



45201 N. Territorial Rd.
Plymouth, MI. 48170
(734) 254-0054

Child Placement/Registration

Child's Name: _____ Name for Cubby tag: _____ Date of Birth: _____

Parents/Guardians: _____ Siblings/Ages: _____

Address: _____ City: _____ Zip: _____

Email address: _____ Phone: _____

Permission to list your address/phone in the class directory? Yes: ___ No: ___ Cell: _____

ALLERGIES OR SPECIAL CIRCUMSTANCES OF YOUR CHILD: _____

I/We _____ agree to enroll our child _____ in The Learning Express Preschool, licensed by the State of Michigan. I/we understand that our registration fee of \$79 is non-refundable. I/we request to enroll our child in the following program:

___ 3's Morning (9:15-11:30 am) ___ 4's Morning (9:15-12 noon) ___ Young 5's Morning (9:00-1:00 pm)
___ 3's Afternoon (12:15-2:30 pm) ___ 4's Afternoon (12:45-3:30pm)

I/we agree to pay the Provider the following applicable monthly rate on the first of each month (August - May):

___ 3's Program Rate of \$145/mo. ___ 4's Program Rate of \$185/mo. ___ 5's Program five day rate of \$309/mo.

I/we also agree to pay any late or returned check fees. I/we understand that classes run from September – May for a period of 32 weeks. (Tuition is only calculated for the weeks in session and is divided into 10 equal payments for the lowest monthly cost. Tuition payments begin August 1st and end May 1st.

Any refund of prepaid and unused tuition can be obtained with a 30 day written notice. I/we agree to give the Provider a 30 day written notice in the event of enrollment drop or pay a penalty of one month's tuition as reasonable compensation.

I/we understand that Provider can terminate enrollment without notice if child's continued participation in the program creates a direct threat to the safety of other students, staff, or if tuition is more than 30 days past due.

I/we acknowledge that Provider will only release our child to those persons authorized on the Child Information Record or if the parent/guardian has sent a written, signed and dated note stating the emergency and who the child may be released to.

(continued on the other side)

This contract constitutes the entire agreement among the parties to it and supersedes any prior understandings or agreements. Each party acknowledges and states that no representation, inducement or condition not set forth in the contract has been made or relied upon by either party. The laws of the State of Michigan govern this agreement

Upon signing this agreement, The Learning Express Preschool (Provider) agrees to (at a minimum) abide by the following provisions of the Michigan Administrative Code:

R400.5106 Program Rule 106

- 1) A center must implement a developmentally appropriate program which shall include all of the following areas:
 - a) Physical development, including large and small muscle activities.
 - b) Social development, including communication skills.
 - c) Emotional development, including positive self-concept.
 - d) Intellectual development
- 2) The center shall provide the following activities daily:
 - a) Quiet and active
 - b) Individual, small and large group
 - c) Large and small muscle
 - d) Child initiated and staff initiated
 - e) Not less than 30 minutes of developmentally appropriate emergent literacy activities
- 3) The center shall prepare for the week a daily guide relating to the program for each age group. The center shall post the guide in a conspicuous place or otherwise make available to parents.
- 4) A center shall permit the parents to visit the program for the purpose of observing their children at all times.
- 5) A center operating with children in attendance for 5 or more continuous hours per day shall provide for outdoor play, unless prevented by inclement weather conditions.
- 6) A center shall provide each child under school age in attendance for 5 or more continuous hours a an opportunity to rest.
- 7) A center shall provide children less than 3 years of age with an opportunity to rest, regardless of the number of hours in care.

R400.5102 License Rule 102

- 2) A licensee shall have the following administrative responsibilities regarding staff:
 - b) Develop and implement a written screening policy for all staff and volunteers, including parents who have contact with children.

Parent/Guardian Signature

Date Signed

CHILD INFORMATION RECORD

State of Michigan Department of Human Services - Bureau of Children and Adult 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
Father/Legal Guardian's Name	Home Phone ()	Mother/Legal Guardian's Name		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
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 Special Instructions (Attach additional sheets, if necessary.)				

BCAL-3731 (Rev. 7-12) Previous editions 9-09, 3-08, 10-07, & 1-06 may be used until 12/31/13.

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.	()

I give permission to _____, licensed by the Department of Human Services <div style="text-align: center; font-size: small;">(Provider's Name)</div>	
to secure emergency medical and/or emergency surgical 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
Department of Human Services (DHS) will not discriminate against any individual or group because of race, religion, age, national origin, color, height, weight, marital status, sex, sexual orientation, gender identity or expression, political beliefs or disability. If you need help with reading, writing, hearing, etc., under the Americans with Disabilities Act, you are invited to make your needs known to a DHS office in your area.						AUTHORITY: 1973 PA 116 COMPLETION: Required PENALTY: Rule Violation Citation.	

