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.

BCAL-3731 (Rev. 7-12) Previous editions 9-09,3-08, 10-07, & 1-06 may be used until 12/31/13.

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 Exzema 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:

_____ / /

Parent/Guardian Signature Date

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 _____ 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 (Hep B)	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 Cickenpox Disease? ☐ Yes ☐ No If yes, date:

VACCINES (Circle Type)	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 (HVP4/HPV2)	1	2
	2	3
	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 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 and regular intervals based on age.

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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.

Notice to Parents

Often, our students are involved in interviews by the local media, reporting on the positive instructional programs of the district. These interviews can include, but are not limited to, classroom activities, concerts and musical programs. The Utica Community Schools Board of Education has approved a policy regarding media relations, which affects students. The policy requires that the news media report to the Office of School/Community Relations or the building principal for prior approval before interviewing students involved in instructional programs.

District employees may release student information to the media only in accordance with applicable provisions of the Family Education Rights and Privacy Act (FERPA) and Board of Education Policy 5124 – Release of Directory Information. (See reference in Student/Parent Handbook.)

By completing the form below, you will give the school district, including the Utica Community Schools cable access TV education station, and the new media permission to interview your child in connection with activities involving the Utica Community Schools for as long as your child is a student of the district. Please complete the form and return it to your building principal. The completed form will be kept in the school office.

Media Release Form

The person named below gives the Utica Community Schools (UCS) permission to allow the news media and/or the school district to photograph, video and/or audio tape his or her child in connection with news events and activities involving the Utica Community Schools. I also give permission to reproduce and record my child's voice. I consent to the use of his/her name and /or the recordation and reproduction of him/her in connection with the production, exhibition, distribution and promotion or other use of any photographs, photo play, audio plays or otherwise. I agree that his/her participation is voluntary and without consideration or compensation. If, at any time, I do not want my child to participate in media interviews, I will notify the building principal in writing.

Please Print Information

I agree to the above release language as parent or legal guardian of:

_____

(child's name)

Date: _____ Name: _____

Relationship: _____ Signature: _____

Must be filled out. If you do not agree, fill out and write "NO" across the top

Use of Student Work/Photograph

Dear Parents:

As part of the communication process, the Utica Community Schools maintain web pages on the Internet. These pages provide information about the activities of the Utica Community Schools, its employees and students, and can be viewed globally.

This form officially documents that you are willing to release your child's projects, photographs, video images and/or voice recordings into the public domain. They can be viewed by anyone with access to the Internet. Group photographs may be used on a web page, however, your child's name and/or individual photograph will not appear on the Internet. There is no monetary compensation for the use of these projects and/or images.

Release

I give my permission for my child's computer projects, photographs, images and/or voice recordings, to be used as described above and are willing to release this for use in the Utica Community Schools web pages on the internet. I understand no monetary compensation will be given for use of the materials.

_____
Student Name (Signature)

_____ _____
Parent/Guardian (Signature) Address

_____ _____
Parent/Guardian name (Printed) City, State, Zip

_____ _____
Date Phone number with area code

Please sign and return to the building principal

Must be filled out.
If you do not agree, fill out and
write "NO" across the top

Utica Community Schools
Community Education
Early Childhood Programs
Student Data Form
2013-2014

Please Print

School _____ Program _____ AM _____ PM ____

Child's Name _____
Last First

_____
Address City Zip

_____ _____ _____ _____
Male Female Birthdate Elementary School Attendance Area

Place of Birth _____
If USA - City/State If outside USA - Country Only

Phone No._____
Home Cell Work

Email Address _____

Racial / Ethnic **(Check One)**

_____ American Indian/Alaskan Native _____ Asian American

_____ Black/African American _____ Hispanic

_____ Caucasian/White _____ Hawaiian/Pacific Islander

Multi Racial (Specify) _____

PLEASE RETURN COMPLETED FORM TO YOUR CHILD'S TEACHER

Utica Community Schools
Community Education
Early Childhood Programs
2013-2014

Early Childhood - Child Background Sheet

Please Print

Child's Name _____
(Last) (First) (Nickname)

Boy Girl (Circle One) Birthdate _____ (Month/Day/Year)

_____ _____
(Father/Legal Guardian's Name) (Mother/Legal Guardian's Name)

Child lives with: (Please list parents, step parents, siblings (ages), grandparents, etc.)

