

## 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.

<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	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. 1 2011) Previous edition 7-12 only may be used.

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. (    )	

**Parent/legal guardian must initial one of the following:**

\_\_\_\_\_ I give permission to \_\_\_\_\_, licensed by the Department of Licensing and Regulatory Affairs to secure emergency medical and/or emergency surgical treatment for the above named minor child while in care.

\_\_\_\_\_ I do not give permission to \_\_\_\_\_, licensed by the Department of Licensing and Regulatory Affairs to secure emergency medical and/or emergency surgical treatment for the above named minor child while in care. I understand I assume responsibility for all emergency medical care.

Signature of Parent or Guardian				Date Signed	
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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.  
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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)	TODAY'S DATE (mm/dd/yy) / /
PARENT/GUARDIAN (Last, First, Middle)			HOME TELEPHONE NUMBER ( )
ADDRESS (Number & Street)	(City)	(ZIP Code)	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 (HepB)	1	3	Hepatitis A (HepA)	1	2
	2			2	3
DTaP/DTP/DT/Td	1	4	Influenza (IIV/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 (HPV9/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)
Pneumococcal Conjugate (PCV7/PCV13)	1	3		1	
	2	4		2	
Rotavirus (RV1/RV5)	1	3	3		
Measles, Mumps, Rubella (MMR)	1	2	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 provider office for medical waiver forms and through your local health department for nonmedical waiver forms.		
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**

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

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 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.



# Application For Enrollment

Nanny's Nursery School

<b>CHILD INFORMATION</b>	<p>_____</p> <p style="text-align: center;">Last Name                      First Name                      Middle Name</p> <p>_____</p> <p style="text-align: center;">First Day of Enrollment      Date of Birth</p> <p style="text-align: right;"> <input type="checkbox"/> Male  <input type="checkbox"/> Female       </p>
<b>FAMILY INFORMATION</b>	<p>_____</p> <p style="text-align: center;">Mother's First Name              Mother's Last Name              Social Security Number</p> <p>_____</p> <p style="text-align: center;">Home Address                      City      State      Zip              Phone</p> <p>_____</p> <p style="text-align: center;">Employer                      Mother's Date of Birth              Driver's License # /State ID</p> <p>_____</p> <p style="text-align: center;">Employer's Address              City      State      Zip              Work Phone</p> <hr/> <p>_____</p> <p style="text-align: center;">Father's First Name              Father's Last Name              Social Security Number</p> <p>_____</p> <p style="text-align: center;">Home Address                      City      State      Zip              Phone</p> <p>_____</p> <p style="text-align: center;">Employer                      Father's Date of Birth              Driver's License # / State ID</p> <p>_____</p> <p style="text-align: center;">Employer's Address              City      State      Zip              Work Phone</p>
<p>MARRIED    <input type="checkbox"/></p> <p>SINGLE        <input type="checkbox"/></p> <p>DIVORCED   <input type="checkbox"/></p> <p>WIDOWED    <input type="checkbox"/></p> <p>SEPERATED   <input type="checkbox"/></p> <p>Who does the child live with? _____</p>	<p><input type="checkbox"/> Full Time    <input type="checkbox"/> Part Time</p> <p>SCHEDULED DAYS:</p> <p><input type="checkbox"/> Monday                      From _____ to _____</p> <p><input type="checkbox"/> Tuesday                      From _____ to _____</p> <p><input type="checkbox"/> Wednesday                      From _____ to _____</p> <p><input type="checkbox"/> Thursday                      From _____ to _____</p> <p><input type="checkbox"/> Friday                      From _____ to _____</p> <p style="text-align: center;">Full day tuition is for up to 9 hours of care</p> <p>Registration Fee \$50.00                      Insufficient Funds Fee \$30.00</p> <p>Late Payment Fee \$20.00                      Late Pick-Up Fee \$1.00/min after 6pm</p>
<b>SCHEDULE INFORMATION</b>	



## ***Parent handbook signature page***

I, \_\_\_\_\_ have read the parent handbook completely and will abide by all rules and regulations stated in the parent handbook.

***Failure to abide by these rules could result in dismissal of your child(ren).***

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Parent signature

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Date

## ***Absent Days Policy Agreement***

I realize that I am responsible for tuition **whether or not** my child **attends** after my allotted absent days have been used. Another option would be to switch to drop in care for \$5 more per day. (Each child is allowed to miss double the number of days enrolled as absent/sick/vacation days. Example: 3 days of enrollment = 6 absent days.)

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Parent Signature



# Nanny's Nursery

## HEALTH CARE POLICY

Nanny's Nursery is not equipped to administer to sick children at our center. The following procedures will be used to determine whether a child is infectious or too sick to participate in regular day care activities. A child that is removed from the normal day care, public school or private school activities will be readmitted to the day care center no sooner than 24 hours after symptoms have disappeared or if a doctor has examined the child and has determined that symptoms are not infectious.

