



**FOR YOUTH DEVELOPMENT  
FOR HEALTHY LIVING  
FOR SOCIAL RESPONSIBILITY**

**Welcome!**

We look forward to having your family join us in the Ann Arbor YMCA Early Childhood Program!

On your child's first day, please bring the following items labeled in permanent marker with your child's name:

- The nap items your child will need to feel comfortable and rest.\*
- A change of clothes to keep at the YMCA for accidents, etc.
- A packed lunch, as we do not provide refrigeration, and we can microwave items.
- Diapers/Wipes, if your child uses them.
- A swimsuit for children in the Aviator Room and Half-Day Pre-K.
- A water bottle to stay at the YMCA
- Sunscreen

\* This may include any or all of the following: a blanket, sheet or pillow. All nap items will be washed weekly at the YMCA. We use an industrial commercial washer & dryer. Please do not send delicate items or keepsakes.

Your family's door code to enter our facility is for your family only. Please do not give this number out. If someone other than a parent or guardian is picking up/dropping off, please have them ring the doorbell. The Child Care Director will provide you with a door code.

We look forward to getting to know you and your family! Please let us know if there is anything you would like us to know about your child or your family.

Thank you,

Sarah Kim  
Early Childhood Center  
Director  
734.661.8058  
skim@annarborymca.org

Lauren Galster  
Aviator Room Lead Teacher  
734.661.8014  
lgalster@annarborymca.org

Melanie Rountrey  
Half-Day Pre-K Co-Lead Teacher  
734.661.8013  
mroundrey@annarborymca.org

Terese Theophilus  
Half Day Pre-K Co-Lead Teacher  
SACC Lead Teacher  
734.661.8013  
ttheophilus@annarborymca.org



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**Ann Arbor YMCA Early Childhood Center Registration Form  
2014-2015 School Year**

Child's Name: \_\_\_\_\_ Start Date \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Gender: M F

Custodial Parent/ Guardian Name \_\_\_\_\_

Home Phone Number: \_\_\_\_\_ Work Phone Number: \_\_\_\_\_

Email: \_\_\_\_\_ Cell Phone Number: \_\_\_\_\_

Secondary Parent/ Guardian Name \_\_\_\_\_

Home Phone Number: \_\_\_\_\_ Work Phone Number: \_\_\_\_\_

Email: \_\_\_\_\_ Cell Phone Number: \_\_\_\_\_

Child's Address: \_\_\_\_\_ City: \_\_\_\_\_ Zip: \_\_\_\_\_

*Check the program your child is registering for:*

**PROGRAM ENROLLMENT**

All-Star Room \_\_\_\_\_ Aviator Room: \_\_\_\_\_ Half-Day Pre-K: \_\_\_\_\_

**TUITION PAYMENT METHOD:**

I plan to pay my fees using the following method:

**AUTOMATIC MONTHLY PAYMENT** \_\_\_\_  
  
This can be done by credit card or draft from your checking account. Automatic payments will be processed on the 20<sup>th</sup> of each month for the following month's tuition. A current draft authorization form with up to date account or credit card information must be on file with the Ann Arbor YMCA ECC.

**ON LINE EDGE PAYMENT** \_\_\_\_  
  
If you choose this option you will receive a monthly billing statement each month prior to the 20<sup>th</sup>. Your payment will be due on the 20<sup>th</sup> of each month for the following month's tuition. **Log into your On Line Edge account and pay your Child Care balance.** Payments received after the last day of the month will be assessed a \$25 late fee.

**We accept publicly funded childcare subsidies. If you are on DHS, a current DHS-198 Form must be on file naming the YMCA as care provider. If you receive funds from Child Care Network, a current contract needs to be on file naming the YMCA as care provider. See the Parent Handbook or call our office for more information on these services.**

**The registration process is not complete until your registration and deposit fees are paid and the following forms are completed and returned to the Ann Arbor YMCA:**

- \_\_\_ Registration Form
- \_\_\_ Child Information Record
- \_\_\_ Permission Form
- \_\_\_ Parent Handbook Acknowledgement
- \_\_\_ Tuition Policy Agreement
- \_\_\_ Health Appraisal
- \_\_\_ Enrollment Background
- \_\_\_ Sunscreen Permission Form

**ATTENDANCE SCHEDULE:**

Monday \_\_\_\_\_ Tuesday \_\_\_\_\_ Wednesday \_\_\_\_\_ Thursday \_\_\_\_\_ Friday \_\_\_\_\_

