WRITTEN INFORMATION PACKET DOCUMENTATION

Michigan Department of Licensing and Regulatory Affairs
Bureau of Community and Health Systems

Child(ren)'s Name(s) (Last, First)	Center Name

A written infonnation packet has been provided at the time of enrollment. The packet included all the following information:

- 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, illnesses.
- Exclusion policy for child illnesses.
- Notice of the availability o□the center's licensing notebook.

  o The licensing noteboo contains all the licensing inspection and special investigabon reports and related corrective action plans since May 28. 2010.

  o The licensing noteboo is available to parents during regular business hours.

  o Licensing inspection and special investigation reports from at least the past two years are available on the child care licensing website at **www.michigan.gov/michildcare.**

- Other _____

1 certify that I received all of the above items.

_____ _____

Parent/Guardian Signature Date

Note: A single BCAL-4340 from may be used for children in the same family

LARA is an equal opportunity employer/program.

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 information is not known or does not apply, "unknown" or "none " is 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 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	Phone Work	Employer Name		Phone Work
Name of Child's Physician or Health Clinic		Physician or Health Clinic's Phone		
Hospital Preferred for Emergency Treatment (optional)				
Allergies, Special Needs and /or Special Instructions? Attach additional sheets, if necessary.) YES NO If yes, explain:				

CCL-3731 (Rev. 3/17/2022) Previous edttions 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 ontacted 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.)

	Phone 1	Phone 2
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.)

	Phone		Phone
1		2	
3		4	

Parent/Legal Guardian initials:

_____ I give permission to _____ licensed by the Department Licensing and regulatory affairs to secure emergency medical treatment for the above named minor child while in care.

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.

PARENT NOTIFICATION OF THE LICENSING NOTEBOOK

Child Care Organizations Act, 1973 Public Act 116

Michigan Department of Licensing and Regulatory Affairs

All child care centers must maintain a licensing nootebook which includes all licensing inspections reports , special investigation reports and all related corrective action plans (CAP). The notebook must include all reports issued and CAPs developed on and after May 27, 2010 until the license is closed.

- This center maintains a licensing notebook of all licensing inspection reports, special investigation reports and all related corrective action plans.
- The notebook will be available to parents for review during regular business hours .
- Licensing inspection and special investigation reports from at least the past two years are available on the Bureau of Community and Health Systems website at **www.michigan.gov/michildcare.**

I have read the above statement issued by _____
Name of Child Care Center

Child(ren)'s Name(s) _____

Parent Name _____

Parent Signature _____ Date _____

LARA is an equal opportunity employer/program.

DHS Co-pay Agreement

Co-Pays are assessed because OHS does not necessarily pay the total amount of your child care in accordance to our rates. Also, co-pays are dependant upon the number of hours your child is in care.

Though the Department of Human Services (DHS) informs you that they wil I pay for your childcare, please understand that there are factors that will not fully cover your child/ren tuition.

For instance:

A. For all children 2 ½ and under: If DHS authorizes your childcare for 90 units at l 00% then your childcare will be covered providing you use all of your hours and you will not have a "Co-Pay."

B. For all children 2 ½ and under: If DHS authorizes your childcare for anything less than 90 units (such as 75 units) then a "Co-Pay" amount will be assessed in accordance to the number of hours your child is in care.

C. For all children 2 ½ and over who receive authorization for 90 units at any percentage then there will be a Co-Pay assessed.

Absence and Ill/Sick Holidays

DHS authorizes **Twenty-Six** Absence and Ill/Sick days per fiscal year which is from **October 1, 2019-October 1, 2020. Eleven** of those days are considered holidays that the Center is closed and will use to receive payment. The other **Fifteen days** are for your child/ren Absence and Ill/Sick days. Once all your days have been used then any days you take off wi II not be covered and therefore you will be responsible for payment.

By signing this agreement you understand that any Co-Pay's assessed in accordance to your child/ren care at Child Star Development Center, you will be responsible for.

Parent Signature _____ Date _____

CHILD STAR DEVELOPMENT CENTER CONTRACT

The following is a legally binding agreement between Child Star Development Center and _____

I understand that Tuition payments and DHS Co-Payments are due on Monday no later than Tuesday by 12:00pm of each current week.

I understand that to hold my child's space I am responsible for tuition payments regardless of my child/ren attendance due to illness, vacations, public holidays, and emergency closings.

I understand that I am responsible for the full amount of tuition, if care is offered at least 3 days.

DHS CO-PAYMENTS: Upon enrollment parents receiving DHS assistance will be responsible for payment at a Part-Time rate until DHS authorization of benefits is received. Any monies paid that exceed benefit(s) amount will be refunded.