Please remember that a child is most highly infectious early in the course of infection, i.e.: just prior to or around the time when the symptoms first become apparent. Therefore, it is important that you check a child thoroughly prior to bringing him/her to the center because if his/her symptoms are detected at the center, he/she will expose classmates.

1. The clinical symptoms which indicate that a child is either too sick to participate in normal daily activities and / or may be a source of communicability to the health of other children which may include any of the following:

- a. Fever – any temperature over 100 degrees (or if the child feels badly or acts listless or out of sorts)
- b. Rash – until the cause has been determined
- c. Red or watery eyes, discharge from the eyes / conjunctivitis
- d. Any draining sore
- e. Vomiting 2 or more times in an hour
- f. Diarrhea
- g. Any and all communicable diseases
- h. Ringworm
- i. Scabies and lice

2. If the Director determines that the child is too sick for normal day care activities or that the child may be a suspected source of communicability, the child will be placed in an isolation area and the parents will be called to pick up the child.

I have read the Health Care Policy, understand its implications, and agree to my responsibility in the execution of this policy

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Date

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Parent Signature



## Health & Restriction Sign-off

Date: \_\_\_\_\_

To the Parent(s)/Guardian(s) of \_\_\_\_\_

My child \_\_\_\_\_ is in good physical health and has no restrictions for regular day care activities.

Signature: \_\_\_\_\_

Date signed: \_\_\_\_\_

# ALLERGY LIST



GLUTEN FREE    WHEAT FREE    SUGAR FREE    NUT FREE



LACTOSE FREE    DAIRY FREE    EGG FREE    SHELLFISH FREE

Child's Name: \_\_\_\_\_

Child's Birthday: \_\_\_\_\_

\_\_\_ Yes, My child has allergies

\_\_\_ No, My child does not have allergies

Please list all allergies in detail:

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# Nanny's Nursery Over The Counter Medication Form

Child's Name

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I give permission to Nanny's Nursery to administer the following over the counter product(s) to my child.

\_\_\_\_\_ Neosporin

\_\_\_\_\_ Oral teething gel (Orajel)

\_\_\_\_\_ Sunscreen

\_\_\_\_\_ Diaper Ointment

\_\_\_\_\_ Bug Spray

\_\_\_\_\_ Tylenol or other pain reliever \*\* Must provide physician note stating the name of the product or medicine, child's name, dosage amount, and how often the product is to be administered to the child.\*\*

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Parent Signature

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Date





## Photo/Video Release Form

I give my permission for my son/daughter to have his/her photo to be taken or to be videotaped for classroom or facility purposes. This may include hanging them on the wall or bulletin board, placing them on poster or in photo albums, or on their own papers.

\_\_\_\_\_ I give my permission

\_\_\_\_\_ I do not give my permission

Your child's photo may also be placed on our website or facebook page.

\_\_\_\_\_ I give permission

\_\_\_\_\_ I do not give permission

Child's Name \_\_\_\_\_

Parent's Signature \_\_\_\_\_

Date \_\_\_\_\_





## **Parent Handbook Confirmation of receipt**

I/We, the parent(s)/legal guardian(s) of \_\_\_\_\_ acknowledge that I/we have received a copy of Nanny's Nursery School's Parent Handbook and have been given the opportunity to read the manual and ask questions about and understand the policies contained therein. Furthermore, I/we agree to abide by the policies set forth in the manual.

We understand that the policies described in the Parent Handbook are not conditions of enrollment, and the language does not create a contract between Nanny's Nursery School and the parents. Nanny's Nursery school reserves the right to alter, amend or otherwise modify these guidelines, in its sole discretion without prior notice.

Signature \_\_\_\_\_ Date: \_\_\_\_\_

Print Name: \_\_\_\_\_

Signature \_\_\_\_\_ Date: \_\_\_\_\_

Print Name: \_\_\_\_\_

**Nanny's tuition must be paid in advance.** Tuition is due on Friday by 6:00pm before the week of care to be provided. When Nanny's is closed for Holidays, tuition is due by 6:00pm on the last day of business for that particular week. Non-payment of tuition could be grounds for dismissal. If you anticipate difficulty paying on time, please discuss the matter with the Director immediately to discuss the possibility of other arrangements.

I agree to abide by Nanny's tuition payment policy

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Parent's signature

Date



Michigan Department of Human Services  
Bureau of Children and Adult Licensing

WRITTEN INFORMATION PACKET DOCUMENTATION

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

**Nanny's Nursery School**

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.

Child Care Organizations Act, 1973 Public Act 116

- 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](http://www.michigan.gov/michildcare)**.

I certify that I received all of the above items.

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

\_\_\_\_\_  
Date