



## ENROLLMENT FORM

**Select One:** Explorers (Ages 1 - 3.5 years)  
3.5 -5)

OR

Adventurers (Ages

**Child's First Name:** \_\_\_\_\_

**Child's Last Name:** \_\_\_\_\_

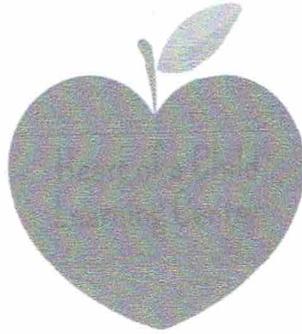
**Male**      **Female**      **Birth Date:** \_\_\_\_\_

**Address:** \_\_\_\_\_

**City:** \_\_\_\_\_ **Zip:** \_\_\_\_\_

Parent / Guardian 1	Parent / Guardian 2
First Name:	First Name:
Last Name:	Last Name:
Street Address:	Street Address:
City, State, Zip	City, State, Zip
Personal #	Personal #
Employer:	Employer:
Work #	Work #
Email:	Email:

**Emergency Contact Name & Phone:** \_\_\_\_\_



### **Parent Handbook Acknowledgment of Receipt**

Please read this handbook carefully and refer any questions you may have to your Center Director.

After you have read this handbook, please complete this acknowledgment, and return it to your Center Director on or before your child's first day.

I have read and fully understand the guidelines and procedures set forth in the Family Handbook.

I have a copy of this handbook for my personal reference.

**Primary Parent or Guardian Full Name (please print)**

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**Child Name(s) (please print)**

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**Primary Parent/Guardian Signature**

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**Date**

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## Policies & Procedures Statement

I have read the Parent Handbook for Heart of a Child Learning Center's programs. I fully understand the stated policies and procedures and agree to follow the policies and procedures stated in the Parent Handbook.

\_\_\_\_ I have read the Parent Handbook for Heart of a Child Learning Center's programs. I fully understand the stated policies and procedures and agree to follow the policies and procedures stated in the Parent Handbook.

### Select One:

\_\_\_\_ I agree to pay my tuition of \$\_\_\_\_ by the 1st of every month on a monthly basis. I understand a late fee of \$50 will be charged for payments received after the 2nd of the month. My tuition will be based on the fees of the program I am enrolled in. I understand tuition may increase yearly. I understand that tuition will be automatically deducted from my bank/card account on file. I understand that if the payment I have on file declines that the NSF fee will be charged to my account.

\_\_\_\_ I agree to pay my tuition of \$625 on the 1st and 15th of every month on a bi-monthly basis. I understand a late fee of \$50 will be charged for payments received after the 2nd and 16th of the month. My tuition will be based on the fees of the program I am enrolled in. I understand tuition may increase yearly. I understand that tuition will be automatically deducted from my bank/card account on file. I understand that if the payment I have on file declines that the NSF fee will be charged to my account.

\_\_\_\_ I agree to provide a 30-day notice to Heart of a Child Learning Center prior to withdrawing my child. If a 30-day notice is not given, I understand that I will be responsible for paying the tuition for that period."

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

Printed Name: \_\_\_\_\_

Date: \_\_\_\_\_



### Common Medications Consent

Student Name \_\_\_\_\_ Program \_\_\_\_\_

Sunscreen, lotions, chapstick and diaper cream are not available at Heart of a Child Learning Center. These must be sent in by a parent/guardian with this signed consent form in order for us to administer this non-prescription medication to your child.

Please list the brand name and expiration date of each item you'll be sending with your student. If you do not wish to provide one of these items, no initials are required. Sunscreen is required during the spring/summer instruction.

Category	Brand Name	Expiration Date	Parent Initials
Sunscreen			
Lotion			
Chapstick			
Diaper Cream			

I hereby give my permission to Berkley Building Blocks school personnel designated by Heart of a Child Learning Center to give the above mentioned non-prescriptions medications/creams to my child. I further agree to hold Heart of a Child Learning Center and all employees harmless in any and all claims arising from the administration of this non-prescription medication in school.

I agree to notify Heart of a Child Learning Center in writing at the termination of this request or when any change in the above is necessary.

Signature of Parent/Guardian \_\_\_\_\_

Printed Name: \_\_\_\_\_

Date: \_\_\_\_\_

# 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.

<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		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.



**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			3	
DTaP/DTP/DT/Td	1	4	Influenza (IIV/LAIV)	1	3
	2	5		2	4
	3	6	Meningococcal (MCV4 / MPSV4)	1	2
Tdap	1		Human Papillomavirus (HPV9/HPV4/HPV2)	1	3
Haemophilus Influenzae type b (HIB)	1	3		2	
Polio (IPV/OPV)	1	3	OTHER Vaccines Specify Date & Type	Type of Vaccine(s)	Date of Vaccine(s)
	2	4		1	
Pneumococcal Conjugate (PCV7/PCV13)	1	3		2	
Rotavirus (RV1/RV5)	1	3	3		
	2				
Measles, Mumps, Rubella (MMR)	1	2	<i>Indicate and attach physician diagnosis or laboratory evidence of immunity as applicable</i>		
Varicella (Chickenpox)	1	2	*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? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, date:			Parent/Guardian refused immunizations: <input type="checkbox"/>		

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 \_\_\_\_\_'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

\_\_\_\_\_ 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.