Registration Fee Enclosed (\$50) \_\_\_\_\_ Deposit Enclosed (\$100) \_\_\_\_\_



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**Ann Arbor YMCA Early Childhood Center Tuition Rates  
September 2014-August 2015**

**All Star Room (2 ½ - 3 ½ years)**

Full Days: Monday through Friday 7:30am to 6:00pm  
5 Days per week \$960  
4 Days per week \$870  
3 Days per week \$ 749

**Aviator Room (potty trained 3 ½ - 5 years)**

Full Days: Monday through Friday 7:30am to 6:00pm  
5 Days per week \$935  
4 Days per week \$855  
3 Days per week \$ 722

**Half Day Pre-K (potty trained 3 - 5 years)**

Half Days: 9:00am-1:00pm  
5 Days per week only \$500  
Tuition for this program is prorated for scheduled closures & snow days.

**BILLING AND REGISTRATION FEES:** There is a non-refundable \$50 registration fee and \$100 deposit. The \$100 deposit will be credited to your last month's tuition should you withdraw from the program with 30 days written notice prior to the first day of the month in which your child has their last day. The annual tuition has been divided into equal monthly payments. Payment options include automatic payment through credit card or bank draft. Payment can be made by signing up for credit card or bank draft automatic payments or using your On Line Edge account to pay your child care balance.

**BILLING LATE FEES:** I understand that my child's tuition is by the 1<sup>st</sup> of every month. If payment is not received by the 1<sup>st</sup>, I will be charged a \$25 late fee per family. If payment arrangements are not made by the 1<sup>st</sup> care will be terminated. If payment is not made in full by the 8<sup>th</sup> care will be terminated.

**VACATIONS FOR CHILDREN IN THE EARLY CHILDHOOD PROGRAM:** Each child receives two weeks of vacation credit per calendar year, at your child's schedule: a child enrolled 5 days per week receives 10 days per year, a child enrolled 3 days per week receives 6 days per year etc. Your vacation credits refresh on January 1<sup>st</sup> & cannot be rolled over from the previous year. You must submit written notice of your child's vacation to the Child Care Director thirty days prior to the first day of the month in which the vacation takes place. Any vacation beyond the two weeks or without one month's notice will not be credited.



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### **Ann Arbor YMCA Child Care Tuition Policies**

**BILLING AND REGISTRATION FEES:** There is a non-refundable \$50 registration fee and \$100 deposit. The \$100 deposit will be credited to your last month's tuition should you withdraw from the program with 30 days written notice prior to the first day of the month in which your child has their last day. The annual tuition has been divided into equal monthly payments. Payment options include automatic payment through credit card or bank draft. Payment can be made by signing up for credit card or bank draft automatic payments or using your On Line Edge account to pay your child care balance.

**BILLING LATE FEES:** I understand that my child's tuition is by the 1<sup>st</sup> of every month. If payment is not received by the 1<sup>st</sup>, I will be charged a \$25 late fee per family. If payment arrangements are not made by the by the 1<sup>st</sup> care will be terminated. If payment is not made in full by the 8<sup>th</sup> care will be terminated.

**LATE PICK-UP FEE:** I understand that I will be billed \$10 for and up until the first 10 minutes that I am late to pick-up my child and \$1 every minute thereafter.

**WITHDRAWAL FROM THE PROGRAM:** I understand that in order to withdraw my child from the program in which he/she is enrolled and to have the deposit returned to me, I must provide written notice of my intent to withdraw my child. Written notice must be provided to the Child Care Director 30 days prior to the first day of the month in which your child has their last day. At that time, my deposit will be deducted from my final month's payment by Childcare Office.

**VACATIONS FOR CHILDREN IN THE EARLY CHILDHOOD PROGRAM:** Each child receives two weeks of vacation credit per calendar year, at your child's schedule: a child enrolled 5 days per week receives 10 days per year, a child enrolled 3 days per week receives 6 days per year etc. Your vacation credits refresh on January 1<sup>st</sup> & cannot be rolled over from the previous year. You must submit written notice of your child's vacation to the Child Care Director thirty days prior to the first day of the month in which the vacation takes place. Any vacation beyond the two weeks or without one month's notice will not be credited.

**CHANGE OF SCHEDULE:** Each family is offered the option to change their child's schedule twice per calendar year with no fee. The ability to add additional days is determined by the availability on any particular day. There will be a fee of \$10 for additional schedule changes.

