WRITTEN INFORMATION PACKET DOCUMENTATION

Michigan Department of Licensing and Regulatory Affairs
Bureau of Community and Health Systems

Child(ren)'s Name(s) (Last, First)	Center Name

A written information packet has been provided at the time of enrollment. The packet included all the following information:

- Criteria for admission and withdrawal.
- Schedule of operation, denoting hours, days, and holidays during which the center is open and services are provided.
- Fee policy.
- Discipline policy.
- Food service program.
- Program philosophy.
- Typical daily routine.
- Parent notification plan for accidents, injuries, incidents, illnesses.
- Exclusion policy for child illnesses.
- Notice of the availability of the center's licensing notebook.
  - The licensing notebook contains all the licensing inspection and special investigation reports and related corrective action plans since May 28, 2010.
  - The licensing notebook is available to parents during regular business hours.
  - Licensing inspection and special investigation reports from at least the past two years are available on the child care licensing website at **www.michigan.gov/michildcare.**
- Other _____

I certify that I received all of the above items.

_____ _____

Parent/Guardian Signature Date

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

LARA is an equal opportunity employer/program.

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 (HepB)	1	3	Hepatitis A (HepA)	1	2
	2		Influenza (IIV/LAIV)	1	3
DTaP/DTP/DT/Td	1	4		2	4
	2	5	Meningococcal (MCV4 / MPSV4)	1	2
	3	6	Human Papillomavirus (HPV9/HPV4/HPV2)	1	3
Tdap	1			2	
Haemophilus Influenzae type b (HIB)	1	3	OTHER Vaccines Specify Date & Type	Type of Vaccine(s)	Date of Vaccine(s)
	2	4		1	
Polio (IPV/OPV)	1	3		2	
	2	4		3	
Pneumococcal Conjugate (PCV7/PCV13)	1	3	*Indicate and attach physician diagnosis or laboratory evidence of immunity as applicable*		
	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:

*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.

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.

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	Received	# 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			

⇨ If yes, list medications:

_____ / / *Parent/Guardian Signature* Date

Birth History:

Are there any current or past diagnosis(es) ☐ Yes ☐ No

If yes, please describe:

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				
		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	Type: _____			
		Date: / /	Negative ☐ Positive ☐ _____ 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:

CHILD INFORMATION RECORD

State of Michigan - Department of Licensing and Regulatory Affairs - Child Care Licensing

Instructions: Unless otherwise indicated, all requested information must be provided. If the information is not known or does not apply, "unknown" or "none" is the required response. A blank field, a line through a field or "N/A" are not acceptable responses.

For Provider Use Only:	Date of Admission	Date of Discharge

Name of Child (Last, First, Middle Initial)				Child's Date of Birth
Address (Number and Street, Building/Apartment Number)		City	State	Zip Code
Parent/Legal Guardian's Name	Home Phone ( )	Parent/Legal Guardian's Name (Optional)		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		
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.)				

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

AUTHORITY: 1973 PA 116
COMPLETION: Required

Wayne County GSRP 2019-2020 Income Verification Form

These materials were developed under a grant awarded by the Michigan Department of Education

Program Name: _____ Child's Name: _____

This child is income-eligible to participate in: _____ Head Start _____ Great Start Readiness Program

	Income Source	Amount Received	Frequency* W, BW, M, 2xM	Annual Total
☐	Income Tax Form 1040			
☐	W-2			
☐	TANF Documentation (Cash Assistance only)			
☐	Pay Stub *Use GROSS earnings, including overtime pay*			
☐	Unemployment			
☐	Written statement from employer			
☐	Foster Care Reimbursement			
☐	SSI Documentation			
☐	Child Support			
☐	Alimony			
☐	Pension(s)			
☐	Other:			
☐	No Income (see below)			
* *W=weekly BW=bi-weekly M=monthly 2xM=2 times per month*			ANNUAL TOTAL:	

Documentation of No Income *(complete only if parent has no income).*

_____ I am a student

_____ I affirm that I do not receive income from any source

_____ I am supported by family members

_____ Other: _____

Parent/Guardian's Name: _____ Date: _____

Parent/Guardian's Signature: _____

_____ GSRP Staff has reviewed income documentation

_____ GSRP Staff has attached copies of the income documentation

Staff Name: _____ Date: _____

Staff Signature: _____

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Great Start Readiness Program
Michigan's Nationally Recognized Pre-K Program

Office Use Only Teacher Assigned: _____UIC: _____ Start Date: ____End Date: _____

% FPL: ___Quintile: ___ GSRP Eligible: ___ Head Start Eligible: ___Date Referred: ____ASQ Date: _____

Eligibility Factors: __1 __2 __3 __4 __5 __6 __7 Supporting Documentation: _____

Staff Name (please print): _____

Staff Signature: _____ Date: _____

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Great Start Readiness Program

EF-4 Idioma primario hablado en el hogar: _____ ¿La etnicidad del estudiante es Hispana o Latina? Si: ___ No: ___

