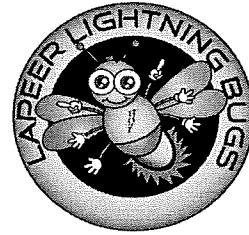


# Kids & Company



## Wee Kids Child Development II Parent Checklist

Please remember, you must have ALL paperwork complete and turned in, along with registration fee in order to be enrolled in the program.

### Included in this packet

- Childcare Registration Form
- Payschools Instructions
- Child Information Card
- All Purpose Permission Form (Peach)
- Parent Notification of Licensing Notebook

### Documents Parent Provides:

- Child's Birth Certificate
- Immunization Record
- Health Appraisal (included in packet)

Available upon request. Can be found on our website at [www.lapeerschools.org](http://www.lapeerschools.org).

- Parent Handbook
- Early Childhood Curriculum Guide

# Kids & Company

Located at: Rolland Warner Middle School

3145 W. Genesee St. Lapeer, MI 48446 - (810) 667-2454



## LCS Child Care Annual Registration Form

Please return this packet with a **non-refundable annual** registration fee as follows: **\$50** per family for current families or **\$75** per family for new families: Annual fee (August- June)

Today's Date \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_ School Child Attends: \_\_\_\_\_ Site Child Attends: \_\_\_\_\_

Child's Name: \_\_\_\_\_ Date of Birth \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_ Grade \_\_\_\_\_

Address: \_\_\_\_\_ City \_\_\_\_\_ Zip \_\_\_\_\_

Home/ Cell Phone: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ email: \_\_\_\_\_

Name of Mother/Guardian: \_\_\_\_\_ Work phone (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

Name of Father/Guardian: \_\_\_\_\_ Work phone (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

### Schedule Information:

Annual registration is required as well as monthly schedules.

Wee-Kids are open Mon-Friday 6:30am-6:00pm.

Elementary School Sites are open 6:30am until school begins and after school until 6:00pm.

Summer Camp has a **separate registration**.

Attending Kids & Company on the first day of school? Yes  No  Requested Start Date: \_\_\_\_\_

Tentative Schedule: Please circle AM, PM or BOTH.

**Mon:** AM/PM/BOTH **Tues:** AM/PM/BOTH **Wed:** AM/PM/BOTH **Thu:** AM/PM/BOTH **Fri:** AM/PM/BOTH

According to the Michigan Department of Human Service regulations, the parent or guardian of a child enrolled in a before/after school program must sign a statement verifying that their child is in good health and able to participate in program activities unless otherwise specified.

This is to verify that to the best of my knowledge my child \_\_\_\_\_ is in good health.

I will inform the child care supervisor of any accidents, illness, health restrictions, allergies or medications my child is taking.

Parent/Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_

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

---

---

---

### Office Use Only:

Amount Paid \_\_\_\_\_ Payment type \_\_\_\_\_ Placement \_\_\_\_\_

Regularly Scheduled LCS Employee: Yes  No  Position \_\_\_\_\_

Office Copy

Bus Copy


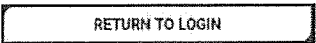
Site Copy

3.18.2020


## Registration

### Create User


- 1) To set up an account, go to [www.payschoolscentral.com](http://www.payschoolscentral.com) and click REGISTER.

- 2) Fill out all fields marked with an asterisk. We strongly suggest adding a mobile number as it will help you reset your password via text if you ever have trouble logging in.
- 3) Review the [User Agreement](#) and check the box before clicking .
- 4) Click  in the pop-up window and check your email inbox for a confirmation email.
- 5) You MUST click the link in the email in order to continue. This link is **ONLY VALID FOR 30 MINUTES**. If you do not activate the link within 30 minutes,


please return to [www.payschoolscentral.com](http://www.payschoolscentral.com) and click I

- 6) [forgot my password](#) to request a new email.
- 7) Create and confirm your password in the Account Activation screen after clicking the link in the email. You can view the password complexity rules by clicking 

