Parchment
Early Learning Center
AND SCHOOL AGE CHILDCARE

Parchment School District
Home of the Panthers

Welcome to Parchment Early Learning Center! We appreciate your consideration of our center, and recognize the importance of the decision to place your child in someone else's care.

We offer the highest quality childcare & preschool with an appropriate academic emphasis. In our care, your children will receive the physical, social, emotional & intellectual support that they need for growth and development. They will also receive continuous love and acceptance from their teachers and caregivers.

At Parchment Early Learning Center, we are building the foundation for lifelong learning and academic success! We strive to teach values such as patience, responsibility, compassion for self and others, communication & teamwork.

Your children will be given endless opportunities to imagine and create! They will be encouraged in their efforts and their successes will be celebrated.

Thank you for the opportunity to partner with your family!

Sincerely,

Anna Wessing and Emily Whittico
Program Directors
Parchment Early Learning Center
Parchment School District

Parchment Early Learning Center			
Childcare Tuition Rates			
Effective Date August 28, 2023			

Early Learners	Full Day:	6:00 – 6:00	$235/week
2 ½ yrs - 3 yrs			$50/day
	Half Day:	5 hrs or less	$40/day

Discovery Kids	Full Day:	6:00 – 6:00	$225/week
3 yrs - 4 yrs			$50/day
	Half Day:	5 hrs or less	$40/day

Preschool	Full Week:	6:00 – 6:00	$220/week
4 yrs - 5 yrs	GSRP/KCReady4s Before School Care:	6:00-8:30	$10/day
	GSRP/KCReady4s After School Care:	3:30-6:00	$10/day
	No School Full Day:	6:00-6:00	$50/day
	No School Half Day:	11:30-6:00	$40/day

School Age Childcare	Before School Care:	6:00 – 8:30	$60/week
			$12/day
	After School Care:	3:35 – 6:00	$60/week
			$12/day
	Full Day:	6:00 – 6:00	$210/week
			$45/day
	Half Day:	5 hrs or less	$35/day

***Schedule:** Charges will be applied the week preceding care. Families are responsible to pay for all scheduled days, even if your child does not attend.

***NSF Fee:** A $5 fee will be applied for any denied payment.

***Late Pickup Fee:** Families will be charged a late pickup fee for each child on the following scale:

6:01-6:15 $10 6:16-6:30 $15 6:31 or later $25

***Multiple Child Discount:** A 10% discount will be given for the second child and after

***Military Discount:** A 10% discount will be given to any former or active military members

***Employee Discount:** A 10% discount will be given to any current Parchment School District employee

***Referral Credit:** If you refer a family that enrolls in our program, we will credit your account $25

CHILD INFORMATION RECORD

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

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	Primary Phone ( )	Parent/Legal Guardian's Name (Optional)	Primary Phone ( )
Home Address (if not child's address)	2nd Phone (if applicable) ( )	Home Address (if not child's address)	2nd Phone (if applicable) ( )
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/or Special Instructions? Yes ☐ No ☐ If yes, explain: (Attach additional sheets, if necessary.)	

CCL-3731 (Rev. 3/17/2022) Previous editions 7-18 & 4-21 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.

CCL-3731 (Rev. 3/17/2022) Previous editions 7-18 & 4-21 may 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 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.

****

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.

Parchment Early Learning Center
AND SCHOOL AGE CHILDCARE

Parchment School District
Home of the Panthers

Childcare Contract and Schedule

Child's name: _____ Requested start date: _____

(K-5 Students) Elementary School: _____ Grade: _____

Please select those that apply:

	Childcare (2 ½ yrs - 4 yrs)					
		Monday	Tuesday	Wednesday	Thursday	Friday
	Drop off time					
	Pick up time					
	Preschool (4 yrs - 5 yrs)					
		Monday	Tuesday	Wednesday	Thursday	Friday
	Full Time	8:30-3:30	8:30-3:30	8:30-3:30	8:30-3:30	8:30-3:30
	Before School (Preschool - 5th grade)					
		Monday	Tuesday	Wednesday	Thursday	Friday
	Drop off time					
	After School (Preschool - 5th grade)					
		Monday	Tuesday	Wednesday	Thursday	Friday
	Pick up time					

I agree to send my child only when they are scheduled to attend and to call the office ahead of time if I need to add additional days or times. I agree to inform the office via phone, email, or Procare for times that my child will not be in attendance.

