Learn, Grow, Thrive

2025-26 Registration

Location: ***Oak Park Early Learning (South Lansing)***

Name of Child (Last, First, Middle)				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 M F NB		Parent/Legal Guardian's Date of Birth		Parent/Legal Guardian's Gender M F NB
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 & Rates

Ages	Select	Schedule	Weekly Tuition	Fees
Infant & Toddler (6 weeks to 35 months)		Full-time (4-5 days)	$299	A non-refundable $100/year registration fee is due at the time of registering for the Child Care Program. Your child is not enrolled or guaranteed a spot until this form and fee are returned.
		Part-time (3 days)	$224	
		Part-time (2 days)	$179	
Preschool (36 to 60 months)		Full-time (4-5 days)	$262	
		Part-time (3 days)	$197	
		Part-time (2 days)	$158	
School-age Program (summers, holiday break, spring break; post-kindergarten to age 11)		Full-time (4-5 days)	$236	A non-refundable $50/week registration fee is due at the time of registering for the School-age Program.

Payment Authorization

In filling out this form, you are providing permission to the YMCA of Metropolitan Lansing to charge your tuition payment weekly, one week in advance of care.

Circle credit card type:	**Visa**	**MasterCard**	**American Express**	**Discover**
Card Number:			Exp. Date:	CVV:
Cardholder Name:				
Authorized Signature:				
Circle for Checking or Savings	Bank Account Number:		Routing Number:	

Oak Park YMCA Early Learning Center
900 Long Boulevard | Lansing, MI 48911
www.lansingymca.org/opchildcare | (517) 827-9696

Learn, Grow, Thrive

2025-26 Agreement

Please initial each item and sign/date form

_____ I have read the Family 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.

_____ 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 they are 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 of Metropolitan Lansing's centers 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 of Metropolitan Lansing's centers are mandated to report to the Department of Health & Human Services any suspected case of child abuse or neglect.

Permissions

_____ I give permission to the YMCA of Metropolitan Lansing's center program staff to apply (twice daily prior to outdoor time) **sunscreen or bug repellant** that I have provided and labeled for my child.

_____ I give permission to the YMCA of Metropolitan Lansing's center program staff to apply (as needed) **lotion** that I have provided and labeled for my child.

_____ I give permission to the YMCA of Metropolitan Lansing's center program staff to apply **hand sanitizer** as needed.

_____ I give permission for my child (aged three years and older) to participate in **swimming activities**. I understand that I will be notified in advance to provide appropriate swimwear. I understand that the YMCA will assess each child's swimming ability prior to participation. I understand that non-swimmers and children under three years old will be engaged in supervised non-swimming activities away from the immediate swimming activity area during swim-time.

Parent Signature _____ Date _____

Director Signature _____ Date _____

Learn, Grow, Thrive

2025-26 Photo/Media Consent and Release

Taking photographs of children at school is a common method of documenting their activities and development. Classroom staff at the YMCA of Metropolitan Lansing's centers are trained to be discerning when photographing children, giving thought to its necessity and purpose in such documentation.

Classroom staff are prohibited from using their personal cell phones and other electronic devices for photographing or recording children's activities. Any photos of children must be taken using only YMCA-issued devices, which are accessible only to center personnel.

Photographs and video of children are intended for educational and communication purposes only. Photographs of an individual child may be shared with that child's family only. Photographs may be displayed in the classroom, especially to indicate allergies to new staff. Group photographs are sometimes used on the YMCA of Metropolitan Lansing's centers' *private* social media page(s) to convey activities and development, but they are not made public.

On rare occasions, the YMCA of the USA seeks photographs from its association members of people and programs, including children. The YMCA of Metropolitan Lansing's centers will release to the YMCA of the USA only photographs of children whose family has given explicit consent on this form.

Please initial only those items to which you consent:

_____ I understand that photographs will be taken of my child by staff at the YMCA of Metropolitan Lansing's centers to document his/her activities and development.

