Parchment Early Learning Center

AND SCHOOL AGE CHILDCARE

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

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

Hours of Operation: 6:00 AM – 6:00 PM, Mon-Fri

600 Edison St, Kalamazoo, MI 49004

www.parchmentschools.org

Phone: 269-488-1360

Fax: 269-488-1363

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,

Sara Tausch, Early Childhood Director
Parchment Early Learning Center
Parchment School District

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. 6-17) Previous editions 4-16, 6-15 and 7-12 may be used until September 30, 2018.

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 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

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Child's Name: _____

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 agree to provide all meals for our child in one of the following ways: purchasing through Chartwell's Food Service *or* packing and sending a lunch from home. If my student is in GSRP, I understand that breakfast and lunch are provided at no additional cost to me.

_____ I give permission for my GSRP student to ride the school bus daily (or as otherwise scheduled) from our pick up location to arrive at PELC at 8:10 AM or at 3:15 PM from PELC to our drop off location.

_____ 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.

_____ I agree to allow PELC to use my child's photo or video in any of the following places: classroom or center wide books, albums, and 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 our School Age child who is enrolled in PELC's Summer Camp to participate in swimming activities. My child is a ____ swimmer ____ non-swimmer.

_____ 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: _ _ _ _

Date: _____

Parent/Guardian printed name: _____

Parent/Guardian signature: _____

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 _____ '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.

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Childcare Schedule

Child's name: _____ Date of birth: _____ Age: _____

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

Childcare (Ages 1-4)

Days	Monday	Tuesday	Wednesday	Thursday	Friday
Drop off					
Pick up					

Before School (GSRP and K-5 students)

Days	Monday	Tuesday	Wednesday	Thursday	Friday
Drop off					
Students will go to school between 8:00-8:20					

After School (GSRP and K-5 students)

Days	Monday	Tuesday	Wednesday	Thursday	Friday
Students will arrive at the center between 3:15-4:15 (Depending on the building they attend school)					
Pick up					

The Parchment School District is closed in some instances that the center is open. In addition to all regularly scheduled days, my child will be attending the following:

- Half days
- No school days
- School breaks (Winter break, Spring break, Summer break)
- Snow days

Childcare Contract Agreement

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 or email 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 one week of the due date, all services will be suspended until the balance is paid in full.

Parent/Guardian Signature _____ **Date** _____

Parchment Early Learning Center

Childcare Tuition Rates

Explorers	Full Day:	6:00-6:00	$230/week
12 mo - 29 mo			$55/day
	Half Day:	5 hrs or less	$40/day

Early Learners	Full Day:	6:00-6:00	$215/week
2 1/2 yrs - 3 1/2 yrs			$50/day
	Half Day:	5 hrs or less	$40/day

Discovery Kids	Full Day:	6:00-6:00	$195/week
3 1/2 yrs - 4 1/2 yrs			$45/day
	Half Day:	5 hrs or less	$30/day

GSRP and School Age Childcare	Before School Care:	6:00-8:20	$50/week
GSRP and School Age			$10/day
	After School Care:	3:20-6:00	$50/week
			$10/day
	No School Days:	6:00-6:00	$165/week
			$40/day
	Half Day:	5 hrs or less	$25/day
GSRP Tuition			$150/week

***Registration Fee:** A $40 fee will be applied for each new enrollee. $20 for re-enrollment

***Schedule** – charges will be applied for the days your child is scheduled. You will have 10 vacation days free of charge.

***Activity Fee:** A $25 fee will be applied for every School Age child participating in Summer Camp

***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

***Un-notified Schedule Change Fee:** A $10/child charge will be applied for any schedule change in which the office was not notified

***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:** A $25 credit will be applied when you refer a family that enrolls in our program

Effective July 1st, 2018 for currently enrolled.

Tuition® Express

Automated Payment Processing
The 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 _____

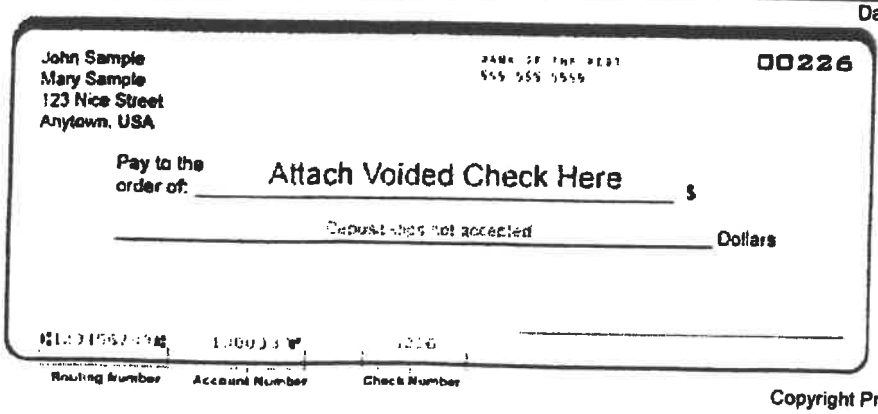
Bank or Credit Union Name _____ Bank or Credit Union Address _____ City _____ State _____ Zip _____

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

Authorized Signature _____ Date _____

For Official Use Only

Date Received
Employee Signature



A service of procare SOFTWARE

Return this completed form to: ***(Insert institution's name, address & telephone number)***

Household Income Eligibility Statement – Child Care Institutions

Part 1 – Households Receiving Food Assistance Program (FAP), Family Independence Program (FIP), or Food Distribution Program on Indian Reservations (FDPIR)

If any member of your household receives FAP, FIP, or FDPIR, provide the name and case number for the person who receives the benefits.

