PARENT FORMS

Everlasting Word

EARLY CHILDCARE CENTER

Specializing in Infants, Toddlers and Preschool

22707 Harmon St.
St Clair Shores, MI 48080

Email: everlastingwordchildcare@gmail.com

Phone: 586-443-5760

everlastingwordearlychildcare.com

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

Everlasting Word
EARLY CHILDCARE CENTER

GSRP DOCUMENTATION CHECKLIST
20___ - 20___

Child's Name: _____
First Last

Date of Birth: _____

Parent/Guardian Name: _____

REQUIRED DOCUMENTATION

Check the box when each document is received

- ☐ **Application**
- ☐ **Parent Identification**
- ☐ **Child Information Card Completed**
- ☐ **Proof of Immunization or Waiver**
- ☐ **Health Appraisal Completed**
- ☐ **Notification of Licensing Notebook**
- ☐ **Written Information Packet Documentation**
- ☐ **Eligibility Form**
- ☐ **Copy of Birth Certificate/Verification of Birth**
- ☐ **Documentation of Income**
  (W2 or 2 periods of paystubs)
- ☐ **Ages and Stages Questionnaire**
- ☐ **Food Reimbursement**
- ☐ **Child Center Registration Form**
- ☐ **Park Permission Slip**
- ☐ **Permission to Photograph**
- ☐ **Program Measurement**
- ☐ **Latchkey Fees Explained**

Eligibility

Total Number of Dependents Claimed_____ **Annual Family Income $** _____
Gross (Before taxes)

☐ **This child qualifies for GSRP** ☐ **This child qualifies for Head Start**

The Head Start referral was faxed on _____ **to (586) 493-5753**

GSRP Staff Name: _____ Date: _____
(Please print)

_____
(Signature)

Revised 11/23

Everlasting Word
EARLY CHILDCARE CENTER

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

INCOME VERIFICATION

Program Name: _____

Child Name: _____ **Date of Birth:** _____

Birthdate Documentation: _____

☐ Birth Certificate ☐ Hospital Record ☐ Other: _____

This childs income-eligible to participate in:

☐ Head Start ☐ Great Start Readiness Program ☐ Other: _____

Income Source	**Amount Received**
☐ Income Tax Form 1040	_____
☐ W-2	_____
☐ TANF documentation	_____
☐ Pay Stub or Pay Envelopes	_____
☐ Unemployment	_____
☐ Written statement from employer(s)	_____
☐ SSI documentation	_____
☐ Child Support	_____
☐ Alimony	_____
☐ Pension(s)	_____
☐ Other	_____
☐ Documentation of no income:	_____

Total of Income Documented Above: $ _____ **# in Household** _____

Percent of Federal Poverty Level: _____ **Quintile:** I II III IV V >V

I verify I have provided true and accurate documentation as indicated above.

_____ _____
Parent / Guardian Signature Date of Verification

I verify I have reviewed the documentation indicated above, recording the information as reflected on said documentation.

_____ _____
Staff Signature and Title Date of Verification

Revised 11/23

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	
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? (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

Center Child Registration Letter

Name of Center	License #	ID #

Dear Parent:
The Child Care Center listed above participates in the Child and Adult Care Food Program (CACFP), a nutrition program funded by the United States Dept. of Agriculture and sponsored by Mid Michigan Child Care Centers, Inc. The purpose of this program is to promote good eating habits among children. As a participant, your child care center has agreed to follow USDA minimum standards in the planning and serving of meals to the children in the child care program.
As one of the conditions of participation, your child care center is required to furnish our office with verification of enrollment of your children in the day care program. Please complete all of the necessary information requested below, sign it, and return to your child care center. This information is needed to conduct and to verify compliance with CACFP regulations.

