Pointe Tremble Early Childhood Center
DAYCARE/PRESCHOOL Registration

INDICATE PREFERENCE:

[ ] Daycare (includes daily preschool class)
[ ] Preschool Classes only (9am-12pm)

INDICATE NEED FOR CHILDCARE:

[ ] FULL TIME (EVERY DAY)
[ ] PART TIME (AT LEAST 2 DAYS PER WEEK)

Daycare ONLY: Indicate days and times needed for childcare each week.

Monday	Tuesday	Wednesday	Thursday	Friday
_____to _____	_____to_____	_____to_____	_____to_____	_____to_____

*Daycare days attended must remain the same each week.

3 Year Old Preschool 9am – 12pm
[ ] 2 days (T/TH)
[ ] 3 days (M, W. F)
[ ] 4 days (M, T, W, TH)

4 Year Old Preschool 9am – 12pm
[ ] 3 Days (M-TH)
[ ] 4 days (M-TH)
[ ] M [ ] T [ ] W [ ] TH

CHILD'S NAME: ______________________________

BIRTHDATE: ____________________ TELEPHONE: ____________________

PARENT / GUARDIAN: ______________________________

ADDRESS: ______________________________

____
City State Zip Code

PHONE NUMBERS WHERE PARENTS CAN BE REACHED WHILE CHILD IS ATTENDING PRESCHOOL / DAYCARE:

MOTHER: ____________________ FATHER: ____________________

____________________ ____________________
Phone Number Phone Number

I, ______________________________, understand that the registration fee is non-refundable.
REGISTRATION FEE: $29.00 PER CHILD

Signature: ______________________________ Date: ______________

Pesticide Application Notification Form

Dear Parent/Guardian:

Algonac Community Schools has adopted an integrated Pest Management program. Inherent with this are the district's efforts to reduce pesticide use as much as possible. While it may occasionally be necessary to apply a pesticide, these will only be used as a last resort.

You have the right to be informed prior to any pesticide application (other than a bait or gel formulation) that might be needed in your children's school. To receive notification, please complete the following information and you will be notified by flyer, email and the districts web site. If the Pre-Notification Request form is not returned we will assume you do not want to be notified. Notification of pesticide applications (other than a bait or gel formulation) will also be posted on the District's website at www.algonac.k12.mi under the title Integrated Pest Management Program, and will be posted at the entrance of the building and the classroom doors. In an emergency, pesticides may be applied without prior notice, but you will be provided notice following any such application. At anytime should you have questions or concerns about Pest Management within your children's school, please contact the Operations Department at 810-794-4911 ext. 1117 or ext. 1101.

Please fill out the following and return it to the Pte. Tremble Early Childhood Center office: (Please Print)

Pesticide Pre-Notification Request

School: ______________________________

Parent/Guardian Name: ________________________________

Home Phone: _____________________ **Work Phone:** ________________________

Email: ____

Parent/Guardian Signature: _____________________________ **Date:** ______________

PLEASE NOTIFY THE OFFICE OF ANY CHANGES IN PHONE NUMBERS AND EMAILS RIGHT AWAY!

All parents and guardians will be notified by the above stated communications for all pesticide applications taking place at the Pte. Tremble Early Childhood Center. (Except for bait or gel formulations).

Photo Permission and Release

Child's Name: ____

[ ] I give my permission for Algonac Childcare to take pictures of my child during their day at Pointe Tremble Early Childhood Center, on fieldtrips, and during holiday and other programs.

[ ] I give Algonac Childcare permission to use my child's photo in the Center's newsletter, the School District's Newsletter, the Center's web page, and the Center's Facebook page as well as any potential newspaper articles or television interviews.

Parent's signature: ____

Algonac Community Schools
Daycare/Preschool Health Release Form

I attest to the fact that my child ____________________________ is in good physical health and that there are not changes in his/her physical condition since receiving a physical on __________.
Date

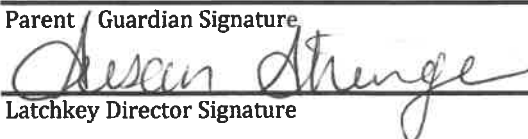
He/she is physically able to participate in all of the activities involved in the Pointe Tremble Early Childhood Center Daycare and Preschool Program and is free from any illness or communicable disease at this time. His/her specific limitations include:

____

____

Should any of the above conditions change, I will PROMPTLY notify the Algonac Latchkey Program Director and Staff.

____
Parent / Guardian Signature Date



____
Latchkey Director Signature Date

Algonac Childcare Program

Child's Name ____________________

SUNSCREEN PERMISSION FORM

As the parent/guardian of the child named above, I recognize that too much exposure to UV rays may increase my child's risk of getting skin cancer someday. Therefore, I give permission to the staff of Algonac Childcare Program to apply the sunscreen product I provided to my child when he/she will be playing outside, especially during the months of May through October between the times of 9AM and 5PM. I agree **I will provide a LOTION (no aerosol)** sunscreen for my child due to FDA recommendation.

