Pointe Tremble Early Childhood Center
INFANT & TODDLER Registration Form

INDICATE PROGRAM:

[ ] INFANT CARE (4 weeks – 18 months)
[ ] TODDLER CARE (18 months – 36 months)

INDICATE NEED FOR CHILDCARE:

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

Indicate approximate days and times needed for childcare each week. Two day minimum.

Monday	Tuesday	Wednesday	Thursday	Friday
____to ____	____to____	____to____	____to____	____to____

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: _____

Pointe Tremble Early Childhood Center
INFANT AND TODDLER 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 Infant and Toddler 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 Infant and Toddler 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 Infant and Toddler Program at the Pointe Tremble Early Childhood Center will not be responsible for anything that my happen as a result of false or incomplete information given at the time of registration.
5. I understand that the Infant and Toddler 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

Pointe Tremble Early Childhood Center
Infant and Toddler Care
Family, Health, and Social History Form

Child's Name: _____ Birth Date _____ Today's Date_____

Family History:

1. Are parents married ____, separated___, divorced___, deceased___, unmarried___?
2. Who does child live with? Both parents ____, mother ___, father ____, guardian___, Guardian's Name _____.
3. Full name of mother _____.
4. Full name of father _____.
5. Please list all persons living in the family home (include parents, grandparents, siblings, friends):

Name	Age	Sex	Relationship to Child

Health History

YES NO Has your child had any major illnesses, injuries, or surgeries?
Please explain: _____

YES NO Does your child have any physical handicaps?
Please explain: _____

YES NO Does your child have any allergies?
Please list: _____

YES NO Is your child presently on medication? Please list and explain: _____
_____

YES NO Does your child seem well most of the time?

YES NO In the past year, has your child has 3 or more ear infections?

YES NO Are you concerned about your child's hearing?

YES NO In the past year, has your child has more than 3 colds or sore throat infections with a fever?

YES NO Has your child even been seen by a medical specialist? If so, who? _____
Why? _____

YES NO What arrangements have you made for the care of your child should he/she become ill at the Center? _____

Sleeping

What is your child's present sleeping schedule?

Night time: from: _____ to: _____
A.M. Nap: from: _____ to: _____
P.M. Nap: from: _____ to: _____

YES NO Do you have any special ways of helping your child go to sleep?

_____

YES NO Does your child cry when going to sleep?
YES NO Does your child need a pacifier while sleeping?
YES NO Does your child need a special blanket or toy?
YES NO Does your child prefer sleeping on his/her back or side?

Feeding: (Infants)
YES NO Is your baby breast fed?
YES NO Is you baby bottle fed? If so, formula type: _____
YES NO Does your baby need to be burped?

(Toddlers)
What is your child's present eating schedule? (specify kind and amount)

	Juices	Food	Milk/Formula
Breakfast	_____	_____	_____
Lunch	_____	_____	_____
Snack	_____	_____	_____

YES NO Does your child have any feeding problems? If so, what are they?

_____

_____

Toileting:

YES NO Does your child have diaper rash? How is the rash treated?

_____

YES NO Is your child toilet trained?
YES NO Does he/she use a potty chair?
What term is used for urination? _____
What term is used for bowel movement? _____
How frequently does your child have a b.m.? _____
What is the normal appearance of b.m.? _____

Social History:
YES NO Does your child have any fears? If so, please explain? _____

_____

YES NO Does your child become easily upset?
How do you comfort your child? _____
How do you handle discipline? _____
What are your child's favorite toys? _____
What are your child's favorite activities? _____
Any other information that you feel is important: _____

_____

Introduce us to your child...

Full Name _____

Nickname _____

Siblings (name/age) _____

Favorite play materials _____

Special interests _____

Pets _____

What opportunities does your child have to play with other children of the same age?

_____

List any allergy alerts _____

List any special health issues or special needs

_____

_____

At what age did your child begin.... Creeping _____ crawling _____ walking _____

Is there any other information we should know in order to know your child better?