**SICK DAYS AND HOLIDAYS:** I understand that I will not be credited for sick days, unless my child has an extended illness. In the case that your child has an extended illness please contact Childcare Director to discuss your child's illness related absences and the possibility of a reduced payment in accordance with the length of their illness. Holidays are already factored into to my child's monthly tuition rate.

I have read and agree to the Ann Arbor YMCA Child Care Program Tuition Plan and Policies including payment of all financial obligations.

CHILD'S NAME: \_\_\_\_\_

PARENT'S NAME: \_\_\_\_\_

PARENT'S SIGNATURE: \_\_\_\_\_

DATE: \_\_\_\_\_



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### Ann Arbor YMCA – Child Care Services Monthly Automatic Payment Agreement

Child(ren) Name(s): \_\_\_\_\_  
School/Child Care Site Name: \_\_\_\_\_  
Name(s) of Parent(s)/Guardian(s): \_\_\_\_\_  
Mailing Address: \_\_\_\_\_  
City: \_\_\_\_\_ MI Zip: \_\_\_\_\_ Phone: \_\_\_\_\_

Amount of Child Care Fee: \$ \_\_\_\_\_ per month

**AGREEMENT:**

1. The Ann Arbor YMCA monthly debit is a continuous payment plan and will be processed on the **20<sup>th</sup> of each month**. I understand that this plan will remain in effect until I wish to terminate my YMCA Child Care or until the end of the school year (school-age care only).
2. I authorize the Ann Arbor YMCA to draft my account for any late pick-up charges which I may incur while participating in the Child Care programs.
3. It is to my complete understanding that if I wish to terminate or change my child care in any way, I must give the Ann Arbor YMCA Child Care Office 30-DAYS WRITTEN NOTICE prior to my next debit date. If proper notice is not received, I will be held responsible for tuition regardless of whether or not my child attends the Ann Arbor YMCA Child Care program.
4. Should any debit not be honored by my bank/credit card company for any reason, I understand that I am still responsible for the payment, plus a \$20.00 service charge applied by the YMCA. This is in addition to any service fee my bank/credit card company may require.

**CREDIT CARD DRAFT:**

Credit Card Type (please circle):            VISA                    MASTERCARD                    DISCOVER

Name of Cardholder (as it appears on the card): \_\_\_\_\_

Card Number: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ Exp. Date of Card: \_\_\_\_\_

I (we) hereby authorize the Ann Arbor YMCA to debit the above credit card on the date and for the amount indicated each month for my child care services.

\_\_\_\_\_ Date

Card Holder's Signature

**BANK DRAFT:**

Depository Name (Bank): \_\_\_\_\_ Account Number: \_\_\_\_\_

\_\_\_\_\_ Routing/Transit Number: \_\_\_\_\_

Name(s) on Account (please print): \_\_\_\_\_

I (we) authorize the Ann Arbor YMCA to initiate debit entries to my/our account on the date and for the amount indicated each month for my child care services. Please provide the Ann Arbor YMCA with a check marked VOID.

\_\_\_\_\_ Date

Authorizing Signature(s)

Ann Arbor YMCA Staff Signature: \_\_\_\_\_ 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.

<b>For Provider Use Only:</b>		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
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**