_____ I give permission to the YMCA of Metropolitan Lansing's centers to use my child's photograph within the classroom.

_____ I give permission to the YMCA of Metropolitan Lansing's centers to use my child's photograph on the center's private social media page(s).

_____ I give permission to the YMCA of Metropolitan Lansing's centers to release my child's photograph to the YMCA of the USA for their exhibition in promotions, advertising, education, and legitimate business uses. Such 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.

Parent Signature _____ Date _____

Director Signature _____ Date _____

Learn, Grow, Thrive

Family Structure and Child Development

The purpose of this questionnaire is to give the teaching staff a better understanding of your child and family. All information is confidential.

GENERAL INFORMATION

Child's legal name_____ Nickname _____ DOB_____

Race/ethnicity_____ Nationality _____ Religion_____

Person providing this information:_____ Relationship to child_____

Is child your: □ biological child □ adopted child □ foster child □ other:_____

FAMILY STRUCTURE & LIVING SITUATION

Father's Name_____ Occupation_____ Highest education: _____

Mother's Name_____ Occupation_____ Highest education: _____

Guardian's Name_____ Occupation_____ Highest education: _____

With whom does child live *at least half* the time? (Check all that apply)

□ both parents in the same home □ mother's home □ father's home
□ other's home (specify) _____

List all people living in household (indicate which household if child lives in multiple homes):

Name	Age	Relationship to child	Which home? (Leave blank if N/A)

Any pets? (Indicate type, name, household)_____

Language(s) spoken at home _____ Primary language at home _____

List all locations (city, state, and/or country) that your child has lived:

1. Birthplace _____ Moved at age _____
2. _____ Moved at age _____
3. _____ Moved at age _____

Are parents of child currently:

□ unmarried, living together
□ married
□ separated
□ divorced
□ never married, not living together

If separated, divorced, or never married and not living together, who has *legal* custody?

□ mother □ father □ both
□ other (specify): _____

If separated or divorced, how do you feel your child has adjusted to separation/divorce?

_____

Is anyone else authorized to share/receive information about the child? □ Yes □ No If so, please indicate name & relationship (i.e., step-parent, grandparent, etc.)

_____

SOCIAL-EMOTIONAL DEVELOPMENT

Has your child had previous experience with a fulltime babysitter/nanny, child care home/center, or other care outside your home?
□ Yes □ No If so, when, with whom, and how often?

Have there been any significant changes in the home over the last few years? (i.e., new marriages, deaths, births, address changes, family separation/divorce, parent dating, money problems, etc.)

What do you feel are your child's…
Strengths_____ Weaknesses_____

Reaction to strangers: _____ Able to play alone? _____

How much time each day does your child typically spend on the following electronic media?
Watching TV: _____ Playing video/computer/phone games: _____ Other_____

Does anyone read aloud to your child at home? □ Yes □ No If so, how often? _____

At what age did your child begin playing with other children? _____

What are your child's favorite activities? _____

Is your child affectionate? _____

Does your child celebrate holidays or special occasions? _____

Are there occasions in which you would rather your child not participate? _____

What are the things your child seems to fear? _____

Has your child had any frightening experiences? If so, describe briefly:

What is the method of behavior management/discipline at home?

HEALTH AND DEVELOPMENT

Any known complications at birth? _____

Serious illnesses and/or hospitalizations:_____

Special physical conditions, disabilities: _____

Is your child currently taking any medication? □ Yes □ No If yes, please list medication and uses:

Has your child ever been identified as having a disability? □ Yes □ No If so, by whom, what age, & what disability?

Has your child ever received psychological counseling? □ Yes □ No If yes, by whom (professional/ agency) and when:

During your child's first few years of life, were any of the following significantly present?

- ☐ Difficult to comfort
- ☐ Was not easily calmed by being held or stroked
- ☐ Colicky
- □ Difficult nursing
- □ Poor eye contact
- □ Did not respond to their name

- ☐ Excessive irritability
- ☐ Diminished sleep
- ☐ Fascination with certain objects
- ☐ Constantly head banging

If you checked any of the above, please describe

_____

PARENTING

Which adult would your child prefer to talk with about a problem? _____

Who is the family member with whom your child feels closest? _____

Who is primarily responsible for discipline at home? _____

What is the most effective way to deal with your child's behavior problems at home?