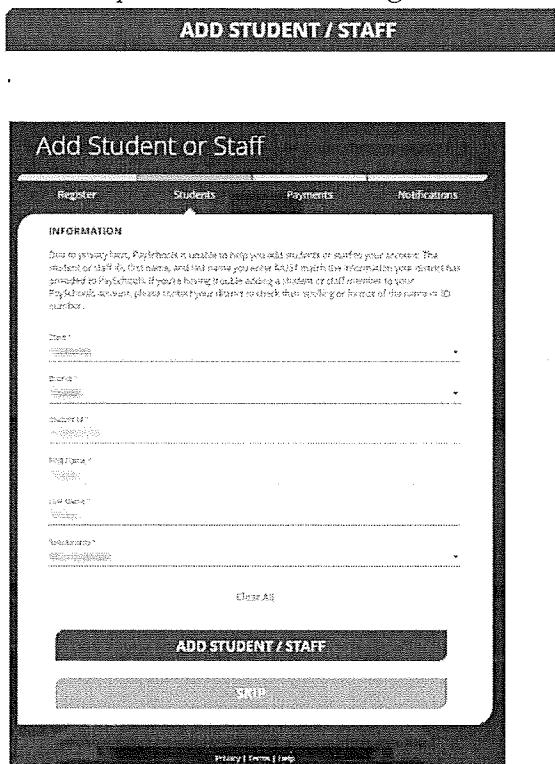
### Secure Account


- 1) Fill out your 3 security questions and answers after setting up your password. Answers must be at least two characters long.
- 2) Click  to continue.

### Add Student and/or Staff

- 1) You have the option to  this step and add your students/staff later via the Dashboard.

- 2) Add your student(s) and staff by filling in all the required fields and clicking

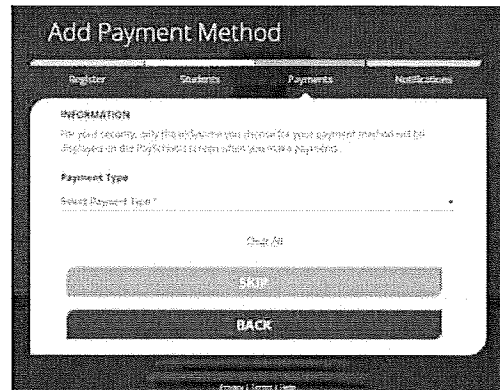



- 3) Once students and staff are added, they will appear at the top of the page where you can remove and manage your students/staff.
- 4) Click  once you've added all of your students and/or staff.
- 5) A summary screen will display all students and staff who've been added. A green circle in a student/patron's card indicates they're active. A red circle indicates they're inactive. If your student or staff is showing up as inactive, please contact your school for assistance.

## Add Payment Methods



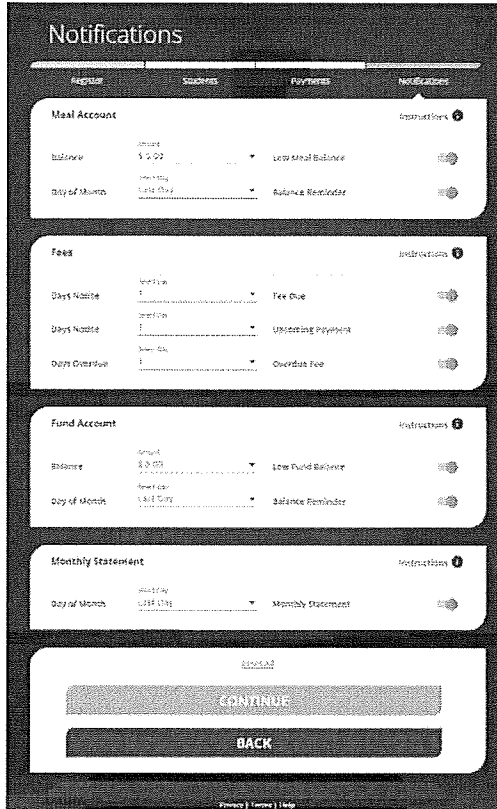
- 1) Choose the payment type. Please note school districts choose which payment methods are accepted.