<b>Emergency Contact &amp; Release of Child:</b> 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.	( )	( )	( )
<b>Release of Child Only:</b> 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 <div style="text-align: center; font-size: small;">(Provider's Name)</div>	
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)	<b>Birth History:</b>  Are there any current or past diagnosis(es) <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, please describe:  If yes, list medications:  Was the health history reviewed by a health professional? <input type="checkbox"/> Yes <input type="checkbox"/> No <b>Examiner's Initials:</b> _____
<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 Eczema 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): _____	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Does your child take any medication(s) regularly?	
			Reason for Medication	
			_____ / /	
			<b>Parent/Guardian Signature</b> _____ 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: _____			
<input type="checkbox"/>	<input type="checkbox"/>	URINALYSIS Date: / /	Sugar Albumin Microscopic				<input type="checkbox"/>	<input type="checkbox"/>	TUBERCULIN Date: / /	Type: _____ Neg.: <input type="checkbox"/> Pos.: <input type="checkbox"/> _____ mm			
<input type="checkbox"/>	<input type="checkbox"/>	BLOOD LEAD LEVEL Date: / /	Level _____ ug/dl				<b>NOTE:</b> 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		VACCINES (Circle Type)	DATE ADMINISTERED MM/DD/YYYY	
Hepatitis B (Hep B)	1	3	Hepatitis A (Hep A)	1	2
	2			2	3
DTaP/DTP/DT/Td	1	4	Influenza (TIV/LAIV)	1	4
	2	5		2	4
	3	6			
Tdap	1		Meningococcal (MCV4 / MPSV4)	1	2
Haemophilus Influenzae type b (HIB)	1	3	Human Papillomavirus (HPV4/HPV2)	1	3
	2	4		2	
Polio (IPV/OPV)	1	3	OTHER Vaccines Specify Date & Type	Type of Vaccine(s)	Date of Vaccine(s)
	2	4		1	
				2	
Pneumococcal Conjugate (PCV7/PCV13)	1	3	3		
	2	4			
Rotavirus (RV1/RV5)	1	3	Indicate and attach physician diagnosis or laboratory evidence of immunity as applicable		
	2		*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.		
Measles, Mumps, Rubella (MMR)	1	2	Parent/Guardian refused immunizations: <input type="checkbox"/>		
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: \_\_\_\_\_

child's name

\_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

Dentist's Signature Date

**PHYSICIAN'S SIGNATURE**

\_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

\_\_\_\_\_ 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 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.





STATE OF MICHIGAN

DEPARTMENT OF COMMUNITY HEALTH  
LANSING

RICK SNYDER  
GOVERNOR

OLGA DAZZO  
DIRECTOR

## IMMUNIZATION WAIVER FORM

### INSTRUCTIONS TO PARENTS OR GUARDIANS:

Vaccine-preventable diseases are still with us. Immunizations are one of the most effective measures to protect children from harmful diseases and even death. A high proportion of children must be immunized to prevent outbreaks of disease in school settings and other places where children work and play closely together.

Sections 9208 and 9211 of the Michigan Public Health Code require that a parent, guardian, or person in *loco parentis* applying to have a child registered for the first time in a Michigan school and/or in 6<sup>th</sup> grade, or in a program of group residence, care, or camping in this state shall present to officials at the time of registration or no later than the first day of school or program enrollment, a certificate of immunization verifying that the child has been vaccinated against diphtheria, tetanus, pertussis, measles, mumps, rubella, polio, hepatitis B, and varicella (chickenpox). Pneumococcal conjugate and *Haemophilus influenzae* type b vaccines are also required for preschool-aged children. Meningococcal vaccine is required for children 11 years of age or older who are in the 6<sup>th</sup> grade or newly enrolled in the district.

A parent or guardian wishing to exempt his or her child from a particular vaccination must provide a written statement indicating the religious or philosophical objections to the vaccination(s). A child who has been exempted from a vaccination is considered susceptible to the disease or diseases for which the vaccination offers protection. **The child may be subject to exclusion from the school or program, if the local and/or state public health authority advises exclusion as a disease control measure.**

By signing this waiver, you acknowledge that you are placing your child and others at risk of serious illness should he or she contract a disease that could have been prevented through proper vaccination.

### ALL INFORMATION MUST BE FILLED IN BELOW.

I object to having my child, \_\_\_\_\_, born \_\_\_\_\_, immunized with the vaccines I have checked below: (First & Last Name) (Birth Date)

- |  |   |
|--|---|
| <input type="checkbox"/> DTaP, DT, Td, Tdap (Diphtheria, Tetanus, Pertussis) | <input type="checkbox"/> <i>Haemophilus influenzae</i> type b |
| <input type="checkbox"/> Polio   | <input type="checkbox"/> Pneumococcal Conjugate               |
| <input type="checkbox"/> Hepatitis B   | <input type="checkbox"/> Varicella (chickenpox)               |
| <input type="checkbox"/> MMR (Measles, Mumps, Rubella)                       | <input type="checkbox"/> Meningococcal                        |

Reason: \_\_\_\_\_

Parent(s)/Guardian(s) Name: \_\_\_\_\_

Address: \_\_\_\_\_ Telephone: \_\_\_\_\_

Child's Address \_\_\_\_\_ Telephone: \_\_\_\_\_  
*If different from parent/guardian*

\_\_\_\_\_  
Parent or Guardian's Signature

\_\_\_\_\_  
Date Signed

\_\_\_\_\_  
Preschool Program or Licensed Day Care Center OR School Name (Required)

**File in the child's permanent record and send a copy to your local health department.**



**FOR YOUTH DEVELOPMENT  
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## Early Child Care Permission Form

### FIELD TRIP PERMISSION

I give permission for my child \_\_\_\_\_, to go on any field trips supervised by the Ann Arbor YMCA Child Care Staff. I understand that most field trips will be short walks to the playground and nearby parks. I understand further that I will be notified in advance about any longer trips and that, if any vehicle is used to transport my child, each child will be required to wear a seat belt or be placed in a car seat that I would provide.

