

COMMUNITY Learning Center

a division of Comstock Community Center

Welcome to the Community Learning Center,

Please completely fill out the enrollment packet.

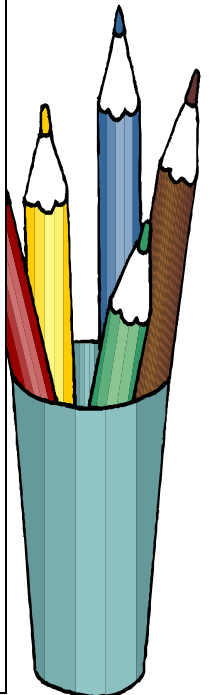
Before your child may attend we need the following items completed:

- **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





Toddler Care (12-24 months) 2025-2026 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 _____
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 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	\$145	\$219	\$177	\$267	\$211	\$318

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>	<i>In at</i> _____	<i>Out at</i>	_____
<i>Tuesday:</i>	<i>In at</i> _____	<i>Out at</i>	_____
<i>Wednesday:</i>	<i>In at</i> _____	<i>Out at</i>	_____
<i>Thursday:</i>	<i>In at</i> _____	<i>Out at</i>	_____
<i>Friday:</i>	<i>In at</i> _____	<i>Out at</i>	_____

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 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)		2 nd Phone (if applicable) ()	Home Address (if not child's address)		2 nd 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.)					

CCL-3731 (Rev. 6/7/2024) Previous editions 7-18, 4-21, & 3-22 may be used

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

CCL-3731 (Rev. 6/7/2024) Previous editions 7-18, 4-21, & 3-22 may be used

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.)**

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
		()

Resolved			# Is your child having any of the problems listed below?		Birth History:	
☐	☐	☐	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)		Are there any current or past diagnosis(es) ☐ Yes ☐ No	
☐	☐	☐	8 Trouble with Passing Urine or Bowel Movements		If yes, please describe:	
☐	☐	☐	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?		If yes, list medications:	
Reason for Medication				⇒		
_____ Parent/Guardian Signature			_____ Date		Was the health history reviewed by a health professional? ☐ Yes ☐ No Examiner's Initials:	

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
☐	☐	VISION	Visual Acuity				☐	☐	HEIGHT & WEIGHT	Height			
			Muscle Imbalance							Weight			
		Date: ____/____/____	Other:				☐	☐	Other: _____	Other			
☐	☐	HEARING	Audiometer				☐	☐	HEMOGLOBIN / HEMATOCRIT				
			Other:				☐	☐	BLOOD PRESSURE	Reading: _____			
		Date: ____/____/____											
☐	☐	URINALYSIS	Sugar				☐	☐	TUBERCULIN	Type: _____			
			Albumin										
		Date: ____/____/____	Microscopic						Date: ____/____/____	Neg.: ☐ Pos.: ☐ _____ mm			
☐	☐	BLOOD LEAD LEVEL	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.						
		Date: ____/____/____											

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: _____			
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 _____ child's name _____'s teeth. As a result of this examination, my recommendation for treatment is: _____

_____ _____ / _____ / _____ Dentist's Signature Date

PHYSICIAN'S SIGNATURE			
_____ Examiner's Signature	_____ / _____ / _____ Date	_____ Examiner's Name (Print or Type)	_____ Degree or License
_____ Number & Street	_____ City	MI _____ 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.

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.