_____

How does your child respond to discipline at home?

_____

List any responsibilities your child has at home: _____
Does your child do these regularly? ☐ Yes ☐ No
Does your child need frequent reminders? ☐ Yes ☐ No

SLEEPING HABITS

Indicate your child's… Bed time? _____ Wake time? _____ Do they sleep well? _____

Does your child sleep in a… ☐ Crib? ☐ Bed? ☐ Other? _____

Does your child sleep *in a room* alone? ☐ Yes ☐ No If not, with whom do they share?

_____

Does your child sleep *in a bed* alone? ☐ Yes ☐ No If not, with whom and how often?

_____

Does your child become tired or nap during the day (include when and how long)?

_____

Describe any special characteristics or needs (stuffed animal, story, mood on waking, etc.)

_____

How does your child fall asleep? (Check all that apply)
- ☐ Rocking chair
- ☐ Laying with someone
- ☐ On their own
- ☐ Other _____

EATING HABITS & NUTRITION

Is your child usually hungry at mealtime? ☐ Yes ☐ No Between meals? ☐ Yes ☐ No

Is your child able to eat with a…
Spoon? ☐ Yes ☐ No
Fork? ☐ Yes ☐ No

Hands? □ Yes □ No

At home, what time does your child eat breakfast? _____ Lunch? _____ Dinner? _____

Favorite foods: _____

Foods refused: _____

Eating problems or difficulties: _____

List foods your child may not eat: _____

TOILETING HABITS

Has toilet learning been attempted? □ Yes □ No

How does your child indicate toileting needs (include special words):

_____

Please describe any particular toileting procedure(s) to be used for your child at the center:

_____

What is used at home?

Pottychair? □ Yes □ No
Special child seat? □ Yes □ No
Regular seat? □ Yes □ No

Is your child ever reluctant to use the toilet? □ Yes □ No If yes, what are the circumstances?

_____

Does your child have accidents? □ Yes □ No If yes, what are the circumstances?

_____

Are bowel movements regular? □ Yes □ No How many per day? _____

Is there a problem with diarrhea? □ Yes □ No If yes, what are the circumstances?

_____

Is there a problem with constipation? □ Yes □ No If yes, what are the circumstances?

_____

ADDITIONAL INFORMATION

Please provide us with any additional information that will help us care for your child.

Food Program Enrollment

The Lansing YMCA child care centers offer healthy meals to all enrolled participants as part of our participation in the U.S. Department of Agriculture's (USDA) **Child and Adult Care Food Program (CACFP)**. The CACFP provides reimbursements for healthy meals and snacks served to participants enrolled in care. Please help us comply with the requirements of the CACFP by completing the attached Household Income Eligibility Statement (HIES). In addition, by filling out this form, we will be able to determine eligibility for free or reduced-price meals.

1. **Do I need to fill out a HIES for each participant enrolled in care?** You may complete and submit one CACFP Household Income Eligibility Statement for all participants enrolled in day care in your household only if those in day care are enrolled in the same center. We cannot approve a form that is not complete, so be sure to read the instructions carefully and fill out all required information. Return the completed form to the Program Director.
2. **Which adult and childcare institutions can receive free meal reimbursement without providing household income information?** Adults receiving Medicaid, Supplemental Security Income (SSI), Food Assistance Program (FAP) Family Independence Program (FIP), or Food Distribution Program on Indian Reservations (FDPIR) are eligible for free meals. Children in households receiving FAP, FIP, or FDPIR can get free meals. Foster children and children enrolled in Head Start Programs are also eligible for free meals.
3. **Who can get reduced price meals?** You may get low-cost meals if your household's income is within the reduced-price limits on the federal income eligibility guidelines, **effective July 1, 2024, until June 30, 2025**, shown below:

