



### YMCA Parkwood Kid's Time Preschool 2023-24 Registration

Name of Child (Last, First)			Gender F    M		Date of Birth
Address (Number and Street, Building/Apartment Number)			City		State    Zip Code
Parent/Legal Guardian's Name		Cell # (required)	Parent/Legal Guardian's Name		Cell # (required)
Parent/Legal Guardian's Date of Birth	Parent/Legal Guardian's Gender F    M		Parent/Legal Guardian's Date of Birth	Parent/Legal Guardian's Gender F    M	
Home Address (if not child's address)			Home Address (if not child's address)		
City	State	Zip Code	City	State	Zip Code
Email Address (required)			Email Address (required)		
Desired Start Date			Anticipated drop-off and pick-up times		

### Enrollment Options

Select one:	Ages and Schedule*		Weekly Rate	Enrollment Fee
	Ages 3 – 4	Mon – Fri, 8:00 a.m. – 5:30 p.m.	\$250	A non-refundable \$100 registration fee is due at the time of registration.  Your child is not enrolled or guaranteed a spot until this form and fee are submitted.
	Ages 4 – 5	Mon – Fri, 8:00 a.m. – 5:30 p.m.		
	Ages 3 – 4	Mon/Wed/Fri, 8:00 a.m. – 1:00 p.m.	\$135	
	Ages 3 – 4	Tue/Thu, 8:00 a.m. – 1:00 p.m.	\$100	
	Ages 4 – 5	Mon/Wed/Fri, 8:00 a.m. – 5:30 p.m.	\$180	
	Ages 4 – 5	Tue/Thu, 8:00 a.m. – 5:30 p.m.	\$125	

\* Schedules may not be altered.

### Credit Card Authorization

In filling out this form, you are providing permission to the YMCA Parkwood Kid's Time Preschool to charge your tuition payment weekly, one week in advance of care.

Circle credit card type:	<b>Visa</b>	<b>MasterCard</b>	<b>American Express</b>	<b>Discover</b>
Card Number:			Exp.Date:	CVV:
Cardholder Name:				
Authorized Signature:				



## YMCA Parkwood Kid’s Time Preschool Agreement 2023-24

Please initial each item and sign/date form

\_\_\_\_\_ I have read the YMCA Parkwood Kid’s Time Preschool Handbook and I agree to abide by all the terms stated in the handbook while my child receives care. The handbook 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.
- Medication policy
- Exclusion policy for child illnesses
- Notice that 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 five 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).

\_\_\_\_\_ I understand that tuition is due weekly, one week in advance of care.

\_\_\_\_\_ I understand that I will be assessed a late payment fee if tuition payments fall behind and a late pick-up fee for any day my child is not picked up on time.

\_\_\_\_\_ I will pay for my child’s enrolled slot even if he/she is not present due to illness, time off or vacation.

\_\_\_\_\_ I understand that I must give two weeks written notice to withdraw my child from the program, and that fees will be due through the end of the two-week period whether or not my child attends.

\_\_\_\_\_ I understand the YMCA Parkwood Kid’s Time Preschool gives priority to full-time enrollment and if necessary I may be asked to rearrange my schedule to meet current vacancies.

\_\_\_\_\_ I understand the YMCA Parkwood Kid’s Time Preschool is mandated to report to the Department of Human Services any suspected case of child abuse or neglect.

### Permissions

\_\_\_\_\_ I give permission to the YMCA Parkwood Kid’s Time Preschool program staff to apply (twice daily prior to outdoor time) sunscreen or bug repellent that I have provided and labeled for my child.

\_\_\_\_\_ I give permission to the YMCA Parkwood Kid’s Time Preschool program staff to apply (as needed) lotion that I have provided and labeled for my child.

\_\_\_\_\_ I give permission to the YMCA Parkwood Kid’s Time Preschool program staff to apply hand sanitizer as needed.

Parent Signature \_\_\_\_\_ Date \_\_\_\_\_

Director Signature \_\_\_\_\_ Date \_\_\_\_\_



## Photo, Audio, Video, and Narrative Release

*Please initial each item and sign/date form*

For my child's 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), I give my consent, now and for all time, to the YMCA and collaborating third parties to make, reproduce, edit, broadcast, or rebroadcast:

- video film or footage of my child
- sound track recordings of my child
- photo reproductions of my child
- any narrative account of my child's 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. My child may or may not be identified in such reproductions; however, my child's name will not be used to endorse any particular commercial products or commercial services.

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 and collaborating third parties will not be liable for any use or disclosure to a third party;
- YMCA shall exclusively own all known or later existing rights to the uses worldwide;
- YMCA can use any video film, footage, sound track recordings and photo reproductions of my child and/or my narrative account for any purpose and without compensation to me.

I agree that my consent is irrevocable. I hereby release and discharge the 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.

Parent Signature \_\_\_\_\_ Date \_\_\_\_\_

Director Signature \_\_\_\_\_ Date \_\_\_\_\_

# 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.

<b>For Provider Use Only:</b>		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		Cell Phone	Parent/Legal Guardian's Name (Optional)		Cell 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 (required)			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    No    If yes, explain:					

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

**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 **Parkwood YMCA Preschool**, 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

## HEALTH APPRAISAL (due within 30 days of enrollment)

**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)	CELL PHONE
ADDRESS (Number & Street) (City) (ZIP Code) MI	WORK TELEPHONE NUMBER

### SECTION I - HEALTH HISTORY (to be completed by parent/guardian)

Yes	No	Resolved	# Is your child having any of the problems listed below?	
			1 Allergies or Reactions (for example, food, medication or other)	<b>Birth History:</b>  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? Yes    No <b>Examiner's Initials:</b> _____
			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	
			_____ <b>Parent/Guardian Signature</b> _____ <b>Date</b>	

### 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	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 Other: _____	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 Microscopic				<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				<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.						

#### 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		Influenza (IIV/LAIV)	1	3
				2	4
DTaP/DTP/DT/Td	1	4	Meningococcal (MCV4 / MPSV4)	1	2
	2	5			
	3	6	Human Papillomavirus (HPV9/HPV4/HPV2)	1	3
Tdap	1			2	
<i>Haemophilus Influenzae</i> type b (HIB)	1	3	OTHER Vaccines Specify Date & Type	Type of Vaccine(s)	Date of Vaccine(s)
	2	4		1	
Polio (IPV/OPV)	1	3		2	
	2	4	3		
Pneumococcal Conjugate (PCV7/PCV13)	1	3	<i>Indicate and attach physician diagnosis or laboratory evidence of immunity as applicable</i>		
	2	4	*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.		
Rotavirus (RV1/RV5)	1	3			
	2		Parent/Guardian refused immunizations: <input type="checkbox"/>		
Measles, Mumps, Rubella (MMR)	1	2			
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					
_____ / _____ / _____ <b>Health Professional's Signature</b>			_____ / _____ / _____ <b>Title</b>		_____ / _____ / _____ <b>Date</b>

**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 \_\_\_\_\_'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.