- 2) Enter in the payment method information, including the payment type, nickname, and card number or routing/account numbers. The "Nickname" field is simply a name you can give your payment method. For example: Jane's Visa CC.
- 3) Please read the Terms and Conditions for each payment method and check the box to agree. Click  to add your payment method.
- 4) You can store multiple payment methods in your account, including credit/debit cards and ACH. To add another payment method, select another payment type from the drop-down menu and follow steps starting on the [Add Payment Methods](#) section of this guide. You can also add more payment methods later by going to the Menu and clicking the [Payment Methods](#) option.


## Email Notifications

- 1) To turn on any of the notifications, simply click the on/off toggle. An orange toggle indicates the notifications are on.




- 2) There are instructions for each section to give you more information about each type of notification. Click **Instructions** to see the notification descriptions.
- 3) To save your notification settings, click **CONTINUE**.

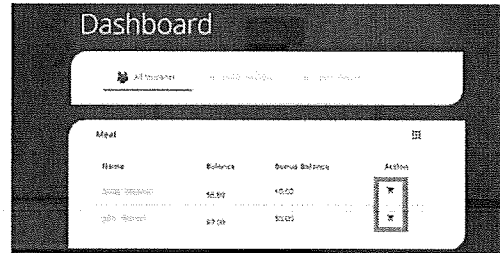
## Meal and Fee Payments

- 1) To make a one-time lunch payment, go to the Dashboard and click the  to the

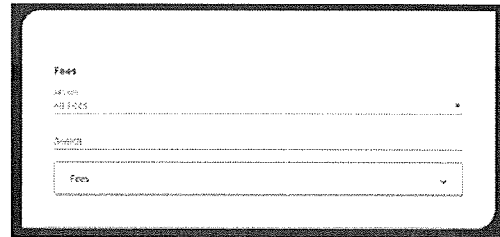


right of your student's name. To make a fee payment, scroll down to the Fees card and click the  next to the fee you wish to pay.

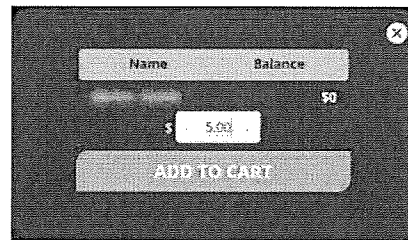
Meal:



Fee:

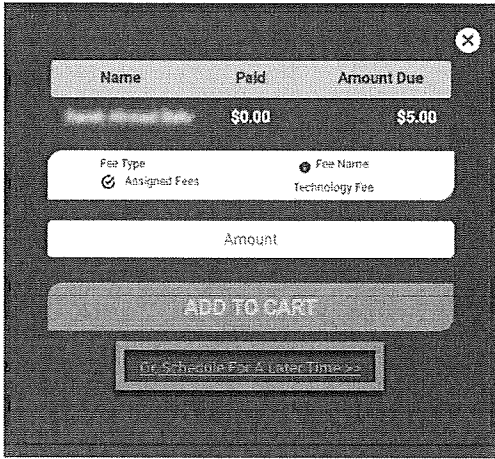


- 2) Enter the amount you wish to add to the lunch account or how much you'd like to pay towards your fee (if partial payments are allowed) and click

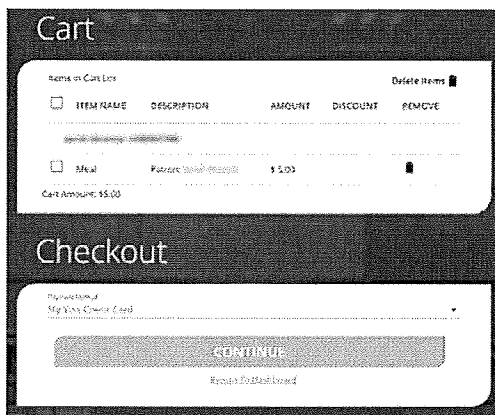


- 3) You will now see a blue circle in the upper right-hand corner of your screen where your cart is. The blue circle indicates there are items in your cart and the number indicates the amount of items.