Family Size	Yearly Income	Monthly Income	Weekly Income
1	$27,861	$2,322	$536
2	$37,814	$3,152	$728
3	$47,767	$3,981	$919
4	$57,720	$4,810	$1,110
For each additional family member add:	$9,953	$830	$192

Refer to the Instructions for Participants/Parents/Guardians Household Income Eligibility Statement on how to complete the HIES. Find the category that most closely defines your household and follow the directions for completing each part of the HIES. If your household income is greater than the levels shown on the above CACFP income guidelines, it is not necessary for you to complete the HIES form.

Families with Children: Your family may be eligible to receive health insurance, called MIChild, through the State of Michigan. MIChild is a health insurance program for uninsured children of Michigan's working families. To determine if your family is eligible, call 1-888-988-6300 for an application or access an online application at the MI Child website (www.michigan.gov/michild). You can also access the MIChild brochure that briefly explains the insurance program.

Your family may be eligible to receive Women, Infants & Children (WIC), a health and nutrition program, that has demonstrated a positive effect on pregnancy outcomes, child growth and development. To determine eligibility, call 1-800-26-BIRTH or access online information at Women, Infants, & Children (WIC) website (http://www.michigan.gov/wic) to learn about WIC and locate a local WIC agency.

4. **May I fill out a form if someone in my household is not a U.S. citizen?** Yes. Participants and family members do not have to be U.S. citizens to qualify for meal benefits offered at the center.
5. **Who should I include as members of my household?** You must include all people in your household (such as grandparents, other relatives, or friends who live with you). You must include yourself and all children who live with you. You also may include foster children who live with you.
6. **How do I report income information and changes in employment status?** The income you report must be the total gross income listed by source for each household member and the frequency the income is received. If recent income does not accurately reflect your circumstances, you may provide a projection of your income. If no significant change has occurred, you may use last month's income as a basis to make this projection. If your household's income is equal to or less than the amounts indicated for your household's size on the federal income eligibility guidelines listed above, the family day care home will receive a higher level of reimbursement. Once properly approved for the higher reimbursement rate, whether through income or by providing a current FAP, FIP, FDPIR case number, or listing the name of other categorically eligible programs, you will remain eligible for those benefits for 12 months. You should, however, notify us if you or someone in your household becomes unemployed and the loss of income unemployment causes your household income to be within the eligibility standards.
7. **What if my income is not always the same?** List the amount that you normally receive. For example, if you normally receive $1,000 every two weeks, but you missed some work in the last two weeks and only received $900, put down that you receive $1,000 per every two weeks. If you normally receive overtime, include it, but not if you only receive it sometimes.
8. **What if I have foster children?** Foster children that are under the legal responsibility of a foster care agency or court are eligible for free meals. Any foster child in the household is eligible for free meals regardless of income. Households may include foster children on the HIES but are not required to include payments received for the foster child as income.
9. **We are in the military. Do we include our housing and supplemental allowances as income?** If your housing is part of the Military Housing Privatization Initiative and you receive the Family Subsistence Supplemental Allowance, do not include these allowances as income. Also, regarding deployed service members, only that portion of a deployed service member's income made available by them or on their behalf to the household will be counted as income to the household. Combat Pay, including Deployment Extension Incentive Pay (DEIP), is also excluded and will not be counted as income to the household. All other allowances must be included in your gross income. In the operation of child feeding programs, the U.S. Department of Agriculture prohibits discrimination against its customers, employees, and applicants for employment on the bases of race, color, national origin, age, disability, sex, gender identity, religion, reprisal, and where applicable, political beliefs, marital status, familial or parental status, sexual orientation, or all or part of an individual's income is derived

from any public assistance program or protected genetic information in employment or in any program or activity conducted or funded by the Department. (Not all prohibited bases will apply to all programs and/or employment activities.)

