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,

Chazlyn Flint
Program Director

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Revised 7/18/2024

Transitional Toddler (24-36 months) 2024-2025 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 is required at time of application. This fee will not include any discount that you may qualify for.

Transitional Toddler (24 months-36 months)	3 Half Days	3 Full Days	4 Half Days	4 Full Days	5 Half Days	5 Full Days
Weekly Tuition	$126	$193	$152	$231	$183	$271

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 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 Lifelong Education, Learning, and Potential - 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	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	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/or Special Instructions? No ☐ Yes ☐ If yes, explain: (Attach additional sheets, if necessary.)	

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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.**	**( )**
5.	**( )**	**6.**	**( )**

Parent/Legal Guardian Initials:

_____I give permission to __Community Learning Center__,licensed by the Department of Lifelong Education, Advancement, and Potential, 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

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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?
☐	☐	☐	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:

_____ / / Was the health history reviewed by a health professional?

Parent/Guardian Signature Date ☐ 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.