

## 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:**

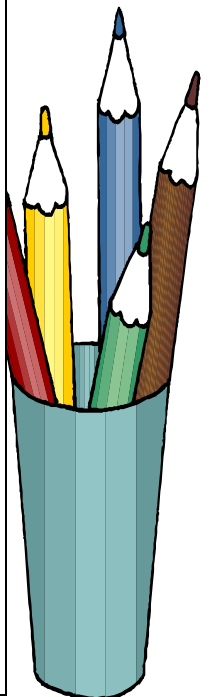
- **Registration form for each child enrolling.**
- **Registration fee for each child (amount is noted on the registration form)**
- **Completed child information record**
- **A copy of your child's immunization record.**
- **Health appraisal form (not required for school age program). The health appraisal 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





## Transitional Toddler (24-36 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](mailto:CLCinfo2@comstockcc.com) ).

### Child's Information

Child's Name \_\_\_\_\_ Today's Date \_\_\_\_\_ Start Date \_\_\_\_\_  
Child's Birth Date \_\_\_\_\_ Age \_\_\_\_\_ Gender: M F

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.**

Transitional Toddler Care (24 months -36 months)	3 Half Days	3 Full Days	4 Half Days	4 Full Days	5 Half Days	5 Full Days
Weekly Tuition	\$121	\$188	\$147	\$226	\$178	\$266

### *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.

<i>Drop off time:</i>	<i>Pick up time:</i>
<i>Monday:</i> In at _____	<i>Out at</i> _____
<i>Tuesday:</i> In at _____	<i>Out at</i> _____
<i>Wednesday:</i> In at _____	<i>Out at</i> _____
<i>Thursday:</i> In at _____	<i>Out at</i> _____
<i>Friday:</i> In at _____	<i>Out at</i> _____

### *Parent/Guardian Agreement*

I hereby enroll my child in the CLC's Transitional 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.

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

See Reverse Side

<b>Emergency Contact &amp; Release of Child:</b> 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.	( )	( )			
<b>Release of Child Only:</b> 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.	( )		

<b>Parent/Legal Guardian Initials:</b>	
_____ I give permission to ____ Community Learning Center _____, licensed by the Department of Licensing and Regulatory Affairs to secure emergency medical for the above named minor child while in care.	

<b>I certify that I accurately completed this form and if anything changes, I will notify the provider by updating this form.</b>	
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	

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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) 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?	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	1 Allergies or Reactions (for example, food, medication or other)	<b>Birth History:</b>  <div style="border: 1px solid black; height: 100px; margin-bottom: 5px;"></div> Are there any current or past diagnosis(es) <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, please describe: <div style="border: 1px solid black; height: 100px; margin-bottom: 5px;"></div> If yes, list medications: <div style="border: 1px solid black; height: 100px; margin-bottom: 5px;"></div> Was the health history reviewed by a health professional? <input type="checkbox"/> Yes <input type="checkbox"/> No <b>Examiner's Initials:</b> _____
<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 Eczema 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 _____	
			_____ / /	
			<b>Parent/Guardian Signature</b> _____	
			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"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	HEIGHT & WEIGHT Other: _____	Height Weight Other: _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	HEARING Date: / /	Audiometer Other: _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	HEMOGLOBIN / HEMATOCRIT BLOOD PRESSURE	⇒ Reading: _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	URINALYSIS Date: / /	Sugar Albumin Microscopic	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	TUBERCULIN Date: / /	Type: _____ Neg.: <input type="checkbox"/> Pos.: <input type="checkbox"/> _____ mm	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<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: / /

<b>SECTION III - IMMUNIZATIONS</b> <small>Statements such as "UP-TO-DATE" or "COMPLETE" will not be accepted. Admission to school may be denied on the basis of this information.*</small>			
VACCINES (Circle Type)	DATE ADMINISTERED <small>MM/DD/YYYY</small>		
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? <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			
_____ <b>Health Professional's Signature</b>		_____ <b>Title</b>	_____ <b>Date</b>

		<b>SECTION IV - RECOMMENDATIONS</b> <small>(Required for Child Care and Head Start/Early Head Start)</small>
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		
_____		
_____		

<b>SECTION V - DENTAL EXAMINATION AND RECOMMENDATIONS (OPTIONAL)</b>
I have examined _____ child's name _____'s teeth. As a result of this examination, my recommendation for treatment is: _____
_____
_____
_____ <b>Dentist's Signature</b>
_____ <b>Date</b>

<b>PHYSICIAN'S SIGNATURE</b>			
_____ <b>Examiner's Signature</b>	_____ <b>Date</b>	_____ <b>Examiner's Name (Print or Type)</b>	_____ <b>Degree or License</b>
_____ <b>Number &amp; Street</b>	_____ <b>City</b>	MI _____ <b>ZIP Code</b>	(_____) _____ <b>Telephone</b>

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.