Food Program Enrollment Form

Instructions:

- List full name of participant enrolled in care.
- Circle the typical days each participant is in care.
- List times each participant is in care.
- Circle the meals and snacks each participant typically receives while in care.
- Select the ethnicity of each participant using the codes indicated.*
- Select one or more racial designations of each participant using the codes indicated.*
- Sign and date the form and return to the Program Director.

Child's First & Last Name	Typical Days in Care (circle all that apply)	Times in Care	Meals/Snacks Received (circle all that apply)	Ethnicity* H = Hispanic or Latino N = Not Hispanic or Latino	Race* A/I = American Indian or Alaskan Native A = Asian B = Black or African American H/PI = Native Hawaiian or Pacific Islander W = White
	Mon Tues Wed Thu Fri	7:30 a.m. – 5:30 p.m.	Breakfast Lunch PM Snack		
	Mon Tues Wed Thu Fri	7:30 a.m. – 5:30 p.m.	Breakfast Lunch PM Snack		
	Mon Tues Wed Thu Fri	7:30 a.m. – 5:30 p.m.	Breakfast Lunch PM Snack		
	Mon Tues Wed Thu Fri	7:30 a.m. – 5:30 p.m.	Breakfast Lunch PM Snack		

** This information is voluntary. This will assist us in assuring the Child and Adult Care Food Program is administered in a nondiscriminatory manner.*

Parent/Guardian Signature _____ Date Signed _____

USDA Nondiscrimination Statement: In accordance with federal civil rights law and U.S. Department of Agriculture (USDA) civil rights regulations and policies, this institution is prohibited from discriminating on the basis of race, color, national origin, sex (including gender identity and sexual orientation), disability, age, or reprisal or retaliation for prior civil rights activity. Program information may be made available in languages other than English. Persons with disabilities who require alternative means of communication to obtain program information (e.g., Braille, large print, audiotape, American Sign Language), should contact the responsible state or local agency that administers the program or USDA's TARGET Center at (202) 720-2600 (voice and TTY) or contact USDA through the Federal Relay Service at (800) 877-8339. To file a program discrimination complaint, a Complainant should complete a Form AD-3027, USDA Program Discrimination Complaint Form which can be obtained online at: USDA Program Discrimination Complaint Form, from any USDA office, by calling (866) 632-9992, or by writing a letter addressed to USDA. The letter must contain the complainant's name, address, telephone number, and a written description of the alleged discriminatory action in sufficient detail to inform the Assistant Secretary for Civil Rights (ASCR) about the nature and date of an alleged civil rights violation. The completed AD-3027 form or letter must be submitted to USDA by:

- mail: U.S. Department of Agriculture, Office of the Assistant Secretary for Civil Rights, 1400 Independence Avenue, SW, Washington, D.C. 20250-9410; or
- fax: (833) 256-1665 or (202) 690-7442; or
- email: program.intake@usda.gov.

This institution is an equal opportunity provider.

USDA Civil Rights Complaint Link:

https://www.usda.gov/sites/default/files/documents/USDA-OASCR%20P-Complaint-Form-0508-0002-508-11-28-17Fax2Mail.pdf

Learn, Grow, Thrive

Household Income Eligibility Statement – Child Care Institutions

Part 1 – Households Receiving Food Assistance Program (FAP), Family Independence Program (FIP), or Food Distribution Program on Indian Reservations (FDPIR)
If any member of your household receives FAP, FIP, or FDPIR, provide the name and case number for the person who receives the benefits.

Name:_____ **Case Number:** _____

Part 2 – Household Information

First and Last Names of All Household Members, Related and Unrelated	Enrolled for Child Care (x)	Age	Birth Date	Foster Child (x)	Amount of Earnings from Work (before deductions)	How Often? (x)					Amount of Welfare, Child Support, or Alimony	How Often? (x)					Amount of All Other Income (Indicate source and amount)	How Often? (x)					Mark if No Income (x)
						Annually	Monthly	2x Month	Bi-Weekly	Weekly		Annually	Monthly	2x Month	Bi-Weekly	Weekly		Annually	Monthly	2x Month	Bi-Weekly	Weekly	

Part 3 – All Households: Signature and Last Four (4) Digits of Adult Social Security Number (Adult household member MUST sign and date)

I certify that all information on this form is true and that all income is reported. I understand that the center or day care home will receive federal funds based on the information I give. I understand that CACFP officials may verify the information. I understand that if I purposely give false information, the participant receiving meals may lose the meal benefits, and I may be prosecuted.

