# Kids & Company


**Located at: Rolland Warner Middle School - 3145 W. Genesee St. Lapeer, MI 48446 - (810) 667-2454**

## LCS Tuition Preschool Registration Form

Today's Date_____/_____/_____ Program(s) Child will attend: _____

Child's Name: _____ Date of Birth _____/_____/_____

Address: _____ City_____ Zip_____

Home Phone: (____) _____-_____ Cell Phone: (____) _____-_____ email: _____

Name of Mother/Guardian: _____ Work phone (____) _____-_____

Name of Father/Guardian: _____ Work phone (____) _____-_____

Siblings Attending Kids & Company at another site: Name: _____ Site: _____

### Schedule Information:

Class days and times are dependent on enrollment and subject to change.

### Indicate your choice by checking box

**3 Year Old Program** (children must by 3 by September 1)

Tues/Wed/Thu 8:45-11:45 AM ☐ $840/Year (payment plans available)

**4 Year Old Program** (children must be 4 by September 1)

Mon/Tue/Wed/Thu 8:45-11:45 AM ☐ $960/Year (payment plans available)

Mon/Tue/Wed/Thu 12:45-3:45 PM ☐ $960/Year (payment plans available)

**$75 non-refundable family registration fee is due to hold a spot.**

**Fees are payable by check, cash or online through payschools. Make checks out to Lapeer Community Schools**

**Parent/Guardian Signature:** _____ **Date:** _____

**Please indicate any health concerns or special needs that you feel our child's teacher should be aware of:**

_____

_____

**Office Use Only:**

Amount Paid _____ Payment type_____ Placement_____

Regularly Scheduled LCS Employee: Yes ☐ No☐ Position _____

# 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.) (please write "none" if your child has no allergies) | | | | |

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 Kids and Company (please initial here) [ ] , 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.

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Kids& Company

**ALL PURPOSE PERMISSION FORM**
**All Kids and Company Programs**

Kids& Company

*Please initial next to each statement you give permission for and sign the bottom.*

I grant permission for my child_____ to participate in the program activities as listed below. Program activities include:

_____ 1. Walking field trips on school property

_____ 2.Photographing or videotaping my child for in-school use only for promotional and personal use for parents (gifts or scrapbook).

_____ 3. Photographing my child for the local newspaper or marketing to promote Kids and Company events. (No names are ever used)

_____ 4. Posting photos of my child on the Kids and Company web pages for promotional use by Kids and Company. (No names are ever used)

_____ 5. Going with staff to a restroom for toilet training.

_____ 6. Riding a Lapeer Community Schools bus or GLTA for any field trip. (Parents will always be notified in advance of any field trip)

_____ 7. Allowing staff to give or apply sunscreen and chapstick to my child as needed (parent to provide sunscreen & chapstick). Special needs regarding sunscreen?

_____

_____

_____ 8. Transport my child to safety on a Lapeer Schools bus or walk to evacuation site in the event the building is deemed unsafe and needs to be evacuated. This also includes drills.

_____ 9. *For School Age Programs Only:* According to the Michigan Department of Human Services, school age programs operating in a school building are exempt from compliance of the 1997 edition of Public Playground Safety regulations and regular inspections. Before and After School Age Programs are exempt from licensing rules 400.5117 (7-9). www.michigan.gov/childcare

_____ 10. I have read and understand all policies and procedures in the Kids and Company Parent Handbook. I agree to adhere to all Kids and Company policies and I understand that violation of any of these policies could result in termination from the program.

_____ _____

Parent Signature Date

Lapeer Community Schools is a dynamic community organization embracing our students with a quality learning environment, developing independent and confident learners for the future.

# PARENT NOTIFICATION OF THE LICENSING NOTEBOOK

Child Care Organizations Act, 1973 Public Act 116
Michigan Department of Human Services

All child care centers must maintain a licensing notebook which includes all licensing inspection reports, special investigation reports and all related corrective action plans (CAP). The notebook must include all reports issued and CAPs developed on and after May 27, 2010 until the license is closed.

- This center maintains a licensing notebook of all licensing inspection reports, special investigation reports and all related corrective action plans.
- The notebook will be available to parents for review during regular business hours.
- Licensing inspection and special investigation reports from at least the past two years are available on the Bureau of Children and Adult Licensing website at www.michigan.gov/michildcare.

I have read the above statement issued by KIDS AND COMPANY
Name of Child Care Center

Child(ren)'s Name(s) _____

_____

Parent Name _____

Parent Signature _____ Date _____

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.

# 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 — Parent completes

| 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 Parent completes & signs

| 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 | | | |

**Birth History:**

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

If yes, please describe:

If yes, list medications: ⇨

_____ / / _____
*Parent/Guardian Signature* Date

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 Dr completes & signs back

### 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: / /