I understand that sunscreen may be applied to exposed skin, including but not limited to the face (except eyelids), tops of ears, nose, bare shoulders, arms and legs.

I have initialed below all applicable information for the use of sunscreen for my child:

____I do not know of any allergies my child has to sunscreen.

____I have provided the following brands/types of sunscreen for use for my child:

____

____For medical or other reasons, please do NOT apply sunscreen to the following areas of my child's body:

____

____My child is allergic to sunscreen. Do NOT apply sunscreen to my child

INSECT REPELLENT PERMISSION FORM

I give permission for the staff at Algonac Childcare Program to apply the insect repellent product I have provided to my child when he/she will be playing outside, especially during the months of May through October and between the times of 9AM and 5 PM daily. I agree to provide a **Non Aerosol brand.**

I have initialed below all applicable information for the use of bug spray for my child:

____I do not know of any allergies my child has to bug spray

____I have provided the following brand/type of bug spray for use for my child:

____

____For medical or other reasons, please do NOT apply bug spray to the following areas of my child's body:

____

____My child is allergic to bug spray. Do NOT apply bug spray to my child.

Parent/Guardian's Name: ____________________________

Parent/Guardian's Signature: __________________________ Date:_______

Pointe Tremble Early Childhood Center
Daycare and Preschool
SOCIAL AND FAMILY HISTORY

Date:____________

Student's Name: ___________________________________ Date of Birth: ___/___/___

Address: ____

____

City State Zip

Phone Number: _____________________________

Primary Language Spoke in Home: _____________________________

FAMILY HISTORY

Parents are: ___Married ___Separated ___Divorced ___Deceased

Child lives with: ___Both Parents ___Mother Only ___Father Only ____Guardian

Guardian Name: ___________________________________ Number: _________________

Mother's Full Name: ________________________________ Number: _________________

Father's Full Name: _________________________________ Number: _________________

Please list ALL persons living in the family home (include parent, children, friends & family members):

NAME	AGE	GENDER	RELATION TO STUDENT

DEVELOPMENTAL HISTORY

Has the child had any major illnesses, injuries or surgeries? If so, please explain:

____

Does the child have any physical handicaps?

____

Does the child have any allergies? ______________________________

Is the child presently on medications? ________ If so, what? ______________

____

SOCIAL HISTORY

Does the child have any problems with any of the following?

___Sleeping ___Bedwetting ___Nightmares ___Eating

If so, please explain: ______________________________

____

Has anything unusual happened to your child (serious accidents, frightening experiences)?

Y/N: ___ If so, please explain: ______________________________

____

Does your child have any fears of which you are aware? (bugs, loud noises, etc.) Y/N: _____

If so, please explain: ______________________________

____

How is discipline handled at home? ______________________________

Any other information that you feel may be of importance? ______________

____

____

______________________________ ______________

Parent/Guardian Signature Date

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.)	

BCAL-3731 (Rev. 7-18) Previous edition 6-17 may be used.

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.	( )

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

LARA is an equal opportunity employer/program.

AUTHORITY: 1973 PA 116
COMPLETION: Required
PENALTY: Rule Violation Citation.

BCAL-3731 (Rev. 7-18) Previous edition 6-17may be used.

Pointe Tremble Early Childhood Center
Daycare and Preschool Permission Form

Dear Parent/ Guardian of ______________________________________:

Please read and sign this statement of permission.

1. I hereby grant permission for my child to use all of the play equipment and participate in all of the activities of the Daycare and Preschool Program at the Pointe Tremble Early Childhood Center.
2. I hereby grant permission for my child to be included in evaluations and pictures connected with the Daycare and Preschool Program at the Pointe Tremble Early Childhood Center.
3. I hereby grant permission for the Director or Caregiver to take whatever steps may be necessary to obtain emergency medical care if warranted. These steps may include, but are not limited to, the following:
    a. Attempt to contact a parent or guardian or other specified person on the child's registration form/emergency card.
    b. Attempt to contact the child's physician, as stated on the Child Information Card.
    c. Attempt to contact the parents through any of the persons listed on the Child Information Card.
    d. If we cannot contact you or your child's physician, we will do any or all of the following:
        i. Call another physician.
        ii. Contact EMS
        iii. Have the child taken to the emergency hospital in the company of a staff member.
    e. Any expense incurred under #3 above will be the responsibility of the child's family.
4. I understand that the Daycare and Preschool Program at the Pointe Tremble Early Childhood Center.
5. will not be responsible for anything that my happen as a result of false or incomplete information given at the time of registration.
6. I understand that Daycare and Preschool Program at the Pointe Tremble Early Childhood Center WILL NOT ASSUME RESPONSIBILITY for a child who has not been signed in when he/she arrives for the day.