Signature:_____ Print Name:_____ Date:_____

Last four digits of Social Security Number: XXX-XX-_ _ _ _ ____I do not have a Social Security Number

For Institution Use Only:

For Institution Use Only			
Total Household Members:	Total Income: $ ___ Annually ___ Monthly ___ 2x Month ___ Bi-Weekly ___ Weekly		APPROVED CATEGORY Categorical Eligibility (A/Free): Foster FIP FAP FDPIR Other Household Children: A (Free) B (Reduced) C (Paid)
Institution Official Signature: _____ Approval Date: _____			

This form is valid for 12 months from the date of institution signature. Approval date and institution signature are required.

Privacy Act Statement: The Richard B. Russell National School Lunch Act requires the information on this application. You do not have to give the information, but if you do not, we cannot approve the participant for free or reduced-price meals. You must include the last four digits of the Social Security Number of the adult household member who signs the application. The Social Security Number is not required when you apply on behalf of a foster child or you list a Food Assistance Program (FAP), Family Independence Program (FIP), or Food Distribution Program on Indian Reservations (FDPIR) case number for the participant or other FDPIR identifier or when you indicate that the adult household member signing the application does not have a Social Security Number. We will use your information to determine if the participant is eligible for free or reduced-price meals, and for administration and enforcement of the Program.

the YMCA

Oak Park YMCA Early Learning Center
900 Long Boulevard | Lansing, MI 48911
www.lansingymca.org/opchildcare | (517) 827-9696

Learn, Grow, Thrive

Household Income Eligibility Statement - Instructions for Parents/Participants/Guardians

If you are applying for foster child(ren) only, follow these instructions:

- **Part 1:** Do not complete.
- **Part 2:** List name, age, and birth date of foster child(ren); check the box for foster child.
- **Part 3:** Sign and date the form. The last four digits of a social security number are not necessary.

If your household receives Food Assistance Program (FAP), Family Independence Program (FIP), or Food Distribution Program on Indian Reservations (FDPIR) benefits, follow these instructions:

- **Part 1:** List the name and case number for any household member (including adults) receiving FAP, FIP, or FDPIR.
- **Part 2:** List the name, age, and birth date for all children enrolled in day care.
- **Part 3:** Sign and date the form. A Social Security Number is not necessary.

Note: *Benefits received under WIC, Medicaid, or Department of Health and Human Services (DHHS) Child Care Assistance Program (where DHHS pays a portion of your child care expense) does not automatically qualify for Category A (free) meals.*

All other households, including households where some of the children are foster children, follow these instructions (not required if household is over the income limits and don't have any foster children):

- **Part 1:** Do not complete.
- **Part 2:** List the names and ages of everyone (related or not related) living in your household, including you, other adults and children (If you need more space, use a separate sheet of paper).
    - Place a ✓ in the column for all children enrolled in child care List household members' ages and dates of birth.
    - Place a ✓ in the next column if children in the household are foster children.
    - If no case number is indicated in Part 1, list (by person) the amount and source of income received last month. List monthly earnings **before** deductions, monthly welfare, child support or alimony or any other income including retirement, Social Security, Supplemental Security Income (SSI), Veteran's (VA) benefits, disability benefits, Worker's Compensation, unemployment, strike benefits, regular contributions of people who do not live in your household or any other income.
    - Place a ✓ in the box for those listed who do not have income.
    - If you are in the Military Housing Privatization Initiative or receive Combat Pay, do not include the housing allowance as income.
    - Foster child payments received by the family from the placement agency are not considered income and do not have to be reported. The presence of a foster child in a family does not make all children in the household automatically eligible for free meals.
    - If you are a farmer or self-employed, monthly income is gross farm or business income received in the month prior to application minus farm or business expenses. Gross wages from other jobs or income from other sources must also be listed as income. A loss from self-employment must be listed as zero income and cannot reduce other income.
- **Part 3**: Sign and date the form and list the last four digits of your Social Security Number or check the box indicating "I do not have a Social Security Number."