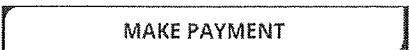
- 4) If you would like to schedule your fee payment for a later date, click [Or, Schedule For A Later Time >>](#).



- 5) To check out, click on the white shopping cart in the upper right-hand corner of the Dashboard screen.
- 6) Review and update the items in your cart and make any necessary changes.
- 7) Select your payment method and click




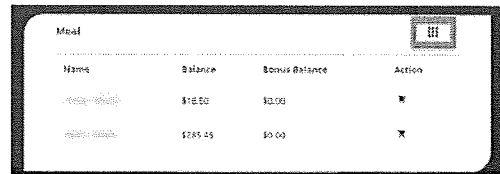
- 8) Check the box in the Totals pop-up window to agree to the terms and conditions and click



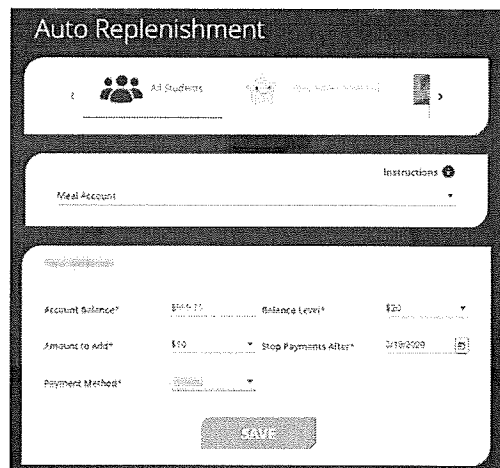
- 9) After completing your purchase, you will receive an email with a receipt listing the item(s) purchased. You can also view your payment history by opening the Menu and clicking on the [Payment History](#) option.

## Auto-Replenishment

- 1) To set up auto-replenish, click the [Auto-Replenishment](#) option in the Menu. You can also access Auto-Replenishment by clicking  in the Meal card.




- 2) You will see your list of students and can either select a single name to set up unique auto-replenish settings or you can select [All Students](#) to apply the same settings to everyone in your account.




- 3) Once you've selected your student(s), enter in the required fields and click




4) Read the Terms and Conditions and agree by putting a check mark in the box and clicking .

5) An orange toggle will appear, which indicates auto-replenishment is on.

6) Once your auto-replenish settings have been saved, you will see a status icon next to the Turn Off switch. Hover over the icon to see the auto-replenish status.

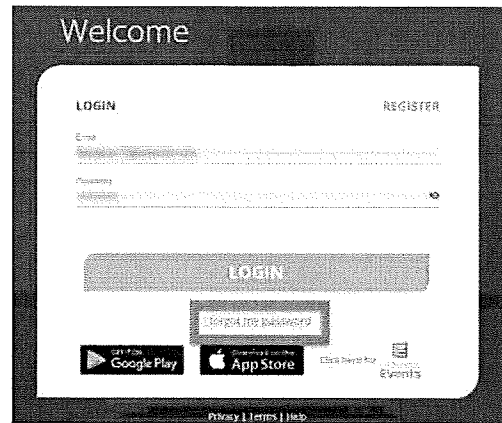
**Status**  indicates the balance level has been met and your account will be replenished that day.

**Status**  indicates the balance level has not yet been met and auto-replenishment has not kicked off.

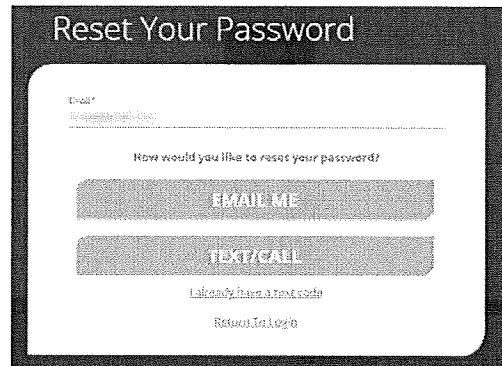
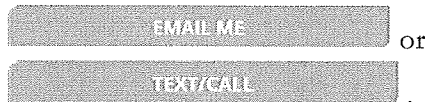
7) To turn off auto-replenish, simply click the orange toggle.

