Huron Valley Schools
Recreation & Community Education

Apollo Childcare Registration Form

Are you a Huron Valley Employee or have a FULL Family Pools & Fitness 1 year Membership? Yes or No (circle one)

CHILDS NAME_____**Birthdate**_____**Today's Date**_____

PARENTS' NAMES_____

ADDRESS_____**CITY**_____**ZIP**_____

HOME PHONE_____ **OTHER:**_____

PRIMARY HOUSEHOLD OF CHILD(REN)

Parent's Names:_____

Address:_____

City, State, Zip:_____

Home Phone:_____

Work Phone:_____

Cell phone:_____

Signature (Required):_____

Email Address_____

OTHER HOUSEHOLD OF CHILD(REN)

Parent's Names:_____

Address:_____

City, State, Zip:_____

Home Phone:_____

Work Phone:_____

Cell Phone:_____

Signature:_____

Email Address_____

STARTING DATE:*_____ *Must be at least one business day between start date and date of registration

Child's Schedule:
(circle days) (Full Day) Mon. Tues. Wed. Thurs. Fri.

(Partial Day) Mon. Tues. Wed. Thurs. Fri.

On Childcare days, my child will also attend: ◯ Comm. Ed. Preschool ◯ GSRP –Full Day Mon. Thurs.
Check all that may apply

◯ Head Start (Mon-Thurs) A.M. P.M. Session (circle a session) ◯ PAL A.M. P.M. Session (circle a session)

_____I have received a copy of the Parent Handbook which includes our program procedures, disciplinary policy and tuition payment schedule.

Parent's Signature:_____

PAYMENT METHOD:

_____Cash

_____ **Check or money order payable to HVS**

Visa/Mastercard/Discover

Acct.#_____

EXP:____/____

_____
Cardholders Signature

REGISTRATION PROCEDURE:

1. Complete this registration form and sign.
2. Enclose annual non-refundable registration fee. Submit to HV Rec. & Comm Educ.
3. Allow at least one business day between the day you register and your start date.
4. Your childs schedule and emergency card is to be turned in on his/her first day of care.

Note: Occasionally, throughout our programs, photos/videos are taken of the children.
Unless indicated, by signing this registration form, you are also giving your consent for your child's photo/video to be included in Huron Valley Community Education's Activity Guides, flyers, Website, Cable's HVTV or other promotional material. The children's names are NEVER disclosed.

CHILDCARE ENROLLMENT CONTRACT

1. I agree that when I receive my Parent Handbook, I will read and follow the rules and procedures in the Parent Handbook.

2. I further agree that if the behavior or health of my child should make it necessary to send him/her home, I, or an emergency contact person, will immediately pick up my child from Child Care.

3. I understand that I must pay a late fee of $1.00 per minute after 6:00pm for every minute that my child is left in Child Care. I understand that the child of a chronic offender may be disenrolled. The deciding clock regarding time is the clock in the Child Care room.

4. I understand that payments are due prior to care given by the center, and that the child may be disenrolled on the first day of the unpaid week if payment is not received.

5. I agree to give two weeks written, advance notice when withdrawing my child from the program. I understand that I am responsible for paying accrued fees until written notice is received in the Child Care office.

6. I confirm that my child is in good health and is able to participate in the Child Care activities, unless otherwise indicated on the Child Information Form.

7. I have read, understood, and agree to all of the above.

Signature of Parent/Guardian: _____

Child's Name: _____ Date: _____

HURON VALLEY SCHOOLS

HURON VALLEY RECREATION & COMMUNITY EDUCATION

CHILD INFORMATION RECORD

State of Michigan Department of Human Services - Bureau of Children and Adult 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
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. 7-12) Previous editions 9-09, 3-08, 10-07, & 1-06 may be used until 12/31/13.

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.	( )

I give permission to _____ , licensed by the Department of Human Services
(Provider's Name)

to secure emergency medical and/or emergency surgical treatment for the above named minor child while in care.

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

Department of Human Services (DHS) will not discriminate against any individual or group because of race, religion, age, national origin, color, height, weight, marital status, sex, sexual orientation, gender identity or expression, political beliefs or disability. If you need help with reading, writing, hearing, etc., under the Americans with Disabilities Act, you are invited to make your needs known to a DHS office in your area.

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

BCAL-3731 (Rev. 7-12) Previous editions 9-09,3-08, 10-07, & 1-06 may be used until 12/31/13.

