COMMUNITY
Learning Center
a division of Comstock Community Center

Welcome to the Community Learning Center,

Please completely fill out the enrollment packet.

**Before your child may attend we need the following items completed:**

- **Registration form for each child enrolling.**
- **Registration fee for each child (amount is noted on the registration form)**
- **Completed child information record**
- **A copy of your child's immunization record.**
- **Health appraisal form (not required for school age program). The health appraisal form must be completed by a physician.** Your doctor's office may complete the form per the last well child checkup and fax it to us at (269) 492-0909. If you need to schedule an appointment and are unable to schedule a doctor's appointment before the date of enrollment please inform the Director, when your appointment is scheduled.

We look forward to having your child(ren) in our program. If you have any questions please call the Community Learning Center at 345-7243 and we will be happy to assist you.

Thank you,

Child Care Director
Chazlyn Flint

Assistant Program Director
Monica Markillie

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Revised 8/9/2022

# Toddler Care (12-24 months)
# 2023-2024 Registration Form

Please complete and turn into the CLC in person, by fax (269-492-0909) or by email ( CLCinfo2@comstockcc.com ).

## *Child's Information*

_____ _____ _____
Child's Name Today's Date Start Date

_____ _____ Gender: M ☐ F ☐
Child's Birth Date Age

Special Considerations (health, allergies, developmental, etc.):

_____

_____

_____

## *Parent/Guardian Information*

| | |
|---|---|
| _____ | _____ |
| Parent/Guardian #1 | Parent/Guardian #2 |
| _____ | _____ |
| Address | Address |
| _____ | _____ |
| City State Zip | City State Zip |
| _____ | _____ |
| Primary Phone Number (i.e. Home, Cell etc.) | Primary Phone Number (i.e. Home, Cell etc.) |
| _____ | _____ |
| Secondary Phone Number (i.e. Cell, Work etc.) | Secondary Phone Number (i.e. Cell, Work etc.) |
| _____ | _____ |
| Email | Email |
| _____ | _____ |
| Driver's License Number | Driver's License Number |

Billing address (circle one): Parent/Guardian #1 Parent/Guardian #2

## *Tuition & Billing Information*

Bills for weekly tuition will be available on childcare software every week. Invoice balances are due within 5 days of receipt, as represented on the billing statement. Bi-weekly and monthly payment arrangements can be made as requested.

Multiple child and military discounts are available. DHHS clients are responsible for co-pay. Tuition rates are subject to change. You will be notified of any changes. Please see the Family Handbook for additional information.

**A non-refundable registration fee of $65 tuition is required at time of application. This fee will not include any discount that you may qualify for.**

| Toddler Care (12 months -24 months) | 3 Half Days | 3 Full Days | 4 Half Days | 4 Full Days | 5 Half Days | 5 Full Days |
|---|---|---|---|---|---|---|
| Weekly Tuition | $139 | $209 | $167 | $252 | $201 | $312 |

## *Hours of Operation & Schedule Request*

The CLC operates year-round 6:45am-5:30pm

Please indicate the **days and times** you would like your child enrolled. Schedule changes can be requested by filling out a change of billing form available at reception or contacting the Director at (269) 345-7243.

| | *Drop off time:* | *Pick up time:* |
|---|---|---|
| *Monday:* | *In at* _____ | *Out at* _____ |
| *Tuesday:* | *In at* _____ | *Out at* _____ |
| *Wednesday:* | *In at* _____ | *Out at* _____ |
| *Thursday:* | *In at* _____ | *Out at* _____ |
| *Friday:* | *In at* _____ | *Out at* _____ |

## *Parent/Guardian Agreement*

I hereby enroll my child in the CLC's Toddler Care program and agree to pay the tuition indicated above for the schedule I have chosen for my child. I agree to read the CLC Parent Handbook in its entirety and abide by the policies, requirements and procedures stated therein. I further assert that my child is in good health and accept responsibility for my child's health.

| _____ | _____ | _____ |
|---|---|---|
| Parent/Guardian #1 Name (Print) | Parent/Guardian #1 Signature | Date |
| _____ | _____ | _____ |
| Parent/Guardian #2 Name (Print) | Parent/Guardian #2 Signature | Date |

**For Office Use Only**

Registration Fee Paid _____ Applied for DHHS_____ DHHS Authorized_____ Sibling Discount_____

Military Discount_____ Tri-Share_____ Employee Discount_____ Added to Count_____

# 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. 6-17) Previous editions 4-16, 6-15 and 7-12 may be used until September 30, 2018. **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 ____Commmunity Learning Center_____, licensed by the Department of Licensing and Regulatory Affairs to secure emergency medical 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

BCAL-3731 (Rev. 6-17) Previous editions 4-16, 6-15 and 7-12 may be used until September 30, 2018.

# 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 for Child Care and Head Start / Early Head Start

### 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 (HepB) | 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 |

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

| VACCINES (Circle Type) | DATE ADMINISTERED MM/DD/YYYY | |
|---|---|---|
| Hepatitis A (HepA) | 1 | 2 |
| Influenza (IIV/LAIV) | 1 | 3 |
| | 2 | 4 |
| Meningococcal (MCV4 / MPSV4) | 1 | 2 |
| Human Papillomavirus (HPV9/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 provider office for medical waiver forms and through your local health department for nonmedical waiver forms.

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 _____ '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 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.