FOR YOUTH DEVELOPMENT®
FOR HEALTHY LIVING
FOR SOCIAL RESPONSIBILITY

LEARN, GROW, THRIVE

PARKWOOD YMCA KIDS TIME PRESCHOOL

2021-2022 REGISTRATION

Child's First Name_____ Last_____

Gender _____ Birthdate____/____/____

YMCA Family Membership YES NO

Parent/Guardian 1 _____ Birthdate____/_____/_____

Phone # _____

Parent/Guardian 2 _____ Birthdate____/_____/_____

Phone # _____

Parent/Guardian Email _____

Address _____

City/State _____ Zip_____

What your preferred method of contact? Phone or Email

I am registering my child for:		Classes	Monthly Tuition Member	Non-Member
_____2 days (Tue/TH)	9am-1:00pm	3, 4 year old	$200	$220
_____3 days (M/W/F)	9am-1pm	3, 4, 5 year old	$280	$310
_____5 days (M-F)	9am-1pm	3, 4, 5 year old	$400	$450
_____5 days (M-F)	9am-3:30pm	3, 4, 5 year old	$630	$680

BEFORE AND AFTER CARE WILL BE AVALIABLE FOR FALL 2021! SEE BACK FOR PRICING.

A $100 registration fee is due at the time of registration. This money will be counted towards your first month's payment. Your child is not enrolled or guaranteed a spot until this form/fee are returned.

_____

Staff Use Only

Date of Registration _____ Amount Paid _____ Date of Meeting with Preschool Director_____

Parkwood YMCA – 2306 Haslett Road – East Lansing, MI – 48823

Phone 517-827-9680 mchristensen@ymcaoflansing.org

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PARKWOOD YMCA KIDS TIME PRESCHOOL

2020-2021 BEFORE & AFTER CARE REGISTRATION

Our Before & After Care program is built to help families who need to extend the day. We offer care from 7:30-9:00 and 3:30-5:30.

7:30-9:00 Before Care

____ 3 days $41 per month

____ 5 days $68 per month

3:30-5:30 After Care

___ 3 days $54 per month

___ 5 days $90 per month

Before & After Care

___ 3 days $84 per month

___ 5 days $140 per month

You must be registered for a Preschool class to attend Before & After Care. The first month of Before & After Care must be paid at the time of registration.

_____

Staff Use Only

Date of Registration _____ Amount Paid _____

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Parkwood YMCA Kids Time Preschool
Parent-Preschool Agreement 2021-2022

I have read the Kids Time Preschool Handbook and I agree to abide by all of the terms stated in the handbook while my child or children receives care at the Parkwood YMCA Kids Time Preschool.

I understand that my tuition of $_____ will be paid in advance, on the first day of the month that my child attends. I also understand that should any fee payments fall behind, I may be assessed a late fee. I will pay for my child's enrolled slot even if he/she is not present due to illness, time off or vacation. I will expect to pay a late fee if my child is not picked up on time every day, as stated in the "pick up time" portion of the Parent Handbook.

I understand that should I withdraw my child from the program, I must give two weeks written notice. Fees will be due through the end of the two week period.

Each day upon arrival, I will bring my child into the classroom, sign my child in and let a staff member know that my child is present before leaving.

I understand Kids Time Preschool give priority to full-time positions and if necessary I may be asked to rearrange my part-time schedule to meet current part-time vacancies.

I understand that the Kids Time Preschool is mandated by the child Protection Law (Act#238) and will report to the Department of Human Services any suspected case of child abuse, child sexual abuse, or child neglect.

I have had the opportunity to view or received a copy of the Licensing Rules For Child Care Centers for the State of Michigan.

_____ _____ _____ _____
Parent Signature Date Director Signature Date

_____ _____
Parent Signature Date

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PHOTO/ AUDIO VISUAL/NARRATIVE RELEASE

I am 18 years of age or older and, if not, my Mother/Father/Legal Guardian has also signed below.

My Consent. For my participation in activities to be conducted by the National Council of Young Men's Christian Associations of the United States of America (YMCA of the USA), and/or YMCA OF LANSING YMCA), I give my consent, now and for all time, to YMCA of the USA, YMCA and collaborating third parties to make, reproduce, edit, broadcast or rebroadcast:

- video film or footage of me,
- sound track recordings of me
- photo reproductions of me
- any narrative account of my experience

My consent gives permission to use the above materials for publication, display, sale or exhibition in promotions, advertising, education and legitimate business uses. Use includes reproductions in any form and media, adaptations and/or revisions, throughout the world and forever.

I understand and agree there may be no compensation for this, and I will not make any claim for payment of any kind. I may, or may not be, identified in such reproductions; however, my name will not be used to endorse any particular commercial products or commercial services.

Ownership, Confidentiality, and Shared Use. With respect to any of the above uses, I further agree:

- All uses shall belong to YMCA of the USA and YMCA and either may share them with others;
- There is no obligation of confidentiality
- YMCA of the USA, YMCA, and collaborating third parties will not be liable for any use or disclosure to a third party
- YMCA of the USA and YMCA shall exclusively own all known or later existing rights to the uses worldwide.
- YMCA of the USA and YMCA can use any video film, footage, sound track recordings and photo reproductions of me and/or my narrative account for any purpose and without compensation to me.