## Reset Your Password


1) If you cannot log into PaySchools Central, or if you would like to change your password, click [I forgot my password](#) on the login screen and follow the steps to reset your password.




2) Enter in the email address associated with your account where indicated and click




### Email

1) The  option will send you an email with a reset password link. Click the link and follow the instructions to reset your password when you reach the Account Activation page.

2) Click  to submit your changes.

**Text**

- 1) The  option will send you a text verification code, which you'll need to enter on the following page:

- 2) For either the email or text/call option, click



to submit your changes. You will see the following pop-up, which indicates you successfully created a new password.



# 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)	2 <sup>nd</sup> Phone (if applicable) ( )	Home Address (if not child's address)	2 <sup>nd</sup> Phone (if applicable) ( )
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/or Special Instructions? Yes <input type="checkbox"/> No <input type="checkbox"/> If yes, explain: (Attach additional sheets, if necessary.)			

CCL-3731 (Rev. 3/17/2022) Previous editions 7-18 & 4-21 may be used

See Reverse Side

<b>Emergency Contact &amp; Release of Child:</b> 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.	( )	( )	
<b>Release of Child Only:</b> 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.	( )

<b>Parent/Legal Guardian Initials:</b>
_____ 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.	

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

*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. Watching PG rated Children Movies, during Kids and Company hours.
- \_\_\_\_\_ 6. Going with staff to a restroom for toilet training.
- \_\_\_\_\_ 7. Riding a Lapeer Community Schools bus or GLTA for any field trip.  
(Parents will always be notified in advance of any field trip)
- \_\_\_\_\_ 8. Allowing staff to give or apply sunscreen and chap stick to my child as needed (parent to provide sunscreen & chap stick). Special needs regarding sunscreen?
- 
- \_\_\_\_\_ 9. 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.
- \_\_\_\_\_ 10. *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](http://www.michigan.gov/childcare)
- \_\_\_\_\_ 11. 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

**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](http://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](http://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.

## 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 & dates

<table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <th style="width: 10%;">Yes</th> <th style="width: 10%;">No</th> <th style="width: 10%;">Researched</th> <th style="width: 80%;"># Is your child having any of the problems listed below?</th> </tr> <tr><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td>1 Allergies or Reactions (for example, food, medication or other)</td></tr> <tr><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td>2 Hay Fever, Asthma, or Wheezing</td></tr> <tr><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td>3 Eczema or Frequent Skin Rashes</td></tr> <tr><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td>4 Convulsions/Seizures</td></tr> <tr><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td>5 Heart Trouble</td></tr> <tr><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td>6 Diabetes</td></tr> <tr><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td>7 Frequent Colds, Sore Throats, Earaches (4 or more per year)</td></tr> <tr><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td>8 Trouble with Passing Urine or Bowel Movements</td></tr> <tr><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td>9 Shortness of Breath</td></tr> <tr><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td>10 Speech Problems</td></tr> <tr><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td>11 Menstrual Problems</td></tr> <tr><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td>12 Dental Problems: Date of Last Exam / /</td></tr> <tr><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td>Other (please describe): _____</td></tr> <tr><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td>Does your child take any medication(s) regularly?</td></tr> <tr><td colspan="4">Reason for Medication _____</td></tr> <tr><td colspan="4">Parent/Guardian Signature _____ / _____ / _____ Date</td></tr> </table>	Yes	No	Researched	# Is your child having any of the problems listed below?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	1 Allergies or Reactions (for example, food, medication or other)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	2 Hay Fever, Asthma, or Wheezing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	3 Eczema or Frequent Skin Rashes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	4 Convulsions/Seizures	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	5 Heart Trouble	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	6 Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	7 Frequent Colds, Sore Throats, Earaches (4 or more per year)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	8 Trouble with Passing Urine or Bowel Movements	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	9 Shortness of Breath	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	10 Speech Problems	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	11 Menstrual Problems	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	12 Dental Problems: Date of Last Exam / /	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Other (please describe): _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Does your child take any medication(s) regularly?	Reason for Medication _____				Parent/Guardian Signature _____ / _____ / _____ Date				<p><b>Birth History:</b></p> <p>Are there any current or past diagnosis(es) <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>If yes, please describe:</p> <p>If yes, list medications:</p> <p>Was the health history reviewed by a health professional? <input type="checkbox"/> Yes <input type="checkbox"/> No Examiner's Initials: _____</p>
Yes	No	Researched	# Is your child having any of the problems listed below?																																																																		
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	1 Allergies or Reactions (for example, food, medication or other)																																																																		
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	2 Hay Fever, Asthma, or Wheezing																																																																		
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	3 Eczema or Frequent Skin Rashes																																																																		
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	4 Convulsions/Seizures																																																																		
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	5 Heart Trouble																																																																		
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	6 Diabetes																																																																		
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	7 Frequent Colds, Sore Throats, Earaches (4 or more per year)																																																																		
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	8 Trouble with Passing Urine or Bowel Movements																																																																		
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	9 Shortness of Breath																																																																		
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	10 Speech Problems																																																																		
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	11 Menstrual Problems																																																																		
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	12 Dental Problems: Date of Last Exam / /																																																																		
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Other (please describe): _____																																																																		
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Does your child take any medication(s) regularly?																																																																		
Reason for Medication _____																																																																					
Parent/Guardian Signature _____ / _____ / _____ Date																																																																					