_____

_____

Has your child had experiences away from home, such as; staying with a sitter, play groups, Sunday school? _____

_____

Language spoken at home (if other than English): _____

Does your child have any fears or anxieties? _____

Is your child typically healthy? _____

_____

Has your child experienced any serious accident, illness, or family difficulty (divorce, death, multiple moves, etc.)? _____

_____

Does your child routinely drink from a cup? Yes _____ No _____

Does your child feed himself/herself with utensils (spoon, fork)? Yes _____ No _____

Does your child refuse any particular food? Yes _____ No _____

Does your child have a special security object or use a pacifier at home? Yes _____ No _____

If yes, explain. _____

How does your child let you know that he/she needs to use the bathroom? _____

_____

What are your child's toileting routines? _____

_____

_____

How does your child challenge your patience? _____

_____

How do you and other family members respond? _____

_____

How does your child calm down or relax? _____

_____

What do you and your child enjoy doing together? _____

_____

What does your child enjoy doing alone? _____

_____

Do you have any specific observations about your child's development that would help us understand your child? (List any evaluations or sevices your child had received.) _____

_____

_____

What are your expectations of the class? _____

_____

_____

_____

Preschool/Nursery Tuition

	Total		Monthly
4 day (3 hr) preschool.	$1,890	or	$210
4 day (2.5 hr) preschool	$1,620	or	$180
3 day (3 hr) preschool	$1,395	or	$155
3 day (2.5 hr) preschool	$1,215	or	$135
2 day (3.0 hr) preschool	$1,080	or	$120
2 day (2.5 hr) preschool	$ 990	or	$110
2 day nursery school	$ 900	or	$100

**__The first payment is a double payment equaling 2 months tuition prepay__.
__This initial payment is due by September 1, 2013__.**

The remaining payments (7) are due on or before the 1st day of each month October 2013 - April 2014.
Payments received 5 business days after the 1st of the month are subject to a $15 late fee and all NSF payments are subject to a minimum $25 fee.

Come Play With Me Tuition

	Total		Monthly
Come Play With Me II.	$ 495	or	$ 55
Come Play With Me III.	$ 540	or	$ 60

**__The first payment is a double payment equaling the 2 months tuition perpay__.
__This initial payment is due by September 1, 2013__.**

The remaining payments (7) are due on or before the 15th day of each month October 2013 - April 2014.
Payments received 5 business days after the 15th of the month are subject to a $15 late fee and all NSF payments are subject to a minimum $25 fee.

Montessori Tuition

	Total		Monthly
3 and 4 years old students	$3,240	or	$ 360

**__The first payment is a double payment equaling 2 months tuition prepay__.
__This initial payment is due by September 1, 2013.__**

The remaining payments (7) are due on or before the 15th day of each month October 2013 - April 2014.
Payments received 5 business days after the 15th of the month are subject to a $15 late fee and all NSF payments are subject to a minimum $25 fee.

Payment Options

1. Payments may be made by check and mailed to:
   Make checks payable to Utica Community Schools

   Community Education Center at Walsh
   Early Childhood Accounting Office
   38901 Dodge Park
   Sterling Heights, MI 48312

2. Visa, MasterCard or Discover payments will be accepted by calling the Child Care Accounting Office at 586.797.6985 or 586.797.4660. For your convenience, by submitting the Payment Authorization, we will automatically charge your credit card each month until April 2014 or until account is paid in full.

3. Payments can also be made online www.uticak12.org. Go to Community, click on Community Education (in the Quick Links section), then go to PaySchools (bottom right) to begin making payments on your child's account.

__Monthly invoices are NOT sent.__
__Teachers are NOT able to accept payments.__

CREDIT CARD PAYMENT AUTHORIZATION FORM

_____ I authorize credit card payment for Nursery/Preschool on the first day of each month (7) times from October 2013 until April 2014 or until account is paid in full for my child's tuition in the Utica Community Schools Early Childhood program.

_____ I authorize credit card payment for Montessori or Come Play With Me on the 15th day of each month (7) times from October 2013 until April 2014 or until account is paid in full for my child's tuition in the Utica Community Schools Early Childhood program.

Child's Name _____ Phone # _____

Credit Card # _____ Expiration Date _____

3 Digit Security Code _____ Monthly Payment $ _____
(Located on back of card)

_____ Initial here if you are authorizing two months tuition prepay now.

_____
Cardholder Name (Print)

_____ _____
Cardholder Signature Date

This document will be kept in a secure location during the school year and will be shredded at the conclusion of the program. In the event your child discontinues the program during the year, this agreement will terminate. Please let us know if there are any changes regarding the credit card used for the authorization period.

Accepted *ONLY* by mail or drop-off at:

Community Education Center at Walsh
Early Childhood Accounting Office
38901 Dodge Park
Sterling Heights, MI 48312

Community Education

Early Childhood Programs

2013 Summer Kid Camps/Smart Start

Health Exemption Form

I attest to the fact that my child:

Child's Name: _____

Is in Good Health Yes _____ No _____

Immunizations are Current Yes _____ No _____

He/She is physically able to anticipate in the activities involved in the Summer Kid Camp Programs/Summer Smart Start, and is free from any illness or communicable disease at this time.

List any information that we should be made aware of (i.e., limitations, food, allergies, medical problems, special needs, etc.)

_____

_____

_____

I understand this program operates according to the guidelines stated in the UCS Nursery and Preschool Handbook. (The handbook is posted. If you wish to have a copy, please notify the teacher.)

Should any of the above conditions change, I will prompty nofity the Teacher.

_____ _____

Parent's Signature Date