NOTE: Parents are responsible for all co-payments DHS does not cover.

I understand that I will be subject to a fee of $10 per child beyond the pick-up time and that after 6 PM there will be a $5 per minute late fee.

I also understand that if I miss a co-pay or tuition payment for 2 weeks consecutively my child will not be admitted to school the following Monday and if my account is habitually in arrears collection procedures will follow as prescribed by law.

I understand that failure to comply with the regulations of Child Star Development Center may result in the disenrollment of my child.

Parent Signature _____ Date _____

****Please sign and return this sheet along with your child's registration pack and daycare agreement.**

Child Star Development Center

Let it be known that I _____ have read and do acknowledge al I of the rules and regulations as stated in the Child Star Development Center Parent Handbook. I agree to uphold Child Star's Mission Statement and all of the Policies & Procedures of the center.

CHILD STAR DEVELOPMENT CENTER

TOPICAL MEDICATION FORM

Dear Parents,

All medications, whether prescription or nonprescription shall be given or applied only with prior permission from you, the parent

This form is to verify that Child Star Development Center caregivers have my permission to apply nonprescription medication, including but not limited to, sunscreen, vasel ine, insect repellant, and/ or diaper rash ointment to my child as needed. I understand that this form is updated annually.

I will supply all ointments.

_____ _____

Parent Signature Date

PHOTO CONSENT FORM

I _____ with a mailing address of

_____ city of _____

Michigan _____ (the "Releaser") grant permission and give my consent to Child Star Development Center Inc (the "Releaser") for the use of the following photograph(s) or electronic media images as identified below for presentation under any legal use.

Children in action for advertisement purposes only

Revocation (check one)

☐ I understand that with my authorization below thephotograph(s) may never be revoked.

☐ I understand that i may revoke this authorization at anytime by notifying Child Star Development Center Inc in writing. The revocation will not effect any actions taken before the receipt of this written notification. Images will be stored in a secure location and only authorized staff will have access to them. They will be kept as long as they are relevant and after that time destroyed or archived.

_____ _____

Releaser's Signature Date

_____ _____

Releasee's Signature Date

Return this completed from to: (Child Star Development Center 10430 W. 7 Rd. Detroit , Mi 48221, 313 -862 4730)

Household Income Eligibilty 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**

Firs and Last Names of All Household Members, Related or Unrelated	Enrolled for Child Care (X)	Age	Birth Date	Foster Child (X)	Amount Of Earnings From Work (Before Deductions	How Often? (X) Annually	Monthly	2XMonth	Biweekly	Weekly	Amount of Welfares Child Support or Alimony	How Often? (X) Annually	Monthly	2XMonth	Biweekly	Weekly	Amount of All Other Income (Indicate source and amount)	How Often? (X) Annually	Monthly	2XMonth	Biweekly	Weekly	Mark If No Income X

PART 3 **All Household: Signatures and Last Four 4 Digits of Adult Social Security Number** (Adult household member must sign and date)
I cerify that all the information on this form is true and that all income is reported. I Understand that the center of day care will receive the federal funds based on the information I give. r 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:** _____

For Institution Use Only

	For Institution Use Only	
Total Household Mempers:	Total Income: $ ____ Annully ____ Monthly ____ 2 x Month ____ Bi weekly ____ Weekly	APPROVED CATEGORY Categorical Eligibility (A/Free): Foster FlP 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. ihe 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: proqram.i ntake@usda.gov. This institution is an equal opportunity provider.

Return this completed from to: (Child Star Development Center 10430 W. 7 Rd. Detroit , Mi 48221, 313 -862 4730)

Participant Enrollment Form

Instructions:

1. List full name of participant enrolled in care
2. Circle the typical days each participant is in care
3. List times each participant is in care
4. Circle the meals and snacks each participant typically receives while in care
5. Select the ethnicity of each participant using the following codes: H = Hispanic or Latino, N = Not Hispanic or Latino*
6. Select one or more racial designations of each participant using the following codes: A/I = American Indian or Alaskan Native, A = Asian, B = Black or African American, H/PI = Native Hawaiian or Pacific Islander, W = White*
7. Sign and date the form and return to your care center

Participant's First and Last Name	Typical Days In Care (circle all that apply)	List Times In Care	Meals/Snacks Received (circle all that apply)	Ethnicity	Race
	MON TUE WED THU FRI SAT SUN		Breakfast AM Snack Lunch PM Snack Supper Evening Snack		
	MON TUE WED THU FRI SAT SUN		Breakfast AM Snack Lunch PM Snack Supper Evening Snack		
	MON TUE WED THU FRI SAT SUN		Breakfast AM Snack Lunch PM Snack Supper Evening Snack		
	MON TUE WED THU FRI SAT SUN		Breakfast AM Snack Lunch PM Snack Supper Evening Snack		

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

Adult/Parent/Guardian's Address

Adult/Parent/Guardian's Phone Number

Signature of Adult/Parent/Guardian

Date Signed

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. Brallle, 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 disablilties may contact USDA through the Federal Relay Service at (800) 877-8339. Additionally, program Information may be made available In languages other than Engllsh.