Help With Income To determine annualized income:

- If paid every week, multiply the total gross income by 52.
- If paid every two weeks, multiply the total gross income by 26.
- If paid once a month, use the total gross monthly income.
- If paid twice a month, multiply the total gross income by 24.
- If paid once a year, use the total gross yearly income.

Return the completed application to the Program Director.

MDHHS-3305, HEALTH APPRAISAL

Michigan Department of Health and Human Services (MDHHS)
(Revised 7-24)

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 1. Section 4 may be certified by the transcription of information from the certificate of immunization. The remaining sections are to be completed by a doctor, nurse, dentist, dental therapist, and dental hygienist.

(BE SURE TO BRING YOUR CHILD'S IMMUNIZATION RECORDS TO THE EXAMINATION).

SECTION 1 – PERSONAL

Child's Name (Last, First, Middle)	Date of Birth (mm/dd/yy)
Address (Number, Street, City, Zip Code)	Today's Date (mm/dd/yy)
Parent/Guardian (Last, First, Middle)	Home/Cell Phone Number
Address (Number, Street, City, Zip Code)	Work Phone Number

SECTION 2 – HEALTH HISTORY

Yes	No	Resolved	Is your child having any of the problems listed below?	Birth History
☐	☐	☐	1. Allergies or Reactions (for example, food, medication or other)	
☐	☐	☐	2. Anaphylaxis	
☐	☐	☐	3. Does your child take any medication(s) regularly?	If yes, list medications
☐	☐	☐	4. Hay Fever, Asthma, or Wheezing	
☐	☐	☐	5. Eczema or Frequent Skin Rashes	
☐	☐	☐	6. Convulsions/Seizures	
☐	☐	☐	7. Heart Trouble	
☐	☐	☐	8. Diabetes	
☐	☐	☐	9. Frequent Colds, Sore Throats, Earaches (4 or more per year)	Are there any current or past diagnosis(es) ☐ Yes ☐ No
☐	☐	☐	10. Trouble with Passing Urine or Bowel Movements	If yes, describe

☐	☐	☐	11. Shortness of Breath	
☐	☐	☐	12. Speech Problems	
☐	☐	☐	13. Menstrual Problems	
☐	☐	☐	14. Dental Problems Date of Last Exam OR Date of Last Assessment	
☐	☐	☐	15. Other (describe)	

Reason for Medication

Concussion History

Parent/Guardian Signature Date

Was the health history reviewed by a health professional? Examiner's Initials

☐ Yes ☐ No

SECTION 3 - PHYSICAL EXAMINATION, INSPECTION, TESTS AND MEASUREMENTS

Required for Child Care and Head Start / Early Head Start

Test and Measurements

Yes	No	Was child test for	Tests and results	Normal	Referred	Under Care
☐	☐	Vision	Visual Acuity	☐	☐	☐
		Date	Muscle Imbalance	☐	☐	☐
			Other	☐	☐	☐
☐	☐	Hearing	☐ Audiometer (R= Right, L=Left)			
		Date	☐ OAE (R= Right, L=Left)			
			☐ Other (R= Right, L=Left)			
☐	☐	Urinalysis	Sugar	☐	☐	☐
			Albumin	☐	☐	☐
			Microscopic	☐	☐	☐
☐	☐	Blood Lead Level	Level ug/dl	☐	☐	☐
		Date				

Note: All children in Medicaid need to be tested at 1 and 2 years of age, or once between 3 and 6 years of age if not previously tested. All children, regardless of Medicaid status, should be tested at those same ages if they live in an area where lead risk is high.