### 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	No	Yes	Was child tested for:	Test results:	Normal	Referred	Under Care
<input type="checkbox"/>	<input type="checkbox"/>	VISION Date: / /	Visual Acuity Muscle Imbalance Other: _____				<input type="checkbox"/>	<input type="checkbox"/>	HEIGHT & WEIGHT Height Weight Other: _____				
<input type="checkbox"/>	<input type="checkbox"/>	HEARING Date: / /	Audiometer Other: _____				<input type="checkbox"/>	<input type="checkbox"/>	HEMOGLOBIN / HEMATOCRIT BLOOD PRESSURE Reading: _____				
<input type="checkbox"/>	<input type="checkbox"/>	URINALYSIS Date: / /	Sugar Albumin Microscope				<input type="checkbox"/>	<input type="checkbox"/>	TUBERCULIN Date: / / Type: _____ Neg.: <input type="checkbox"/> Pos.: <input type="checkbox"/> _____ mm				
<input type="checkbox"/>	<input type="checkbox"/>	BLOOD LEAD LEVEL Date: / /	Level _____ ug/dl				<p><b>NOTE:</b> 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.</p>						

#### 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		VACCINES (Circle Type)	DATE ADMINISTERED MM/DD/YYYY	
Hepatitis B (HepB)	1	3	Hepatitis A (HepA)	1	2
	2			1	3
DTaP/DTP/DT/Td	1	4	2	4	
	2	5	Meningococcal (MCV4 / MPSV4)	1	2
	3	6		2	
Tdap	1		Human Papillomavirus (HPV9/HPV4/HPV2)	1	3
Haemophilus Influenzae type b (HIB)	1	3	2		
	2	4	OTHER Vaccines Specify Date & Type	Type of Vaccine(s)	Date of Vaccine(s)
1	3	1			
2	4	2			
Pneumococcal Conjugate (PCV7/PCV13)	1	3	3		
	2	4	<i>Indicate and attach physician diagnosis or laboratory evidence of immunity as applicable</i>		
Rotavirus (RV1/RV5)	1	3	*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.		
	2				
Measles, Mumps, Rubella (MMR)	1	2	Parent/Guardian refused immunizations: <input type="checkbox"/>		
Varicella (Chickenpox)	1	2			
History of Chickenpox Disease? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, date:					
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	
<input type="checkbox"/>	<input type="checkbox"/>	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:
<input type="checkbox"/>	<input type="checkbox"/>	Should the child's activity be restricted because of any physical defect or illness? If yes, check and explain degree of restriction(s): <input type="checkbox"/> Classroom <input type="checkbox"/> Playground <input type="checkbox"/> Gymnasium <input type="checkbox"/> Swimming Pool <input type="checkbox"/> Competitive Sports <input type="checkbox"/> 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 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.