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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)	TODAY'S DATE (mm/dd/yy) / /
PARENT/GUARDIAN (Last, First, Middle)			HOME TELEPHONE NUMBER ()
ADDRESS (Number & Street)	(City)	(ZIP Code)	WORK TELEPHONE NUMBER ()

SECTION I - HEALTH HISTORY

Yes	No	Resolved	# Is your child having any of the problems listed below?	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	1 Allergies or Reactions (for example, food, medication or other)	Birth History: Are there any current or past diagnosis(es) <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, please describe: If yes, list medications: Was the health history reviewed by a health professional? <input type="checkbox"/> Yes <input type="checkbox"/> No Examiner's Initials: _____
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	2 Hay Fever, Asthma, or Wheezing	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	3 Exzema or Frequent Skin Rashes	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	4 Convulsions/Seizures	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	5 Heart Trouble	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	6 Diabetes	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	7 Frequent Colds, Sore Throats, Earaches (4 or more per year)	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	8 Trouble with Passing Urine or Bowel Movements	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	9 Shortness of Breath	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	10 Speech Problems	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	11 Menstrual Problems	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	12 Dental Problems: Date of Last Exam / /	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Other (please describe): _____	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Does your child take any medication(s) regularly?	
			Reason for Medication	
			_____ / /	
			Parent/Guardian Signature _____ Date _____	

SECTION II - PHYSICAL EXAMINATION, INSPECTION, TESTS AND MEASUREMENTS

Required for Child Care and Head Start / Early Head Start

Tests and Measurements

No	Yes	Was child tested for:	Test results:	Normal	Referred	Under Care	No	Yes	Was child tested for:	Test results:	Normal	Referred	Under Care
<input type="checkbox"/>	<input type="checkbox"/>	VISION Date: ___/___/___	Visual Acuity Muscle Imbalance Other: _____				<input type="checkbox"/>	<input type="checkbox"/>	HEIGHT & WEIGHT Other: _____	Height Weight Other: _____			
<input type="checkbox"/>	<input type="checkbox"/>	HEARING Date: ___/___/___	Audiometer Other: _____				<input type="checkbox"/>	<input type="checkbox"/>	HEMOGLOBIN / HEMATOCRIT BLOOD PRESSURE	➡ Reading: _____			
<input type="checkbox"/>	<input type="checkbox"/>	URINALYSIS Date: ___/___/___	Sugar Albumin Microscopic				<input type="checkbox"/>	<input type="checkbox"/>	TUBERCULIN Date: ___/___/___	Type: _____ Neg.: <input type="checkbox"/> Pos.: <input type="checkbox"/> _____ mm			
<input type="checkbox"/>	<input type="checkbox"/>	BLOOD LEAD LEVEL Date: ___/___/___	Level _____ ug/dl				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		VACCINES (Circle Type)	DATE ADMINISTERED MM/DD/YYYY	
Hepatitis B (Hep B)	1	3	Hepatitis A (Hep A)	1	2
	2			2	3
DTaP/DTP/DT/Td	1	4	Influenza TIV/LAIV	1	3
	2	5		2	4
	3	6			
Tdap	1		Meningococcal MCV4 / MPSV4	1	2
Haemophilus Influenzae type b (HIB)	1	3	Human Papillomavirus (HVP4/HPV2)	1	2
	2	4		2	3
Polio - IPV / OPV	1	3	OTHER Vaccines Specify Date & Type	Type of Vaccine(s)	Date of Vaccine(s)
	2	4		1	
				2	
Pneumococcal Conjugate (PCV7/PCV13)	1	3	3		
	2	4			
Rotavirus (RV1/RV5)	1	3	<i>Indicate and attach physician diagnosis or laboratory evidence of immunity as applicable</i>		
	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 child's school or local health department.		
Measles, Mumps, Rubella (MMR)	1	2	Parent/Guardian refused immunizations: <input type="checkbox"/>		
	2				
Varicella (Chickenpox)	1	2			
History of Chickenpox Disease? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, date: _____					
I certify that the immunization dates are true to the best of my knowledge					
_____			_____		____/____/____
<i>Health Professional's Signature</i>			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: _____

child's name

_____ / _____ / _____

Dentist's Signature Date

PHYSICIAN'S SIGNATURE

_____ / _____ / _____

Examiner's Signature Date *Examiner's Name (Print or Type)* Degree or License

_____ MI _____ (____) _____

Number & Street City ZIP Code Telephone

Information required for:

Early On - Hearing and Vision Status; Diagnosis; Health Status

Child Care Licensing - Physical Exam, Restrictions, Immunizations

Head Start/Early Head Start - Determination that child is up-to-date on a schedule of age-appropriate preventive and primary health care, including medical, dental, and mental health. The schedule must incorporate the schedule of well-child care 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 and regular intervals based on age.

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.