_____

_____

_____

_____

Introduce us to your Infant...

Daily schedule:

Sleep Schedule (time)	NAPPING (how long?)	Eating Schedule (time)	Indicate food and formula

Sleeping Patterns:

1. How does your baby show you he or she is ready for sleep? _____
2. How do you prepare your baby for nap? _____

Eating Patterns:

1. Name of formula currently using: _____
2. Are you currently breast-feeding? _____
3. What type of bottles and nipples do you use? _____
4. Do you feed your baby water? If so, how often? _____
5. Are there any eating difficulties? _____
6. Has your baby started cereal? If yes, how often and how much? _____
7. Does your baby have any allergies? _____
8. Does your baby take a pacifier? _____
9. How does your baby indicate that he/she is hungry? _____
10. Do you have any nutrition concerns we should be aware of? _____

Elimination Patterns:

1. How often do you change your baby's diaper at home? _____
2. How frequently does your baby eliminate (b.m.)? _____
3. What is the usual color and consistency of the stool? _____

Infant/Toddler 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 Infant and Toddler 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 Childcare Program Director and Staff.

_____

Parent/Guardian Signature **Date**

_____

Program Director Signature **Date**

Photo Permission and Release

Child's Name: _____

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

[ ] I give Algonac Childcare Program 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, and any other media outlets that may be advertising or showcasing our facility.

Parent/Guardian Signature: _____

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:_____

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).

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

Acknowledgement of Parent Manual

The Parent Manual is a valuable tool that you will need to keep and look through when you have questions that arise throughout the year. If you lose your copy or require a new copy you can stop by the Childcare office or find it on the Algonac Community Schools website www.algonac.k12.mi.us

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Acknowledgement of Parent Manual

I acknowledge that I have received and understand the parent manual that was provided to me before my child's enrollment in Algonac Childcare Program.

Child's Name: _____

Parent's Name: _____

Date: _____

Parent's Signature: _____

Director's 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.

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	Visual Acuity			
			Muscle Imbalance			
		Date: / /	Other:			
☐	☐	HEARING	Audiometer			
			Other:			
		Date: / /				
☐	☐	URINALYSIS	Sugar			
			Albumin			
		Date: / /	Microscopic			
☐	☐	BLOOD LEAD LEVEL	Level _____ ug/dl ⇨			
		Date: / /				

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: / /	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

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	

History of Chickenpox Disease? ☐ Yes ☐ No If yes, date:

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 _____ '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.

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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.

Pointe Tremble Early Childhood Center

INFANT & TODDLER

Your Child's Daily Needs

Toddlers (18 to 36 months)

- Small blanket and pillow for naptime
- 2 plastic bibs (if used)
- 2 pacifiers (if used)
- Pacifier holder (if pacifier is used)
- 8 or more disposable diapers
- 1 box of baby wipes
- 2 complete changes of clothing
  (Undershirt, socks, shirt, pants)
- Milk, water and/or 100% juice
- Food and snacks for the day
- Feeding dish, drinking cup & spoons (in a Ziploc bag)
- Appropriate outdoor clothing
- Shoes (**NO** open toed sandals!)

PLEASE LABEL ALL ITEMS WITH YOUR CHILD'S NAME!
We will not be accountable for unlabeled items.

- Four or more containers of milk, 100% fruit juice, and water**
- Food for each meal and snack**; name on every food container. Food must meet your child's nutritional needs.
- Breakfast, two a.m. snacks, lunch, 2 p.m. snacks
- Dishes for each meal/snack. Please provide one of the following for each meal that your child will be served while in our care.
  - Feeding dish/bowl
  - Sippy cup
  - Spoon/fork
  - Napkin
  - A plastic bag to place used eating utensils in
  - Name on all of the above
- Prepackaged, nutritious foods and disposable eating/serving utensils may be sent to avoid dish washing.
  We are NOT equipped to prepare food/meals (i.e. add water and microwave). We are able to warm up meals.