To file a program complaint of discrimination, complete the USDA Program Discrimination Complaint Form, (AD-3027) (http://www.ascr.usda.gov/complaint_fillng_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) mall: 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.lntake@usda.gov. This institution is an equal opportunity provider.

SECTION III - PHYSICAL EXAMINATION, INSPECTION, TESTS, AND MEASUREMENTS

EXAMINATIONS AND/OR INSPECTIONS

ESSENTIAL FINDINGS DEVIATING FROM NORMAL AND/OR RECOMMENDATIONS

TEST AND MEASUREMENTS

	Normal	Under Care	Refered		Normal	Under Care	Refered
Vision Tested? YES NO Date _____ Visual activity Ocular Muscle Other_____				Urinalysis Done? YES NO Date _____ Sugar Albumin Microscopic			
Hearing Tested? YES NO Date _____ Audiometer Other_____				Blood Presure Measured? YES NO Reading _____			
Hemoglobin/Hemotocrit Tested? YES NO				Hight _____ Weight _____ Other _____			
Blood Lead Level Tested? YES NO Date _____ Reading _____				Blood Lead level recommended for all children age six and under			

ESSENTIAL FINDINGS DEVIATING FROM NORMAL ANO/OR RECOMMENDATIONS

Tuberculin Test (if given) Date _____ Type _____ Negative Positive _____mm

SECTION IV-RECOMMENDATIONS

Is there any defect of vision, hearing or other condition for which the school could help by seating or other action? if Yes please explain ☐ YES ☐ NO
Should the students's activity be restricted because of any physical defect or illness? YES NO If yes , Check below and explian degree of restriction Classrom Playground Gynmasium Swimming Pool Competitive Sports Camp Other

Examiner's Signature	Date	Examiner's Name (Print or Type	Degree or License
Number and street	City	Zip	Telephone

SECTION V- DENTAL EXAMINATION AND RECOMMENDATIONS OPTIONAL

I have examined _____ teeth and make the following recommendations for treatment
Child Name

Doctor's Signature Date

COMMENTS

Developed in Cooperation With
Department of Human Services
Department of Community Health, and Education
Michigan State of Medical Society
Michigan Association of Osteopathic Physicians and Surgeons

HEALTH APPRAISAL

School
Children's Group
Child Care Center
Child Caring Institution
Other _____

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

PERSONAL

Child's Name _____ Sex _____ Date of Birth _____
Last First Middle

Address _____ Today's Date _____
Number and Street City Zip

Parent's or Guardian's Name _____ Telephone Home _____
Last First Middle

Address _____ Telephone Work _____
Number and Street City Zip

SECTION I- HEALTH HISTORY

Is your child having any of the problem listed below	YES	NO
1: Allergies or reactions (for example food medication or others		
2: Hay Fever , asthma or wheezing		
3: Eczema or frequent skin rashes		
4: Convulsions / Seizures		
5: Heart trouble		
6: Diabetes		
7: Frequent cold, sore throats, earaches (4 or more per year)		
8: Trouble with passing urine or bowl movements		
9: Shortness or breath		
10: Speach problem		
11: Menstrual problem		
12: Dental problem. Date of last examination?		
13: Other		

Please explain any problem areas identified above

Does your Child take any medication regularly? YES NO

If yes, what medication? _____

Reason of medication? _____

Parent's Signature _____

Statements such as *UPTO DATE* or * COMPLETE* will not be accepted. Admission to school may be denied on the basis of this information

VACCINE	Type	Mo/Day/Yr	Type	Mo/Day/Yr
DTaP/DTP/Td (Specify type)		1		6
		2		7
		3		8
		4		9
		5		10
Haemophilus Influenzae type b (HIB)		1		3
		2		4
POLIO IPV/OPV (Specify type)		1		4
		2		5
		3		
NOTE: If measles, Rubella or Mumps vaccines were given before 12 months of age, the dosage must be repeated				
MMR		1		2
Varicella (Chickenpox)		1		2
Chickenpox History of disease	YES	NO	Date	
Hepatitis B HBV		1		3
		2		
Pneumococcal Conjugate (PCV)		1		3
		2		4
Other Vaccines				
Indicate physician diagnosis or laboratory evidence of immunity as applicable				

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

Validating Signature: Tittle Date