THE FOLLOWING MUST BE COMPLETED BY PARENT OR GUARDIAN - *PLEASE PRINT*

Name of Parent or Legal Guardian			Home Phone ( )
Address			Work Phone ( )
City	State	Zip	Alternate Phone ( )
Email Address:			

1. Child's First Name	Child's Last Name	Age	Date of Birth	Classroom (if applicable)	Gender M F

Please circle the days your child is in the day care center	Arrival Time Write in times, we cannot accept "varies."	Departure Time Write in times, we cannot accept "varies."	Circle meals the center will normally serve to child:
M T W Th F SAT SUN	AM or PM	AM or PM	Breakfast AM Snack Lunch PM Snack Dinner Eve Snack

Name of public/private school child attends	Days child attends school	Time child leaves day care for school	Time child returns to day care from school
	M T W Th F		

Is this child a foster child? Yes No	Does the child have "special needs" and would need care after the age of 12? Yes No

2. Child's First Name	Child's Last Name	Age	Date of Birth	Classroom (if applicable)	Gender M F

Please circle the days your child is in the day care center	Arrival Time Write in times, we cannot accept "varies."	Departure Time Write in times, we cannot accept "varies."	Circle meals the center will normally serve to child:
M T W Th F SAT SUN	AM or PM	AM or PM	Breakfast AM Snack Lunch PM Snack Dinner Eve Snack

Name of public/private school child attends	Days child attends school	Time child leaves day care for school	Time child returns to day care from school
	M T W Th F		

Is this child a foster child? Yes No	Does the child have "special needs" and would need care after the age of 12? Yes No

Ethnicity (select one): ( )Hispanic or Latino ( ) Not Hispanic or Latino

Race (select one or more): ( )American Indian or Alaskan Native ( )Native Hawaiian or Other Pacific Islander ( )Asian ( )White ( )Black or African American

I hereby certify that the information on this sheet is true and correct to the best of my knowledge.

SIGNATURE OF PARENT OR GUARDIAN_____ **DATE**_____

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.

Mid Michigan Child Care Food Program • Mid Michigan Child Centers, Inc.
P.O. Box 610 • Freeland, MI 48623 • (989) 695-2683 • 1-800-742-3663
Fax (989) 695-5488 • Email: rachel@midmichigancc.com

GSRP PRESCHOOL APPLICATION

Everlasting Word EARLY CHILDCARE CENTER | Great Start Readiness Program

Date of Application:_____ School District:_____ Home School:_____

Child's Birthdate:_____ (must be 4 yrs. old on or before Sept. 1) Gender: ☐ Boy ☐ Girl

Child's Name: _____ Place of Birth _____

Address: _____ City:_____ Zip Code: _____

Mother's Name:_____ Place of Birth: _____

Address (if not child's address) _____ City: _____ Zip Code: _____

Home Phone:_____ Cell: _____ Work:_____

Email Address:_____

Marital Status: ☐ Married ☐ Single ☐ Divorced ☐ Widowed ☐ Separated

Father's Name: _____ Place of Birth: _____

Address (if not child's address) _____ City: _____ Zip Code: _____

Home Phone:_____ Cell: _____ Work:_____

Email Address:_____

Marital Status: ☐ Married ☐ Single ☐ Divorced ☐ Widowed ☐ Separated

(R-7) Who has legal custody of the child? (Documentation may be required)

☐ Both Parents ☐ Mother ☐ Father ☐ Foster Care ☐ Legal Guardian ☐ Grandparent

If guardian or foster parent (other than biological parent), please complete:

Legal Guardian's Name(s): _____

Address: _____ City:_____ Zip Code: _____

Home Phone:_____ Cell: _____ Work:_____

Email Address:_____

Marital Status: ☐ Married ☐ Single ☐ Divorced ☐ Widowed ☐ Separated

List all persons living in the household including student		
Name	**Relationship to Child**	**Age**

Office Use Only:

Start Date: _____ ID: _____ SC: _____ DA: _____ End Date: _____

%FPL_____ H.S. Elig. _____ Placement Location: _____ AM ____ PM _____ Full _____

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

GSRP ELIGIBILITY FORM

Everlasting Word EARLY CHILDCARE CENTER

MISD

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

Child's Name: _____ DOB: _____

	STATE GUIDELINE FACTORS	YES	NO	DOCUMENTATION (Please specify)
1	**Low Family Income** Head Start Referral Needed ☐ Yes ☐ No ☐ Mother Employed ☐ Father Employed	☐	☐	
2	**Diagnosed Disability or Identified Delay**	☐	☐	
	a. Special Education/IEP	☐	☐	
	b. Developmental delay	☐	☐	
	c. Chronic health issue	☐	☐	
3	**Severe or Challenging Behavior**	☐	☐	
	a. Child has been expelled from preschool	☐	☐	
	b. Social Services or professional letter	☐	☐	
4	**Primary Home language (Other than English)**	☐	☐	
	a. Is a language other than English spoken in the home?	☐	☐	
	b. Is English the child's first language?	☐	☐	
5	**Parent/Guardian with Low Educational Attainment: (Did not graduate High School)**	☐	☐	
6	**Abuse/Neglect of Child or Parent**	☐	☐	
	a. Domestic sexual, or physical abuse	☐	☐	
	b. Substance abuse (drugs, alcohol, etc) by a family member or in the home	☐	☐	
7	**Environmental risk**	☐	☐	
	a. Parental loss/absence	☐	☐	
	b. Sibling issues *(chronic illness, behavior, disability, death)*	☐	☐	
	c. Teen parent *(not yet age 20 at birth of first child)*	☐	☐	
	d. Housing stability *(homeless, foreclosure, frequent moves)*	☐	☐	
	e. Residence in high-risk neighborhood *(poverty, crime, crowded housing)*	☐	☐	
	f. Prenatal/postnatal exposure to toxic substances.	☐	☐	

Please explain any other factors that may cause learning or school adjustment problems for this child:

_____

_____

I certify that all the above information is true and correct and that all income is reported. I understand that this information is being collected to determine eligibility for the State-funded Great Start Readiness Program.

Parent/Guardian Signature _____

Interviewer Signature _____ Date: _____

AUTHORIZATION TO ADMINISTER MEDICATION

Date_____

Child's Name _____

Everlasting Word Early Childcare Center has my permission to administer the following prescription medications to my child:

_____and _____

Dosage instructions _____

Everlasting Word Early Childcare has my permission to administer the following over the counter medications to my child: _____

Dosage instructions _____

Everlasting Word Early Childcare has my permission to apply the following creams, lotions, or ointments on my child: _____ _____

Application instructions _____ __

Everlasting Word Early Childcare has my permission to apply the following sunscreen or sun block on my child._____ _____

Application instructions _____ __

_____ _____

Signature of Parent or Guardian Date

_____ _____

Signature of Parent or Guardian Date

E.W.E.C.C.
EVERLASTING WORD
EARLY CHILDCARE CENTER

PARENT NOTICE OF PROGRAM MEASUREMENT*

_____is required to work with the Michigan Department of Education (MDE) to measure the effect of the state-wide Great Start Readiness Program (GSRP). Information is sometimes collected about GSRP staff, enrolled children, and their families. Program staff or a representative from MOE might:

- Ask parents questions about their child and family.
- Observe children in the classroom.
- Measure what children know about letters, words, and numbers.
- Ask teachers how children are learning and growing.

Information from you and about your child will not be shared with others in any way that you or your child could be identified. It is protected by law.

Questions? Contact: mde-gsrp@michigan.gov or 517-373-8483
Or
MDE, Office of Early Childhood Education and Family Services.
608 W. Allegan, P.O. Box 30008, Lansing, MI 48909

*Provided to parents upon enrollment.

_____ _____
Parent Signature Date

_____ _____ _____
GSRP Staff Signature Position/Title Date

PARK FIELD TRIP PERMISSION

We are going to **Frederick Park/Walking** on **any days that the weather permits**

Restrictions on this trip includes or please send the following:

_____

_____

_____

Transportation: **Walking.**

I _____ and/or _____
(Parent/Guardian) (Parent/Guardian)

Give permission for my child _____ to participate in
(Print Child's Name)

the field trip to **Frederick Park/Walking** on **any days that the weather permits** .
(Parent/Guardian) (Date of Trip)

If an emergency arises while on this field trip, I give permission for my child to have any necessary medical treatment. I release **Everlasting World Early Childcare Center** from any liability or responsibility as long as reasonable care was provided.

