MONTESSORI children's center

SHOWING LOVE THE MONTESSORI WAY

Family Application & Contract

Child Information Record

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

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

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.**	**( )**

Emergency Treatment Release

Parent/Legal Guardian Initials:

_____I give permission to _ Montessori Children's Center _, 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.

Family Information

E-mail address: _____

Relationship to Child:_____

If divorced, who has legal custody?

_____

May the non-custodial parent pick up the child? Yes No
(Court documentation must be on file if answer is no)

Please list siblings and all other people that live in the home:

Name_____Relationship to Child_____Age_

Name_____Relationship to Child_____Age_

Name_____Relationship to Child_____Age_

Name_____Relationship to Child_____Age____

Enrollment Session

School year 20___- 20___

APPLICATION FEE $300 due with contract to reserve enrollment.

___By checking I authorize the above registration fee to be charged through kangarootime.

___The registration fee has already been paid or will be paid by cash/check upon submission of this contract.

Program Schedule

Start Date _____ Please select classroom age group at start date:

___Infants: 0 to 18 months **5-days**

___Toddlers: 18 mo. - 30 mo. **5-days**

___Pre-Primary 30 mo. - 4 yrs. **2, 3 or 5 days**

_____ Tues / Thurs _____ Mon / Wed / Fri _____ 5-days

___Primary: 3yrs. - 6 yrs. and toilet independent **SCHOOL DAY ONLY 8am - 3pm**

___Tues / Thurs ___Mon / Wed / Fri _____ 5-day

___Primary 3 yrs. - 6 yrs. and toilet independent **FULL DAY 7am - 6 pm**

____Tues / Thurs _____Mon / Wed / Fri _____ 5-day

___Kindergarten

____**FULL DAY 7am - 6 pm** _____ **SCHOOL DAY ONLY 8am - 3pm**

____ **SCHOOL-AGE (3 YRS – 12 YRS) SUMMER CAMP JUNE – AUGUST**

Current Tuition Rates Are Attached

Food Program Information

Please circle all meals that your child will receive (if schedule varies throughout the week, circle every meal that may apply during the week)

Breakfast AM Snack Lunch PM Snack

Please circle the ethnicity of your child:

Hispanic or Latino Not Hispanic or Latino

Please circle one or more racial designations:

American Indian or Alaskan Native / Asian / Black or African American / Native Hawaiian or Pacific Islander / White

*You are not required to select ethnicity or racial designations for your child. If this information is not selected, we will report ethnicity and/or racial designation based on observation.

Emergency Authorization

☐ I hereby authorize the staff and director representing the center to give consent for all necessary emergency medical and First Aid care to include transportation, if needed, for my child while he/she is in the center's custody.

☐ I acknowledge that this center cannot be held liable in any way for accidents that occur on or off premises while my child is under this center's care.

School-Age Health Statement **(if in public school system)**

___ My child, _____, is in good physical condition and has no health concerns which would limit normal participation in the regular program of the center.

___ My child, _____, has a condition which would limit normal participation in the regular program of the center. (Please submit explanation and relevant medical documentation

Additional Forms **(if not in public school system)**

___ I agree to provide a current Health Appraisal for my child who is not yet enrolled in public school.

___ I agree to provide an up-to-date immunization record at the time of enrollment (if child is not in the Michigan Immunization System.

Field Trips

I give my permission for my child to leave Montessori Children's Center premises with Montessori Children's Center staff for program activities within walking distance, as planned by the center staff. I understand that I will be notified by email and posted notice prior to field trips.

Pesticide Policy

If pesticide treatment becomes necessary, notification (written notice and posted notice) will be given to parents in advance of treatment including the reason for treatment, the location, date and type of treatment.

Licensing Rules

- This center maintains a licensing notebook of all licensing inspection reports, special investigation reports and all related corrective action plans, and it is available to parents for review.

- Licensing inspection and special investigation reports from at least the last two years are available at Michigan.gov/michildcare.

☐ I have read the above statement issued by Montessori Children's Center.

Photography

Permission (is / is not) given for photography for publicity purposes to be used in print promotions, email, or use on the company's web site including social media sites.

Lotions / Baby Wipes

I give the center permission to apply the selected items to my child in accordance with the directions on the label of the container:

☐ Baby wipes
☐ Band-Aids
☐ Sunscreen
☐ Insect Repellant
☐ Non-prescription ointment (such as A&D ointment, Vaseline)
☐ Other (please specify) _____

Enrollment & financial policies

I agree to electronic withdrawal of tuition fees on the first day of each month. I am aware that I will be charged a fee for unsuccessful tuition withdrawal.

I am aware that I will be charge a fee for late pick-ups.

I have received the Parent Handbook, containing additional policies and procedures

I understand that current rates are subject to change.

I am aware that there are no refunds of tuition. If for any reason I choose to withdraw from Montessori Children's Center, a two-week written notice is required. I will be obligated to pay a termination fee, which is equal to one full month of tuition from the last day of attendance. Once the termination fee is paid, the remainder of the tuition contract will be voided. If I do not submit the withdrawal to the director, or if I do not submit the termination fee, the contract will not be voided, and I will be obligated to pay tuition until the contract ends.

I am aware that the center is within its rights to collect any unpaid tuition, fees and collection or court costs associated with collection of these charges.

Full form Signature

I have read this document and agree to abide by the statements within.

Parent signature_____ **Date** _____

Montessori Children's Center

Kangarootime Payment Authorization Form

Note: a 3% charge is added to all DEBIT and CREDIT cards.

Credit Card Authorization

I (we) hereby authorize Montessori Children's Center to initiate recurring credit card charges to the below referenced credit card account. To properly affect the cancellation of the agreement, I (we) are required to give 14 days written notice.