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 (Hep B)	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 (Hep A)	1	2
Influenza (TIV/LAIV)	1	3
	2	4
Meningococcal (MCV4 / MPSV4)	1	2
Human Papillomavirus (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 child's school or local health department.

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 Departments of Human Services, Education, Community Health, 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.

Huron Valley Schools Recreation & Community Education
Child Information Form

Please complete this form and bring it to daycare on the first day.

Child's Name: _____ Age: _____

Name child likes to be called: _____ Birthday: _____

Address: _____

Phone: ( ) _____ Other phone numbers: _____

Family Information:

Mother's Name: _____ Father's Name: _____

Name and age of brother(s):

_____

_____

Name and age of sister(s):

_____

_____

Pets: _____

Have there been major changes in the family; such as, divorce, death, difficulties or crises that may affect the emotional well being of your child? If so, please explain: _____

_____

School History:

Has your child been cared for by anyone other than parents? Yes___ No___

Describe: _____

Has your child previously attended a daycare center/preschool? Yes ___ No___

Please list the names: _____

Developmental Information:

At what age did your child:

Sit Alone? _____ Crawl? _____ Walk Alone? _____

At what age did your child begin talking in words? _____

In sentences? _____ Any speech problems now? _____

_____

Does your child have any words or expressions that may not be understood by an outsider? Describe:

_____

At what stage of toilet training is your child? _____

Does your child use the restroom independently? Yes ___ No ___

If no, please describe what they may need help with: _____

_____

Does your child need help dressing or undressing?

Indoor Clothing: Yes___ No___ Outdoor Clothing: Yes___ No___

Does your child take a nap? Yes___ No___

If yes, how often: _____

Does your child have any special fears? Yes___ No___

(Thunder storms, costumes, separation from mom/dad, loud noises, animals, strangers, the dark, etc)

Please describe this fear (how they react or what they do. . .): _____

_____

Does your child prefer one hand over the other to write? ____ Left ____ Right

to draw? ____ Left ____ Right

to eat? ____ Left ____ Right

Does your child dislike any particular foods? Yes ___No____ Drinks? Yes___ No___

Please list the foods or drinks: _____

Please list any food allergies that your child has: _____

_____

Does your child have any other allergies? (bees, animals…) Yes___ No___

Explain: _____

_____

Has your child had any of the following? (If yes, please explain)

____ Vision problems

____ Hearing problems

____ Frequent ear infections

____ Frequent sore throats

____ Seizures or convulsions

____ On-going health problems?

____ Delayed walking – age: _____

____ Delayed talking – age: _____

____ Delayed toilet training – age: _____

Please list any concerns that you have that may affect your child in the child care setting. _____

_____

Please list any positive attributes that may affect your child in the child care setting. _____

_____

Pediatrician: _____ Phone: _____

Play Experiences:

Favorite games: _____

Favorite toys: _____

Outdoors: _____

With other children: _____

Favorite books: _____

Favorite TV shows: _____

Favorite movies: _____

Favorite animal: _____

Please list some activities that you and your child do together.

_____

_____

Does your child:

_____ Play independently with blocks, puzzles and construction toys?

_____ Hold a pencil or crayon properly?

_____ Write his or her first name legibly?

_____ Use scissors to cut paper?

_____ Draw pictures that are recognizable?

Please describe your child's temperament (i.e. highly active, quiet, happy):

_____

Does your child:

_____ Require adjustment time in new situations?

_____ Cry easily?

_____ Often have temper tantrums?

_____ Usually follow directions?

_____ Have a very short attention span?

_____ Feel comfortable speaking to new people?

_____ Speak clearly enough for strangers to understand?

Social Information:

What method of discipline is most effective with your child? _____

_____

What specific concerns do you have about your child starting daycare? _____

_____

_____

How does your child feel about starting daycare? _____

_____

_____

Please share any information that will help us make your child's daycare experience special.

_____

_____

_____

***Please share a recent *wallet-size* photo of your child**

Parent Signature: _____ Date: _____

4064

PERMISSION FORM FOR TOPICAL **NON-PRESCRIPTION** MEDICATION

I give permission to Apollo Child Care Center to apply the following topical non-prescription ointment, cream or lotion to my child:

_____

(Please circle:)

Sunscreen – Diaper Cream – Bug repellant – Other _____

Date to begin application: _____

Date to end application: _____

When to apply: (Please write what "as needed" means:)

_____

_____

_____

_____

_____

_____

This form will need to be updated annually.

Parent Signature: _____