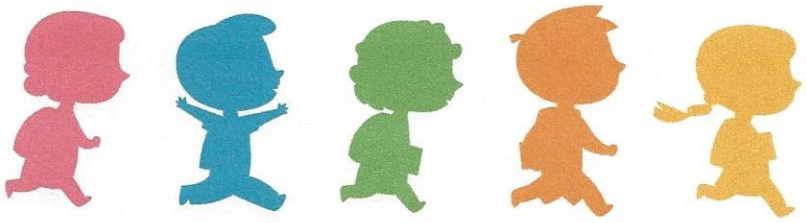
In case of an emergency, a parent/guardian may be reached at the following phone number(s):

_____ _____
(Phone #1) (Phone #2)

_____ _____
Signature of Parent or Guardian Date

Park Location: (Around the corner from Everlasting World Early Childcare Center)
Frederick Park
22600-22712 Pallister St.
St. Clair Shores, MI 48080

Everlasting Word
EARLY CHILDCARE CENTER



Revised 11/23

Everlasting Word
EARLY CHILDCARE CENTER

PERMISSION TO PHOTOGRAPH

I, _____ , give permission for **Everlasting Word Early**
(Parent or Guardian name)

Childcare Center to photograph my child, _____ , for the following purposes:
(Child's name)

Type of Use:	Grant Permission	Decline Permission
Still Photographs:		
Display in my personal scrapbook	☐	☐
Give photographs possibly containing your child to current clients	☐	☐
Display in facility's scrapbook or bulletin boards, shown to current and prospective clients	☐	☐
Display still photos on the Everlasting Word Facebook page	☐	☐
Other:	☐	☐
Videos:		
Give video to current parents	☐	☐
YouTube promotional video	☐	☐
Other:	☐	☐
Other (please list)		
Child Pilot App	☐	☐

*Only first names and possibly last initials (in the event of two or more children with the same first name) will be displayed on the facility website.

I understand that it is my responsibility to update this form in the event that I no longer wish to authorize one or more of the above uses. I agree that this form will remain in effect during the term of my child's enrollment.

_____ _____
Parent / Guardian Signature Date of Verification

Revised 11/23

WRITTEN INFORMATION PACKET DOCUMENTATION

Michigan Department of Licensing and Regulatory Affairs
Child Care Licensing Bureau

Child(ren)'s Name(s) (Last, First)	Facility's Name and License Number

A written information packet has been provided at the time of enrollment. The packet included all the following information *(R 400.8146 (1-2)):*

- Criteria for admission and withdrawal.
- Schedule of operation, denoting hours, days, and holidays during which the center is open, and services are provided.
- Fee policy.
- Discipline policy.
- Food service program.
- Program philosophy.
- Typical daily routine.
- Parent notification plan for accidents, injuries, incidents, and illnesses.
- Transportation policy, if applicable.
- Medication policy.
- Exclusion policy for child illnesses.
- Notice of the availability of the center's licensing notebook. (CENTER MUST CHECK ONE)

  ☐ The center keeps a licensing notebook containing a summary sheet, all licensing inspections and special investigation reports, and related corrective action plans for the last 5 years. The licensing notebook is available to parents/guardians during regular business hours. Reports from at least the past three years are available at www.michigan.gov/michildcare.

  ☐ The center does not keep a licensing notebook, but internet is available onsite. Reports from at least the last three years are available at www.michigan.gov/michildcare.

- Other _____

I certify that I received all of the above items.

_____ _____

Parent/Guardian Signature **Date**

Note: A single CCL-4340 form may be used for all children in the same family.

LARA is an equal opportunity employer/program.