I agree to pay for services as listed on the Pricing Sheet. I am aware of the weekly billing cycle and procedures as described in the Center Policies. I agree to pay for any charges incurred if my weekly payments are declined.

I understand that if my balance is not paid within two weeks of the due date, all services will be suspended until the balance is paid in full.

Parent/Guardian Signature _____ **Date** _____

Parchment Early Learning Center
AND SCHOOL AGE CHILDCARE

Parchment School District
Home of the Panthers

Written Agreements

Child's Name: _____ Date: _____

Please initial ALL that apply

_____ I verify that I received a written information packet containing information regarding:

- Criteria for admission and withdrawal
- Schedule of operation, denoting hours, days, and holidays that the center provides services to families
- Billing and fee policy
- Discipline policy
- Food service policy
- 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

_____ I understand that breakfast and lunch are provided to my child on days when school is in session. I agree to provide my child breakfast and lunch on any day when school is not in session. I agree to provide an afternoon snack for my child on a daily basis.

_____ I give permission for PELC staff to administer any topical, nonprescription medication to my child that is labeled with my child's name and that I have provided, including, but not limited to, sunscreen.

_____ I agree to allow PELC to use my child's photo in my child's classroom or the hallway of PELC

_____ I agree to allow PELC to use my child's photo or video in any of the following places: center-wide photo albums, newsletters, the website, Panther Press, and the Kalamazoo Gazette. I understand that photos or videos posted outside of the center will not have my child's name attached to them.

_____ I agree to allow my **School Age** child to play on the Elementary School's playgrounds. I understand that a school playground is not required to meet the same playground safety regulations that licensed childcare centers are required to meet.

_____ I agree to allow Parchment School District to provide routine transportation for my **School Age** child to and from their elementary school and PELC when my child attends the Before or After school program.

_____ I understand that a door entry code will be activated for my family. I agree to keep the code confidential and not share it with others. The following 4 digits is my preferred entry code: _ _ _ _

Parent/Guardian printed name: _____

Parent/Guardian signature: _____

Automated Payment Processing

Procare SOLUTIONS

Safe. Convenient. Easy.

We are excited to offer the safety, convenience and ease of Tuition Express®—a payment processing system that allows secure, on-time tuition and fee payments to be made from either your bank account or credit card.

ELECTRONIC FUNDS TRANSFER AUTHORIZATION FOR BANK ACCOUNT AND CREDIT CARD

I (we) hereby authorize (business name)_____ to initiate credit card charges to the below-referenced credit card account (Section A) OR, initiate debit entries to my (our) checking or savings account, indicated below (Section B). To properly affect the cancellation of this agreement, I (we) are required to give 10 days written notice. Credit union members: please contact your credit union to verify account and routing numbers for automatic payments. Check with the center for accepted credit card types.

COMPLETE ONE SECTION ONLY

SECTION A (Credit Card)

Cardholder Name _____ Phone # _____

Cardholder Address _____ City _____ State _____ Zip _____

Account Number _____ Expiration Date _____

Cardholder Signature _____ Date _____

SECTION B (Bank Account)

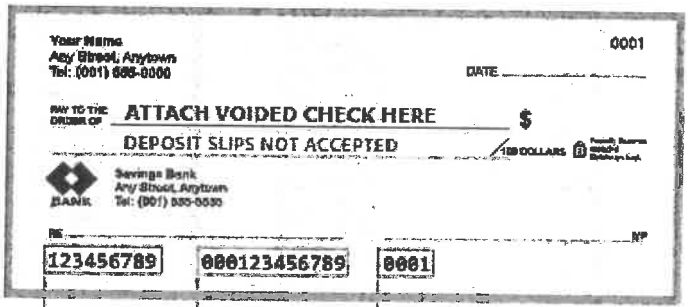
Your Name _____ Phone # _____

Address _____ City _____ State _____ Zip _____

Bank or Credit Union Name _____ Bank or Credit Union Address _____ City _____ State _____ Zip _____

Routing Transit Number (see sample below) _____ Account Number (see sample below) _____ ☐ Checking ☐ Savings

Authorized Signature _____ Date _____



FOR OFFICIAL USE ONLY

Date Received

Employee Signature

800.338.3884 • procaresoftware.com