility for payments, I must arrange a payment method with the other parent. If I choose to have a separate School Age Child Care account, I will register separately and pay a separate Registration Fee and Tuition Fee.
11. I understand the School Age Child Care Program CLOSES AT 6:00PM. If I am late, I will be charged a late fee of $1 per minute, PER CHILD, until my child is picked up. I understand that if I call and notify the School Age Child Care staff that I will be late, it will NOT eliminate the late fee charges.
12. I understand there are also additional fees for the following:
    - $10 Unexpected Attendance
    - $5 No call no show
    - $15 Late Payment Fee

Parent/Guardian Signature: _____ Date: _____

MADISON
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MDPS School Age Child Care Program

Policy Agreement

(One form per child)

Child's Last Name _____ Child's First Name _____

- I agree to sign my child in/out every day they attend the School Age Child Care program.
- I agree to provide Child Care staff my child's schedule a week in advance and I will inform them of any changes in my child's schedule.
- I agree to call the Madison Elementary Office to inform staff whenever my child will be absent. If my child is ill, I will NOT send my child to school and agree to make alternate arrangements.
- I will complete and submit all enrollments forms. I will keep all enrollment information current and up-to-date.
- I will read all communications from the School Age Child Care program, i.e. emails, Newsletters, and Dojos.
- I will keep School Age Child Care staff members informed of any changes or incidents at home that might result in a change in my child's behavior or attitude.
- I confirm that my child is in good health, able to participate in all activities *independently* unless otherwise indicated on the Certificate of Good Health Form, and is up to date on his/her immunizations.
- I agree and assume full responsibility for any damages to person or property caused by my child.
- If a medical emergency arises, School Age Child Care staff will first attempt to contact me. If I cannot be reached, the staff will contact the person(s) on the Child Information Record. If the emergency is such that immediate hospital attention is necessary, appropriate emergency procedures will be followed.
- I agree that if the behavior or health of my child should necessitate sending him/her home, I (or someone on my Child Information Record Form) will IMMEDIATELY pick up my child from the program. I agree to keep my Child Information Record up-to-date.
- I understand that if my child has a persistent pattern of negative behavior and interventions have not been successful, I will be asked to remove my child from the School Age Child Care program.
- I understand that I may provide a nutritious snack for my child.
- I understand there may be field trips or special activities that my child may participate in and I must sign up for and pay for in advance. NO REFUNDS will be issued for field trips.
- If I need to withdraw my child from the School Age Child Care program, I must give written notice to the Program Director two weeks in advance. If withdrawal notice is NOT given, I will still be responsible for the tuition fee from the withdrawal date.
- I may request additional days if my child(ren) attend the School Age Child Care program part time.

I have read, understand and agree to all of the above. If I have any questions or concerns, I will contact the School Age Child Care Program Director.

Parent/Guardian Signature: _____ Date: _____

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School Age Child Care Program Permissions

Please complete every section of the form. One form must be completed for each child.

_____ _____

Child's Last Name Child's First Name

Movie Release

On occasion a G or PG movie will be shown. Please indicate your permission to the movie ratings listed below.

G Rated Movies YES _____ NO _____ PG Rated Movies YES _____ NO _____

Media Release

Periodically the media may be invited to visit the child care center. I hereby give permission for my child and/or child's projects, photographs, video images, and/or voice recordings to be released to the paper, shown on the community channel, or posted on the internet. I will immediately notify the Child Care coordinator or staff member in writing should any of the above conditions change. There is no monetary compensation for the use of these images or projects.

_____ YES, I give permission _____ NO, I do not give permission

Walking Field Trips

At times, child care staff may take students on a walking field trip around the neighborhood or to nearby parks/playgrounds. Please indicate your permission for walking field trips.

_____ YES, I give permission _____ NO, I do not give permission

_____ _____

Parent Signature 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	Level _____ ug/dl ⇨			
		Date: / /				

No	Yes	Was child tested for:	Test results:	Normal	Referred	Under Care
☐	☐	HEIGHT & WEIGHT	Height			
			Weight			
☐	☐	Other: _____	Other			
☐	☐	HEMOGLOBIN / HEMATOCRIT	⇨			
☐	☐	BLOOD PRESSURE	Reading: _____			
☐	☐	TUBERCULIN	Type: _____			
		Date: / /	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.