Parent/Guardian Signature \_\_\_\_\_ Date \_\_\_\_\_

### PHOTOGRAPHY AND RECORDING PERMISSION

I give permission to the Ann Arbor YMCA Childcare Programs to take photographs, sound recordings, and video recordings of my child \_\_\_\_\_, and to use them for educational or professional purposes, and/or public information for the YMCA. There is no expectation of any reimbursement in connection with their use.

Parent/Guardian Signature \_\_\_\_\_ Date \_\_\_\_\_

### LIABILITY

I understand the physical activities which my child may participate in at the YMCA include, but may not be limited to: swimming, running, playing and sports. I agree to assume all liability and release the YMCA from any liability for the risk of injury, illness or death on account of my child's presence in a YMCA facility or on account of my child's involvement in any activity at a YMCA facility whether caused by negligence of the YMCA or another person on the premises or at the sponsored activity.

Parent/Guardian Signature \_\_\_\_\_ Date \_\_\_\_\_

### SWIMMING

I give permission for my child \_\_\_\_\_, to participate in the YMCA Youth Aquatics Program. Children enrolled in Aviators and Half Day Pre-K will participate in swim classes with instruction and free play.

Parent/Guardian Signature \_\_\_\_\_ Date \_\_\_\_\_

### PERMISSION FOR OBSERVATION

I understand that the Ann Arbor YMCA Child Care Programs may have a number of students from Eastern Michigan University, University of Michigan, or Washtenaw Community College observe the children enrolled. I give permission for my child to be observed knowing that the Ann Arbor YMCA Child Care Programs will exercise due discretion in allowing only studies that are in no way harmful to my child.

Parent/Guardian Signature \_\_\_\_\_ Date \_\_\_\_\_



**Ann Arbor YMCA Childcare  
Enrollment Background**

**FOR YOUTH DEVELOPMENT  
FOR HEALTHY LIVING  
FOR SOCIAL RESPONSIBILITY**

Today's Date: \_\_\_\_\_ Enrollment Date: \_\_\_\_\_

Child's Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Nickname: \_\_\_\_\_ Gender: \_\_\_\_\_ (M) \_\_\_\_\_ (F)

Primary Language of the Child: \_\_\_\_\_



Other children in the family or persons living with the family:

Name	Age	Relationship
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Pets in the family: \_\_\_\_\_

Has your child been in any form of childcare before?

\_\_\_\_\_ No \_\_\_\_\_ Yes

If yes, please give a brief description of the routine, other children, the philosophy, etc.

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

If yes, why are you changing to the Ann Arbor YMCA Childcare Programs?

\_\_\_\_\_

\_\_\_\_\_

Has your child ever had a serious illness and/or ever been hospitalized? If yes, please describe:

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**Allergies and Medications**

Does your child have any food allergies: \_\_\_\_\_

Does your child have any seasonal allergies? (i.e. hay fever) \_\_\_\_\_

Skin Allergies? \_\_\_\_\_ Insects? \_\_\_\_\_

Medications? \_\_\_\_\_ Food? \_\_\_\_\_

Is your child currently taking any Vitamins or Fluoride? \_\_\_\_\_

Does your child take medications regularly? \_\_\_\_\_

If so, please describe the nature of the medication, condition, and any reactions to the medication such as drowsiness, thirst, etc. Additionally, if medication needs to be dispensed during your child's care at the YMCA, please complete a "permission to dispense medication" form.

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**Birth History**

Did the mother have regular medical care during the pregnancy? \_\_\_\_\_

Did the mother have any difficulties during the pregnancy? \_\_\_\_\_

Was your child premature or very late? \_\_\_\_\_

Did your child require any special medical care or prolonged hospitalization at birth? \_\_\_\_\_

What was your child's birth weight? \_\_\_\_\_

**Health History**

At approximately what ages did your child have any of the following?