- ☐ Visa
- ☐ Mastercard

Cardholder Name_____

Phone _____

Cardholder Address

_____

_____

Account Number _____ Exp. Date _____

Cardholder Signature _____

CSV _____ Date _____

Bank Authorization

I (we) hereby authorize Montessori Children's Center to initiate debit entries to my (our) Checking or Savings Account indicated below. To properly affect the cancellation of the agreement, I (we) am required to give 14 days written notice. (Credit union members, please contact credit union to verify account and routing numbers for automatic payment)

Your Name_____

Phone _____

Cardholder Address

_____

_____

Bank Name _____

Bank Address _____

Routing Transit # _____ Account #_____

- ☐ Checking Account
- ☐ Savings Account

Signature _____Date _____

Complete and return signed form by email to Jared@NilesKids.Com OR fax to 269-683-0411

Montessori Children's Center | 1000 Miners Road, St. Joseph, MI 49085 | (269) 256-4456

Return this completed form to: ***(Insert institution's name, address & telephone number)***

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) Annually	Monthly	2 x Month	Bi-Weekly	Weekly	Amount of Welfare, Child Support, or Alimony	How Often? (x) Annually	Monthly	2 x Month	Bi-Weekly	Weekly	Amount of All Other Income (Indicate source and amount)	How Often? (x) Annually	Monthly	2 x Month	Bi-Weekly	Weekly	Mark if No Income (x)

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.

Non-Discrimination Statement
In accordance with Federal civil rights law and U.S. Department of Agriculture (USDA) civil rights regulations and policies, the USDA, its Agencies, offices, and employees, and institutions participating in or administering USDA programs are prohibited from discriminating based on race, color, national origin, sex, disability, age, or reprisal or retaliation for prior civil rights activity in any program or activity conducted or funded by USDA.

Persons with disabilities who require alternative means of communication for program information (e.g. Braille, large print, audiotape, American Sign Language, etc.), should contact the Agency (State or local) where they applied for benefits. Individuals who are deaf, hard of hearing or have speech disabilities may contact USDA through the Federal Relay Service at 800-877-8339. Additionally, program information may be made available in languages other than English.

To file a program complaint of discrimination, complete the USDA Program Discrimination Complaint Form, (AD-3027) (http://www.ascr.usda.gov/complaint_filing_cust.html) online, and at any USDA office, or write a letter addressed to USDA and provide in the letter all of the information requested in the form. To request a copy of the complaint form, call 866-632-9992. Submit your completed form or letter to USDA by: (1) mail: U.S. Department of Agriculture, Office of the Assistant Secretary for Civil Rights, 1400 Independence Avenue, SW, Washington, D.C. 20250-9410; (2) fax: 202-690-7442; or (3) email: program.intake@usda.gov. This institution is an equal opportunity provider.

MICHIGAN Department of Education
Rev 6/2020

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:

_____ / /
Parent/Guardian Signature Date

Was the health history reviewed by a health professional?
□ Yes □ No ***Examiner's Initials:*** _____

SECTION II - PHYSICAL EXAMINATION, INSPECTION, TESTS AND MEASUREMENTS. Required

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 (Hep B)	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

VACCINES (Circle Type)	DATE ADMINISTERED MM/DD/YYYY	
Hepatitis A (Hep A)	1	2
Influenza (TIV/LAIV)	1	3
	2	4
Meningococcal (MCV4 / MPSV4)	1	2
Human Papillomavirus (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 child's school or local health department.

History of Chickenpox Disease? □ Yes □ No If yes, date:

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 _____ (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.

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Developed in Cooperation with the Departments of Human Services, Education, Community Health, 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.

Montessori Children's Center | 1000 Miners Road, St. Joseph, MI 49085 | (269) 256-4456

Montessori Children's Center

210 Main Street, Niles, MI 49120 (269) 683-0405

Dear Parents,
Please complete these questions so we can help your child through the orientation process and begin adjusting our class curriculum to reflect things that are important to your child and special about your family. If you are uncomfortable with any of the questions you do not have to answer them, but the questions on this form are asked solely for the purpose of improving your child's experience with us. Feel free to use the back of the form if you need more room to write. Thank you for allowing us to share in helping your child grow in every area!

Name of child _____Male _____Female _____
What does your child prefer to be called? _____Date of birth _____
What email address would you like us to use for daily updates? _____
Mother's name _____Father's name _____
Child resides with: Mother _____ Father _____ Both _____ Other _____

Siblings Names Ages (Please list in birth order)
1. _____
2. _____
3. _____
4. _____
5. _____

Language(s) spoken at home: English _____ Other _____

Child's Preferences

Please list your child's favorite:
Foods:_____
Songs: _____
Books: _____
Videos: _____
Toy: _____
Inside Activity: _____
Outdoor Activity: _____

If my child has trouble falling asleep I usually

_____

_____

My child is afraid of

_____

Child's Personality

1. How would you describe your child's personality? _____

2. What are some of the things your child likes to do in his/her spare time? _____

Family History

1. What family activities or hobbies does your child particularly enjoy? _____

2. Which family member(s) is your child particularly close to? Please describe: ___

3. What responsibilities does your child have now? _____

4. Have there been any major changes in your child's life that may be affecting or have affected your child's growth or development? (death, divorce, serious illness, etc.) _____

3. Please list a brief history of care/school arrangements for your child from birth to present: (babysitting, family care, nursery school, preschool, day care, day camp, etc.)

Age _____ arrangement _____
Age _____ arrangement _____
Age _____ arrangement _____
Age _____ arrangement _____