Name:_____ **Case Number:** __ __ __ __ __ __ __ __ __

Part 2 – Household Information

First and Last Names of All Household Members, Related and Unrelated	Enrolled for Child Care (x)	Age	Birth Date	Foster Child (x)	Amount of Earnings from Work (before deductions)	How Often? (x)					Amount of Welfare, Child Support, or Alimony	How Often? (x)					Amount of All Other Income (Indicate source and amount)	How Often? (x)					Mark if No Income (x)
						Annually	Monthly	2x Month	Bi-Weekly	Weekly		Annually	Monthly	2x Month	Bi-Weekly	Weekly		Annually	Monthly	2x Month	Bi-Weekly	Weekly	

Part 3 – All Households: Signature and Last Four (4) Digits of Adult Social Security Number (Adult household member MUST sign and date)

I certify that all information on this form is true and that all income is reported. I understand that the center or day care home will receive federal funds based on the information I give. I understand that CACFP officials may verify the information. I understand that if I purposely give false information, the participant receiving meals may lose the meal benefits, and I may be prosecuted.

Signature: _____ Print Name:_____ Date: _____

Last four digits of Social Security Number: XXX-XX-_ _ _ _ ____ I do not have a Social Security Number

For Institution Use Only:

For Institution Use Only		
Total Household Members:	**Total Income: $** ___ Annually ___ Monthly ___ 2x Month ___ Bi-Weekly ___ Weekly	**APPROVED CATEGORY** Categorical Eligibility (A/Free): Foster FIP FAP FDPIR
Institution Official Signature: _____ **Approval Date:** _____		**Other Household Children:** A (Free) B (Reduced) C (Paid)

This form is valid for 12 months from the date of institution signature. Approval date and institution signature are required.

Return this completed form to: (*insert institution's name, address & telephone number)*

Participant Enrollment Form

Instructions:

1. List full name of participant enrolled in care
2. Circle the typical days each participant is in care
3. List times each participant is in care
4. Circle the meals and snacks each participant typically receives while in care
5. Select the ethnicity of each participant using the following codes: H = Hispanic or Latino, N = Not Hispanic or Latino*
6. Select one or more racial designations of each participant using the following codes: A/I = American Indian or Alaskan Native, A = Asian, B = Black or African American, H/PI = Native Hawaiian or Pacific Islander, W = White*
7. Sign and date the form and return to your care center

Participant's First and Last Name	Typical Days in Care (circle all that apply)	List Times in Care	Meals/Snacks Received (circle all that apply)	Ethnicity	Race
	Mon Tues Wed Thu Fri Sat Sun		Breakfast AM Snack Lunch PM Snack Supper Evening Snack		
	Mon Tues Wed Thu Fri Sat Sun		Breakfast AM Snack Lunch PM Snack Supper Evening Snack		
	Mon Tues Wed Thu Fri Sat Sun		Breakfast AM Snack Lunch PM Snack Supper Evening Snack		
	Mon Tues Wed Thu Fri Sat Sun		Breakfast AM Snack Lunch PM Snack Supper Evening Snack		

* This information is voluntary. This will assist us in assuring the Child and Adult Care Food Program is administered in a nondiscriminatory manner.

Adult/Parent/Guardian's Address

Adult/Parent/Guardian's Phone Number

Signature of Adult/Parent/Guardian

Date Signed

Non-Discrimination Statement

In accordance with Federal civil rights law and U.S. Department of Agriculture (USDA) civil rights regulations and policies, the USDA, its Agencies, offices, and employees, and institutions participating in or administering USDA programs are prohibited from discriminating based on race, color, national origin, sex, disability, age, or reprisal or retaliation for prior civil rights activity in any program or activity conducted or funded by USDA. Persons with disabilities who require alternative means of communication for program information (e.g. Braille, large print, audiotape, American Sign Language, etc.), should contact the Agency (State or local) where they applied for benefits. Individuals who are deaf, hard of hearing or have speech disabilities may contact USDA through the Federal Relay Service at 800-877-8339. Additionally, program information may be made available in languages other than English.

To file a program complaint of discrimination, complete the USDA Program Discrimination Complaint Form, (AD-3027) (http://www.ascr.usda.gov/complaint_filing_cust.html) online, and at any USDA office, or write a letter addressed to USDA and provide in the letter all of the information requested in the form. To request a copy of the complaint form, call 866-632-9992. Submit your completed form or letter to USDA by: (1) mail: U.S. Department of Agriculture, Office of the Assistant Secretary for Civil Rights, 1400 Independence Avenue, SW, Washington, D.C. 20250-9410; (2) fax: 202-690-7442; or (3) email: program.intake@usda.gov. This institution is an equal opportunity provider.