Release from Liability. I agree that my consent is irrevocable. I hereby release and discharge YMCA of the USA, YMCA, their related parties and those they have given permission to use the above, from any and all claims, actions, lawsuits or demands of any kind arising out of my consent, the use, or the shared use of the above materials.

Signature: _____ Date: _____

Printed Name: _____ Age: _____

Address: _____

_____

I am the Mother/Father/Legal Guardian of (child's name). For the consideration contained herein, I hereby consent to the foregoing on behalf of my minor child.

Signature of Mother/Father/Legal Guardian: _____

Printed name: _____

Name of Child: _____

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Parkwood YMCA Kids Time Preschool
Credit Card Authorization Form

In filling out this form, you are providing the Parkwood YMCA permission to charge your monthly Preschool payment on the 1st of each month.

Child's Name:_____

Circle Class Time:

TuTh 9am-1:00pm MWF 9am-1pm M-F 9am-1pm

MWF 9a-3:30pm M-F 9am-3:30pm Before Care After Care

Price: _____ per month

Circle Credit card type: Visa MasterCard American Express Discover

Card Number:_____Exp.Date:_____CVV:_____

Cardholder Name:_____

Authorized Signature:_____

FOR STAFF RECORDS:

Month	**Paid**
September	_____
October	_____
November	_____
December	_____
January	_____
February	_____
March	_____
April	_____
May	_____

CHILD INFORMATION RECORD

State of Michigan - Department of Licensing and Regulatory Affairs - Child Care 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

Parent/Legal Guardian's Name	Home Phone ( )	Parent/Legal Guardian's Name (Optional)	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	
Employer Name	Work Phone ( )	Employer Name	Work Phone ( )
Name of Child's Physician or Health Clinic		Physician's or Health Clinic's Phone Number ( )	
Hospital Preferred for Emergency Treatment (optional)			
Allergies, Special Needs and Special Instructions (Attach additional sheets, if necessary.)			

BCAL-3731 (Rev. 7-18) Previous edition 6-17 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.

BCAL-3731 (Rev. 7-18) Previous edition 6-17may be used.

HEALTH APPRAISAL

Dear Parent or Guardian: The following information is requested so that the school can work with the parent to meet the physical, intellectual and emotional needs of the child. Fill out the information requested in Section I. Section III may be certified by the transcription of information from the certificate of immunization. The remaining sections are to be completed by a doctor, nurse and dentist. (**BE SURE TO BRING YOUR CHILD'S IMMUNIZATION RECORDS TO THE EXAMINATION**.)

PERSONAL

CHILD'S NAME (Last, First, Middle)			DATE OF BIRTH (mm/dd/yy) / /
ADDRESS (Number & Street)	(City)	(ZIP Code) MI	TODAY'S DATE (mm/dd/yy) / /
PARENT/GUARDIAN (Last, First, Middle)			HOME TELEPHONE NUMBER ( )
ADDRESS (Number & Street)	(City)	(ZIP Code) MI	WORK TELEPHONE NUMBER ( )

SECTION I - HEALTH HISTORY

Yes	No	Resolved	# Is your child having any of the problems listed below?
☐	☐	☐	1 Allergies or Reactions (for example, food, medication or other)
☐	☐	☐	2 Hay Fever, Asthma, or Wheezing
☐	☐	☐	3 Eczema or Frequent Skin Rashes
☐	☐	☐	4 Convulsions/Seizures
☐	☐	☐	5 Heart Trouble
☐	☐	☐	6 Diabetes
☐	☐	☐	7 Frequent Colds, Sore Throats, Earaches (4 or more per year)
☐	☐	☐	8 Trouble with Passing Urine or Bowel Movements
☐	☐	☐	9 Shortness of Breath
☐	☐	☐	10 Speech Problems
☐	☐	☐	11 Menstrual Problems
☐	☐	☐	12 Dental Problems: Date of Last Exam / /
☐	☐	☐	Other (please describe): _____
☐	☐		Does your child take any medication(s) regularly?
Reason for Medication			

Birth History:

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

If yes, please describe:

If yes, list medications:

_____ / / Was the health history reviewed by a health professional?

Parent/Guardian Signature Date ☐ Yes ☐ No ***Examiner's Initials:*** _____

SECTION II - PHYSICAL EXAMINATION, INSPECTION, TESTS AND MEASUREMENTS

Required for Child Care and Head Start / Early Head Start

Tests and Measurements

No	Yes	Was child tested for:	Test results:	Normal	Referred	Under Care
☐	☐	VISION 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: / /

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? ☐ Yes ☐ 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	
	Type of Vaccine(s)	Date of Vaccine(s)
OTHER Vaccines Specify Date & Type	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: ☐

I certify that the immunization dates are true to the best of my knowledge

_____ _____ ___/___/___

Health Professional's Signature Title Date

SECTION IV - RECOMMENDATIONS

(Required for Child Care and Head Start/Early Head Start)

No	Yes	
☐	☐	Is there any defect of vision, hearing or other condition for which the school could help by seating or other actions? If yes, please explain:
☐	☐	Should the child's activity be restricted because of any physical defect or illness? If yes, check and explain degree of restriction(s): ☐ Classroom ☐ Playground ☐ Gymnasium ☐ Swimming Pool ☐ Competitive Sports ☐ Other

Other Recommendations

SECTION V - DENTAL EXAMINATION AND RECOMMENDATIONS (OPTIONAL)

I have examined _____ '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.