____

Parent/Guardian Signature Date

____

Signature of Program Director Date

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 Eczema or Frequent Skin Rashes
☐	☐	☐	4 Convulsions/Seizures
☐	☐	☐	5 Heart Trouble
☐	☐	☐	6 Diabetes
☐	☐	☐	7 Frequent Colds, Sore Throats, Earaches (4 or more per year)
☐	☐	☐	8 Trouble with Passing Urine or Bowel Movements
☐	☐	☐	9 Shortness of Breath
☐	☐	☐	10 Speech Problems
☐	☐	☐	11 Menstrual Problems
☐	☐	☐	12 Dental Problems: Date of Last Exam / /
☐	☐	☐	Other (please describe): ____________

☐ ☐ Does your child take any medication(s) regularly?

Reason for Medication

______________ / /

Parent/Guardian Signature Date

Birth History:

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

If yes, please describe:

If yes, list medications:

Was the health history reviewed by a health professional?

☐ Yes ☐ No ***Examiner's Initials:*** ______________

SECTION II - PHYSICAL EXAMINATION, INSPECTION, TESTS AND MEASUREMENTS

Required for Child Care and Head Start / Early Head Start

Tests and Measurements

No	Yes	Was child tested for:	Test results:	Normal	Referred	Under Care
☐	☐	VISION Date: / /	Visual Acuity			
			Muscle Imbalance			
			Other:			
☐	☐	HEARING Date: / /	Audiometer			
			Other:			
☐	☐	URINALYSIS Date: / /	Sugar			
			Albumin			
			Microscopic			
☐	☐	BLOOD LEAD LEVEL Date: / /	Level ________ 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 (HepB)	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 Chickenpox Disease? ☐ Yes ☐ No If yes, date:

VACCINES (Circle Type)	DATE ADMINISTERED MM/DD/YYYY	
Hepatitis A (HepA)	1	2
Influenza (IIV/LAIV)	1	3
	2	4
Meningococcal (MCV4 / MPSV4)	1	2
Human Papillomavirus (HPV9/HPV4/HPV2)	1	3
	2	
OTHER Vaccines Specify Date & Type	Type of Vaccine(s)	Date of Vaccine(s)
	1	
	2	
	3	

Indicate and attach physician diagnosis or laboratory evidence of immunity as applicable

*NOTE: According to Public Act 368 of 1978, any child enrolling in a Michigan school for the first time must be adequately immunized, vision tested and hearing tested. Exemptions to these requirements are granted for medical, religious and other objections, provided that the waiver forms are properly prepared, signed and delivered to school administrators. Forms for these exemptions are available at your 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.

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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.

State Board of Education Approved Home Language Survey*

The Algonac Community School District is collecting information regarding the language background of each of its students. This information will be used by the district to determine the number of children who should be provided bilingual instruction according to Sections 380.1152 - 380.1157 of the School Code of 1995, Michigan's Bilingual Education Law. Would you please help by providing the following information?

Name of Student ______________________________ Grade ________ Age____________

School Building:

1. Is your child's native tongue a language other than English? ____Yes ____No
   What is the language? ____

2. Is the primary language** used in your child's home or environment a language other than English?
   ____Yes ____No
   What is the language? ____

____________________________ ______________________________________
Signature of Parent or Guardian Address

____
Date

*Translation of this survey form in Spanish, Arabic, French, Italian and Ojibwa is available at the Office of Field Services at 517-373-6066.
** "Primary language" means the dominant language used by a person for communications.

McKinney-Vento Pre-Screening form

Algonac Community Schools is dedicated to servicing its students and families. With the recent economic hardship that has affected our state; we realize that many of our families may be in need of extra assistance. Under the McKinney-Vento Assistance Act, you may be eligible for additional services. Please indicate if any of the options below pertain to your student:

Presently, my student is living:

- ☐ in a shelter
- ☐ with more than one family in a home/apartment
- ☐ with friends/family members (other than the parent/guardian)
- ☐ in a motel, car, or campsite
- ☐ Other ____

Please provide the information below. Your information will be sent to our coordinator at the St. Clair County RESA. They will process the information and contact you to discuss services that you may be eligible for.

School: ____
Name of Student:_______________________________________ (Male/Female)
Date of Birth:___________________
Address:____
Signature of Parent/Legal Guardian:_________________________________ Date:__________

Please complete both sections of this form and return to the building secretary or to the Algonac Board of Education office.

Rev. 8-7-13