Measles \_\_\_\_\_ German Measles \_\_\_\_\_

Scarlet Fever \_\_\_\_\_ Mumps \_\_\_\_\_ Whooping Cough \_\_\_\_\_

Chicken Pox \_\_\_\_\_ Rheumatic Fever \_\_\_\_\_

Pneumonia \_\_\_\_\_ Tuberculosis \_\_\_\_\_

Has your child ever:

had a heart murmur?	Yes	No
had a serious head injury?	Yes	No
broken any bones?	Yes	No
had a seizure?	Yes	No
had a burn or cut serious enough to require medical attention?	Yes	No
taken any medications or poisons accidentally?	Yes	No
been in the hospital for any other reason?	Yes	No
had any other significant illnesses or accidents not described above?	Yes	No

**Hearing**

Does your child hear well? \_\_\_\_\_

How often does your child get a cold or stuffy nose? Under what circumstances, and how is it treated? \_\_\_\_\_

Has your child ever had asthma or wheezing? Under what circumstances, and how is it treated? \_\_\_\_\_

Has your child ever had their ears checked? When? \_\_\_\_\_

Has your child ever had tubes put in their ears? When? Date of last check-up? \_\_\_\_\_

**Vision**

Does your child see well? \_\_\_\_\_

Do your child's eyes ever cross or drift to the side? \_\_\_\_\_

Does your child ever tilt their head often? Squint a lot? If so, during what activities? \_\_\_\_\_

Have your child's eyes ever been checked? Were glasses prescribed? When is your child due for a re-check? \_\_\_\_\_

**Nutrition**

Does your child eat non-foods such as dirt, leaves, etc.?

What foods does your child like? dislike?

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Do you consider your child's appetite to be good, fair or poor?

How often does your child have: milk \_\_\_\_\_ water \_\_\_\_\_ soda \_\_\_\_\_  
juice \_\_\_\_\_

Is your child on a special diet and if so, what is the diet and who recommended it?

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**Developmental History**

At what age did your child: Sit Alone \_\_\_\_\_ Feed themselves w/ a spoon? \_\_\_\_\_

Crawl \_\_\_\_\_ Walk Alone \_\_\_\_\_

Become toilet trained: Bladder \_\_\_\_\_ Bowel \_\_\_\_\_ Nighttime \_\_\_\_\_

Say first words, & what were they \_\_\_\_\_

Say first sentence (two words or more) \_\_\_\_\_

Drink from a cup \_\_\_\_\_

Dress self \_\_\_\_\_ Dressing w/: Buttons \_\_\_\_\_ Snaps \_\_\_\_\_

Zippers \_\_\_\_\_ Tie Shoelaces \_\_\_\_\_

Does your child understand what people say to them? Do others, not in the family, understand what your child is saying to them?

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Is your child well coordinated with their body? \_\_\_\_\_

Is your child well coordinated with their hands? \_\_\_\_\_

Which hand does your child favor? \_\_\_\_\_

Does your child have any problems with bowel movements? \_\_\_\_\_

What words does your child use when she is sad? \_\_\_\_\_  
Angry? Has to use the toilet? Hungry? \_\_\_\_\_

### **Social History**

Please describe your child's personality; i.e. are they happy, affectionate, a sense of humor, what makes your child laugh, does your child watch TV and what is watched, does your child read or are they read to, how does your child get along with other children.

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What experiences has your child had with other children and what are the names of some of your child's special friends?

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What activities does your child enjoy?

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What are your child's favorite toys?

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Does your child get along well with adults? \_\_\_\_\_

Does your child have a difficult time when you leave them? \_\_\_\_\_

If so, please explain what happens and how you handle the situation:

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Have you moved recently and how old was your child? \_\_\_\_\_

Is your child afraid of anything such as animals, thunderstorms, the dark, etc?

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Many children, under stress, exhibit certain behaviors. Does your child:

Bite Nails  
Suck Thumb or Fingers

Temper Tantrums  
Hold Their Breath

Wet the Bed  
Twirl Hair

Sleep Walk  
Have Nightmares

What method of discipline do you use with your child?

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Is there any special information, which would help us take care of your child?

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Are there skills, interests, or hobbies you would be willing to bring to the Early Childhood Program to share with the staff or children?

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Thank you very much for filling out this form. All the information you have given us will help make your child's adjustment to our program smoother and easier. If you ever have any further information that you feel we should be aware of, please let us know.

Early Childhood Staff