¿Cuál de los siguientes es la raza del estudiante? (Si es multirracial, coloque una marca de verificación para cada uno que corresponda):

___Indígena Americano o Nativo de Alaska ___Aciano Americano ___Moreno o Afro-Americano

___ Caucásico ___Hispano o Latino ___Nativo de Hawái o Islas Pacíficas

¿Ha asistido su hijo a la escuela en algún lugar antes? ____ SI es así, fecha en que comenzaron: _____

Nombre de la Escuela: _____ Ciudad, Estado: _____

EF-1 Ingresos Familiares (Ingresos anuales estimados (últimos 12 meses) antes de las deducciones, incluidas las horas extras): $_____ ____ *(DEBE incluir el ingreso de todos los miembros de la familia responsables de la manutención del niño: 1040, W2, los recibos de sueldo más recientes, desempleo, manutención de los hijos, pensión alimenticia, DHS, SSI)*

EF-1 ¿Recibe su familia beneficios del Departamento de Servicios Humanos (DHS), SSI?_____

Si es así, por favor explique: _____

Estado de Empleo del Padre/Tutor: __Desempleado __Medio Tiempo __Tiempo Completo __ Temporal

Descripción del trabajo: _____

Estado de Empleo del Padre/Tutor: __Desempleado __Medio Tiempo __Tiempo Completo __ Temporal

Descripción del trabajo: _____

EF-5 Grado más alto completado: Padre/Tutor: _____ Padre/Tutor: _____

EF-2 ¿Su hijo ha sido diagnosticado con una discapacidad o retraso en el desarrollo? _____

Si es así, por favor explique: _____

Los padres <u>DEBEN</u> entregar el IEP más actual a la oficina de GSRP durante el proceso de solicitud.

EF-3 ¿Han expulsado a su hijo de una guardería o un centro de cuidado infantil? _____

EF-6 ¿Alguna vez alguien en su hogar ha sido víctima de abuso y/o negligencia? _____

EF-7 ¿Hay alguna otra información que considere que calificaría a su hijo para nuestro programa?**

Por favor explique: _____

**Consulte la Guía de Factor de Elegibilidad para otras calificaciones

¿Cómo supo del programa "Great Start Readiness"? _____

Al firmar esta solicitud, usted certifica que la información proporcionada es verdadera y precisa según su conocimiento.

Nombre del Padre/Tutor: _____

Firma de Padre/Tutor: _____ **Fecha:**_____

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Great Start Readiness Program

Solicitud de Preescolar GSRP 2019-2020

Estos materiales fueron desarrollados bajo una subvención concedida por el Departamento de Educación de Michigan

Fecha de Aplicación: _____ Nombre del Estudiante: _____

Fecha de Nacimiento: _____Lugar de Nacimiento: _____ Género: _____

Prueba de Nacimiento* (Tipo de documento): _____

*Consulte la hoja de orientación del factor de elegibilidad para otras calificaciones.

Si corresponde, Fecha de Llegada a los Estados Unidos: _____

Dirección: _____Cuidad: _____ Código Postal: _____

Tipo de seguro de Medicaid:_____ # del Caso: _____ ID del Niño: _____

OTRO seguro medico: _____Número de Póliza: _____ NO seguro medico: _____

Nombre de Padre/Tutor:_____ Lugar de Nacimiento: _____

Dirección (si es diferente a la de su niño): _____Ciudad:_____ Código Postal:_____

Teléfono de Casa: _____ Celular:_____ Teléfono del Trabajo: _____

Correo Electrónico: _____

Estado Civil: ___Casado ___ Soltero ___Divorciado ___ Viudo ___Separado

Nombre de Padre/Tutor:_____ Lugar de Nacimiento: _____

Dirección (si es diferente a la de su niño): _____Ciudad:_____ Código Postal:_____

Teléfono de Casa: _____ Celular:_____ Teléfono del Trabajo: _____

Correo Electrónico: _____

Estado Civil: ___Casado ___ Soltero ___Divorciado ___ Viudo ___Separado

(EF-7) Quien tiene custodia legal del niño?___ Madre ___Padre ___Orfanato___ Tutor Legal___ Abuelo

Si es tutor o padre de crianza temporal (que no sea el padre biológico), complete:

Nombre(s) de Tutor Legal: _____ Número del Caso: _____

Haga una lista de TODOS los miembros del hogar de los cuales usted es financieramente responsable (incluyéndose a sí mismo, a otros adultos y niños).

Nombre	Relación hacía el niño	Edad

Important:

GSRP does not operate on Fridays. We are Monday-Thursday only.

The GSRP program DOES NOT have latchkey. Pick up is between 3:00 and 3:10 P.M. We have a strict late pickup policy that we follow. If you need references to places that offer daycare pickup we can provide those for you.

ATA students ARE NOT permitted to pick up preschoolers. Preschoolers must be dropped off and signed out by adults 18 or older.

Please keep these in mind when applying for our program. Thank You! ☺