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: ____/____/____

Address: _____ (Number & Street) _____ (City) MI _____ (ZIP Code) Today's Date: ____/____/____

Parent/ Guardian: _____ (Last) _____ (First) _____ (Middle) Telephone: (___ __) _____ (Home)

Address: _____ (Number & Street) _____ (City) MI _____ (ZIP Code) Telephone: (___ __) _____ (Work)

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 Date: _____/_____/_____	Visual Acuity			
			Muscle Imbalance			
			Other:			
❒	❒	HEARING Date: _____/_____/_____	Audiometer			
			Other:			
❒	❒	URINALYSIS Date: _____/_____/_____	Sugar			
			Albumin			
			Microscopic			
❒	❒	BLOOD LEAD LEVEL Date: _____/_____/_____	Level: _____ µg/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	DATE ADMINISTERED MM/DD/YYYY	
Hepatitis B (Hep B)	**1**	**3**
	2	
DTaP/DTP/DT/Td/Tdap (Circle Type)	**1**	**5**
	2	**6**
	3	**7**
	4	**8**
Haemophilus Influenzae type b (HIB)	**1**	3
	2	4
Polio – IPV / OPV (circle type)	**1**	**3**
	2	**4**
Pneumococcal Conjugate (PCV7)	**1**	**3**
	2	**4**
Rotavirus (Rota)	**1**	**3**
	2	
Measles, Mumps, Reubella (MMR)	**1**	**2**
Varicella (Chickenpox)	**1**	**2**

History of Chickenpox Disease? ❒ Yes ❒ No If yes, date:

VACCINES	DATE ADMINISTERED MM/DD/YYYY	
Hepatitis A (Hep A)	1	2
Influenza TIV/LAIV	1	3
	2	4
Meningococcal MCV4 / MPSV4	1	2
Human Papillomavirus (HPV)	1	3
	2	4
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 child's school or local health department.

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 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 at 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

Preschool Enrollment Questionnaire

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 birth date: _____

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 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, which? _____

How old was your child when he/she began to walk? _____ Talk? _____

Does your child have any special fears? _____ 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? _____ 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 a computer? _____

What school will your child attend for kindergarten? _____

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

_____

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

Family's traditions and cultural heritage:

Special Needs:

WCS

Warren Consolidated Schools / Early Childhood

31300 Anita – Warren, Michigan 48093

Parent Notification of the Licensing Notebook Requirement

Child Care Organizations Act, 1973 Public Act 116

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 Adult Licensing website at www.michigan.gov/michildcare.

I have read the above statement issued by: Warren Consolidated School District .

Parent Name _____

Parent Signature _____ Date _____

Child's Name _____ School: _____

2013-2014 Early Childhood Program Policies

Please initial all statements that you have read the following and turn in to the teacher by the first day of class. This form can also be found the Parent Handbook.

— I understand that the 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 payments are done on-line.

— I understand that if I am late picking up my child 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 the toilet-trained 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 understand 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 ICHAT 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 Early Childhood Parent Handbook and I agree to the policies described within it.

Date:_____ Parent/Guardian's Signature _____

ICHAT

WARREN CONSOLIDATED SCHOOLS
HUMAN RESOURCES DEPARTMENT
BACKGROUND CHECK AUTHORIZATION FORM

It is the policy of Warren Consolidated Schools to secure criminal conviction history information as mandated by Michigan state law for **public school employees and volunteers**.

If this information is being requested for a volunteer, list the building asking for the information. Background check forms must be submitted two weeks prior to trip or event.

Name of School:	**Date of Event:**
Student's Name	**Teacher:**
Sibling's Name	**Teacher:**

Have you filled out a background check form for any other schools in our district this school year? _____ **If so, what school?** _____

NAME _____
LAST FIRST MIDDLE

Maiden Name/Names previously used _____

Date of Birth _____ **Gender** _____

Phone Number _____ / _____
Home **Cell**

Driver's License Number _____

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

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

nf 7/28/09

Early Childhood Early Dismissal Form

_____
Child's Name

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

_____ Mother's/Guardian's Name	_____ Father's/Guardian's Name
_____ Daytime Address	_____ Daytime Address
_____ Daytime Phone Number	_____ Daytime Phone Number

In the event that I am not able to pick up my child from school, I give the school my permission to release my child to the following individual(s):

1. _____ Name - _____ Relationship to Child

_____ Address	_____ City, Zip
_____ Phone Number	_____ Cell Phone Number

2. _____ Name _____ Relationship to Child

_____ Address	_____ City, Zip
_____ Phone Number	_____ Cell Phone Number

_____ _____
Parent's Signature Date

OCI
Office of Curriculum & Instruction