☐	☐	Height & Weight	Height	☐	☐	☐
			Weight	☐	☐	☐
☐	☐	Other	Other	☐	☐	☐
☐	☐	Hemoglobin/Hematocrit	⇨	☐	☐	☐
☐	☐	Blood Pressure	Reading	☐	☐	☐

Complete pediatric tuberculosis risk assessment available at:
https://www.michigan.gov/documents/mdhhs/4._MI_Pediatric_TB_Risk_Assessment_661537_7.pdf **OR** feel free to use the attached QR code instead of the full link text.

Examinations and/or Inspections

Essential Findings Deviating from Normal — Exam Date

SECTION 4 – IMMUNIZATIONS

Statements such as "UP-TO-DATE" or "COMPLETE" will not be accepted. Admission to school may be denied based on this information.*****

Vaccines (Select Type)	Date Administered (mm/dd/yy)		
Hepatitis B (HepB)	1.	2.	3.
	4.		
DTaP/DTP/DT/Td	1.	2.	3.
	4.	5.	6.
Tdap	1.		
Haemophilus Influenzae type b (HIB)	1.	2.	3.
	4.		
Polio (IPV/OPV)	1.	2.	3.
	4.	5.	
Pneumococcal Conjugate (PCV)	1.	2.	3.
	4.		
Rotavirus (RV1/RV5)	1.	2.	3.
Measles, Mumps, Rubella (MMR/MMRV)	1.	2.	3.
Varicella (Chickenpox), (Var, MMRV)	1.	2.	
Hepatitis A (HepA)	1.	2.	3.

Influenza	1.	2.	3.
(IIV/LAIV)	4.		
Meningococcal (MCV4, MenABCWY)	1.	2.	3.
Meningococcal B (Bexsero, Trumenba, MenABCWY)	1.	2.	3.
Human Papillomavirus (HPV)	1.	2.	3.

Additional Vaccines Specify Date & Type

Type of Vaccine(s)	Date of Vaccine(s)
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.

History of Chickenpox Disease? If yes, date

☐ Yes ☐ No

☐ Parent/Guardian refused recommended immunizations at visit.

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

Health Professional Signature Title Date

SECTION 5 - RECOMMENDATIONS (Required for Child Care and Head Start/Early Head Start)

Is there any defect of vision, hearing, or other condition for which the school could help by seating or other actions?

☐ Yes ☐ No

If yes, explain

Should the child's activity be restricted because of any physical defect or illness?

☐ Yes ☐ No

Check all that apply

☐ Classroom ☐ Playground ☐ Gymnasium

☐ Swimming Pool ☐ Competitive Sports ☐ Other

If yes, explain degree of restriction(s)

Other Recommendations

SECTION 6 - DENTAL EXAM OR ASSESSMENT RECOMMENDATIONS

Child's Name

Type of Service
☐ Dental Exam ☐ Dental Assessment

Findings (Check all that apply)
☐ No findings ☐ Treated Decay ☐ Untreated Decay

Recommendations (Check one)
☐ Routine Care
☐ Referral for dental treatment
☐ Referral for urgent dental care

Provider Signature | Date

Check one
☐ Dentist ☐ Dental Therapist ☐ Dental Hygienist

SECTION 7 - PHYSICIAN'S SIGNATURE

Examiner's Name (Print) | Degree or License | Telephone Number

Examiner's Signature | Date

Address | City | State **MI** | Zip Code

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 preventative and primary health care, including medical, dental, and mental health. The schedule must incorporate the well-childcare 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.

CHILD INFORMATION RECORD

State of Michigan - Department of Lifelong Education, Learning, and Potential - 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	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 (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? No ☐ Yes ☐ If yes, explain: (Attach additional sheets, if necessary.)	

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.**	**( )**
5.	**( )**	**6.**	**( )**

Parent/Legal Guardian Initials:

_____I give permission to _**YMCA of Metropolitan Lansing**_____, licensed by the Department of Lifelong Education, Advancement, and Potential, 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