PARENT NOTIFICATION OF THE LICENSING NOTEBOOK

Child Care Organizations Act, 1973 Public Act 116

Michigan Department of Licensing and Regulatory Affairs

Child Care Licensing Bureau

CENTER MUST CHECK ONE

☐ The center keeps a licensing notebook containing a summary sheet, all licensing inspections and special investigations, and related corrective action plans for the last 5 years. The licensing notebook is available to parents/guardians during regular business hours. Reports from at least the past three years are available at **www.michigan.gov/michildcare**.

☐ The center does not keep a licensing notebook, but internet is available onsite. Reports from at least the last three years are available at **www.michigan.gov/michildcare**.

I have read the above statement issued by _____

Name of Child Care Center

Child(ren)'s Name(s):	

Parent Name _____

Parent Signature _____ Date _____

LARA is an equal opportunity employer/program.

Everlasting Word Early Childcare

Specializing in Infants, Toddlers, and Pre-School

Getting To Know Your Child

Help me learn all I need to know to help your child have an enjoyable and successful year.

Your child's name: _____

What does your child prefer to be called: _____

My child's favorite things
Favorite color: _____

Favorite book: _____

Favorite toy: _____

Other favorites: _____

_____

_____

My child is good at: _____

_____

_____

My child likes to: (check all that apply)

- ☐ Listen to stories
- ☐ Play alone
- ☐ Play outside
- ☐ Go to friends house
- ☐ Draw and color
- ☐ Play with other children
- ☐ Play quiet games inside
- ☐ Play make-believe

My child doesn't like to: _____

_____

_____

_____

I would like you to know this about my child: _____

_____

_____

My child learns best by: _____

_____

Return this completed form to: *Mid Michigan Child Care Centers, Inc., P.O. Box 610, Freeland, MI 48623; Fax: 989-695-5488*

Center Name: Everlasting Word Early Childcare Center ID#: 189754

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 Other Household Children: A (Free) B (Reduced) C (Paid)
Institution Official Signature: _____ Approval Date: _____		

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

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?
h	h	h	1 Allergies or Reactions (for example, food, medication or other)
h	h	h	2 Hay Fever, Asthma, or Wheezing
h	h	h	3 Eczema or Frequent Skin Rashes
h	h	h	4 Convulsions/Seizures
h	h	h	5 Heart Trouble
h	h	h	6 Diabetes
h	h	h	7 Frequent Colds, Sore Throats, Earaches (4 or more per year)
h	h	h	8 Trouble with Passing Urine or Bowel Movements
h	h	h	9 Shortness of Breath
h	h	h	10 Speech Problems
h	h	h	11 Menstrual Problems
h	h	h	12 Dental Problems: Date of Last Exam / /
h	h	h	Other (please describe): _____
h	h		Does your child take any medication(s) regularly?
Reason for Medication			

Birth History:

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

If yes, please describe:

If yes, list medications:

_____ / / _____
Parent/Guardian Signature Date

Was the health history reviewed by a health professional?
h Yes h 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
h	h	VISION Date: ___/___/___	Visual Acuity			
			Muscle Imbalance			
			Other:			
h	h	HEARING Date: ___/___/___	Audiometer			
			Other:			
h	h	URINALYSIS Date: ___/___/___	Sugar			
			Albumin			
			Microscopic			
h	h	BLOOD LEAD LEVEL Date: ___/___/___	Level _____ ug/dl			

No	Yes	Was child tested for:	Test results:	Normal	Referred	Under Care
h	h	HEIGHT & WEIGHT	Height			
			Weight			
h	h	Other: _____	Other			
h	h	HEMOGLOBIN / HEMATOCRIT	⇨			
h	h	BLOOD PRESSURE	Reading: _____			
h	h	TUBERCULIN Date: ___/___/___	Type: _____ Neg.: h Pos.: h _____ 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? h Yes h 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: h

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	
h	h	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:
h	h	Should the child's activity be restricted because of any physical defect or illness? If yes, check and explain degree of restriction(s): h Classroom h Playground h Gymnasium h Swimming Pool h Competitive Sports h 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.