
EVERLASTING WORD
EARLY CHILDCARE CENTER

## Specializing in Infants, Toddlers, Pre-School

**Everlasting Word Early Childcare**
**22707 Harmon, St. Clair Shores, MI 48080**
**PH: (586) 443-5760**
**FAX: (586) 443-5260**
**EMAIL: everlastingwordchildcare@gmail.com**

# Parent Forms

# 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

# 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.

  ☒ 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 the above items.

_____ _____

**Parent/Guardian Signature** **Date**

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

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**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**

☒ 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 _____

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# 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

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EARLY CHILDCARE CENTER

# Permission to Photograph

## INFORMATION

| Name | Date |
|---|---|
| Grant permission to | Everlasting Word Early Childcare Center |
| To photograph my child | |

## THE AGREEMENT

I, the undersigned parent/guardian of the child named above, hereby grant permission to use my child's photographic image, including still photographs and videos, for the following purposes:

- ☐ EWECC Facebook page (still photos)
- ☐ EWECC Website (still photos)
- ☐ Display in personal scrapbook
- ☐ Display in Center's scrapbook or bulletin boards
- ☐ Child Pilot App

I understand that my child's image may be used for the purposes outlined above, and I hereby release _____**Everlasting Word**_____ from any and all claims arising out of the use of my child's image.

I have read and understood the above statement and agree to its terms.

| VIDEO USE | Accept | Decline |
|---|---|---|
| Child may be used in video that other parents receive | ☐ | ☐ |
| Youtube and/or promotional | ☐ | ☐ |
| Other: | ☐ | ☐ |

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 Signature/date**

# PARK OUTING PERMISSION

We are going to **Frederick Park/ Walking** on **any days that the weather permits.**
(Destination of Trip) (Date of Trip)

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 outing to **Frederick Park/ Walking** on **any days that the weather permits.**
(Destination of Trip) (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 Word Early Childcare**
(Provider/Center Name)

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 the Center
22600-22712 Pallister St.
St. Clair Shore, MI 48080

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# Child Care Services Contract

**PARTIES:**
This Child Care Contract made (date) _____ is between:
Provider(s): _____ and
Parent(s)/Guardian(s): _____.

**FOR THE CARE OF:**
Child Name: _____ DOB_____
Child Name: _____ DOB _____
Child Name: _____ DOB _____
Child Name: _____ DOB _____

Provider may amend the contract by giving the Parent/Guardian a copy of the new or changed policies at least 30 days before any changes go into effect.

**HOURS OF CARE NEEDED:** (the center hours are 7:00am-5:30pm)

| | SUN | MON | TUES | WED | THURS | FRI | SAT |
|---|---|---|---|---|---|---|---|
| DROP OFF | | | | | | | |
| PICK UP | | | | | | | |

**PAYMENT FOR CARE PROVIDED:**

1st Child $_____per week
2nd Child$ _____ per week
3rd Child $ _____ per week
4th Child $ _____ per week

**PAYMENTS/FEES:**
Payments are due the Monday before care. Payment may be made by check, money order, cash, or through the ChildPilot app. A late fee of $40 will be assessed if payment is not made in full by the end of the day on Monday. The child's space in the program will not be held if a payment is not made, and may be given to another family during this time.

**TRIAL PERIOD:**
All children will be accepted on a 2 week trial period to ensure that the child is a good fit for our daycare. During this 2 week trial period, the Provider or Parent/Guardian can terminate this agreement with 1 day written notice if it believed that the child is not a good fit for our daycare. After the 2 week trial period, care can be terminated by either the Provider or Parent/Guardian by providing a 2 week written notice and a reason.

**AGREEMENT SIGNATURES**
IN WITNESS WHEREOF, the Parties hereto agree to the above terms and have caused this Agreement to be executed in their names.

Provider Name _____
Provider Signature _____
Date: _____

Parent/Guardian Name _____
Parent/Guardian Signature _____
Date: _____

Parent/Guardian Name _____
Parent/Guardian Signature _____
Date: _____

# Acknowledgement Form

It is important that parents and families are aware of Everlasting Word Early Childcare Center's policies and guidelines for care. Please read and familiarize yourself with these and use them as a reference for situations like tuition fees, illness, meals, and other day-to-day questions.

**Acknowledgement**

My/our signature(s) below verify that I/we have read the Everlasting Word Early Childcare Center Parent Handbook and agree to follow and abide by the guidelines and policies within.

Please return the form to the office to be kept with your child's file. All forms and documents as listed below must be submitted before your child may begin care.

_____ _____

**Signature** **Date**

_____ _____

**Signature** **Date**

**Required Documents**

- ☐ **Child Information Record**
- ☐ **Notification of Licensing Notebook**
- ☐ **Health Appraisal and Immunization Records**
- ☐ **Permission Forms (Field Trip, Transportation, and Media Release)**
- ☐ **Childcare Services Contract**
- ☐ **Parent Handbook Acknowledgement**

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EARLY CHILDCARE CENTER

# 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 | Visual Acuity | | | |
| | | | Muscle Imbalance | | | |
| | | Date: / / | Other: | | | |
| h | h | HEARING | Audiometer | | | |
| | | | Other: | | | |
| | | Date: / / | | | | |
| h | h | URINALYSIS | Sugar | | | |
| | | | Albumin | | | |
| | | Date: / / | 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 | Type: _____ | | | |
| | | Date: / / | 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 |

| 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 | |
| | Type of Vaccine(s) | Date of Vaccine(s) |
| OTHER Vaccines Specify Date & Type | 1 | |
| | 2 | |
| | 3 | |

History of Chickenpox Disease? h Yes h 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: 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 _____ (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

_____ _____ 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.