# *New Era Christian School Childcare Checklist*

**Prior to start date:**

- ☐ Child Information Card
- ☐ Copy of Child's Birth Certificate
- ☐ Immunization Record
- ☐ Health Appraisal
- ☐ Written Information Packet
- ☐ Recall List & Licensing Rulebook Form
- ☐ Volunteer Background Check
- ☐ Field Trip Form
- ☐ Permission Slip for Topical, Non-prescription Meds
- ☐ Statement of Belief
- ☐ Contract/Financial Agreement

New Era
Christian School

# 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.) | |

**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 _____, 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 |
|---|---|---|---|---|---|---|---|
| | | | | | | | |

Individuals with disabilities may contact the MiLEAP ADA Coordinator to request an alternative format to these materials. Please visit www.Michigan.gov/ADA for a list of state ADA Coordinators

**MiLEAP is an equal opportunity employer/program.**

# MDHHS-3305, HEALTH APPRAISAL

Michigan Department of Health and Human Services (MDHHS)
(Revised 7-24)

**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 1. Section 4 may be certified by the transcription of information from the certificate of immunization. The remaining sections are to be completed by a doctor, nurse, dentist, dental therapist, and dental hygienist.

**(BE SURE TO BRING YOUR CHILD'S IMMUNIZATION RECORDS TO THE EXAMINATION).**

## SECTION 1 – 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/Cell Phone Number |
| Address (Number, Street, City, Zip Code) | Work Phone Number |

## SECTION 2 – HEALTH HISTORY

| Yes | No | Resolved | Is your child having any of the problems listed below? | Birth History |
|---|---|---|---|---|
| ☐ | ☐ | ☐ | 1. Allergies or Reactions (for example, food, medication or other) | |
| ☐ | ☐ | ☐ | 2. Anaphylaxis | |
| ☐ | ☐ | ☐ | 3. Does your child take any medication(s) regularly? | If yes, list medications |
| ☐ | ☐ | ☐ | 4. Hay Fever, Asthma, or Wheezing | |
| ☐ | ☐ | ☐ | 5. Eczema or Frequent Skin Rashes | |
| ☐ | ☐ | ☐ | 6. Convulsions/Seizures | |
| ☐ | ☐ | ☐ | 7. Heart Trouble | |
| ☐ | ☐ | ☐ | 8. Diabetes | |
| ☐ | ☐ | ☐ | 9. Frequent Colds, Sore Throats, Earaches (4 or more per year) | Are there any current or past diagnosis(es) ☐ Yes ☐ No |
| ☐ | ☐ | ☐ | 10. Trouble with Passing Urine or Bowel Movements | If yes, describe |

| | | | | |
|---|---|---|---|---|
| ☐ | ☐ | ☐ | 11. Shortness of Breath | |
| ☐ | ☐ | ☐ | 12. Speech Problems | |
| ☐ | ☐ | ☐ | 13. Menstrual Problems | |
| ☐ | ☐ | ☐ | 14. Dental Problems<br>Date of Last Exam OR<br>Date of Last Assessment | |
| ☐ | ☐ | ☐ | 15. Other (describe) | |

Reason for Medication

Concussion History

Parent/Guardian Signature Date

Was the health history reviewed by a health professional? Examiner's Initials
☐ Yes ☐ No

**SECTION 3 - PHYSICAL EXAMINATION, INSPECTION, TESTS AND MEASUREMENTS**
Required for Child Care and Head Start / Early Head Start

**Test and Measurements**

| Yes | No | Was child test for | Tests and results | Normal | Referred | Under Care |
|---|---|---|---|---|---|---|
| ☐ | ☐ | Vision | Visual Acuity | ☐ | ☐ | ☐ |
| | | Date | Muscle Imbalance | ☐ | ☐ | ☐ |
| | | | Other | ☐ | ☐ | ☐ |
| ☐ | ☐ | Hearing | ☐ Audiometer (R= Right, L=Left) | | | |
| | | Date | ☐ OAE (R= Right, L=Left) | | | |
| | | | ☐ Other (R= Right, L=Left) | | | |
| ☐ | ☐ | Urinalysis | Sugar | ☐ | ☐ | ☐ |
| | | | Albumin | ☐ | ☐ | ☐ |
| | | | Microscopic | ☐ | ☐ | ☐ |
| ☐ | ☐ | Blood Lead Level | Level ug/dl | ☐ | ☐ | ☐ |
| | | Date | | | | |

**Note:** All children in Medicaid need to be tested at 1 and 2 years of age, or once between 3 and 6 years of age if not previously tested. All children, regardless of Medicaid status, should be tested at those same ages if they live in an area where lead risk is high.

| | | | | | | |
|---|---|---|---|---|---|---|
| ☐ | ☐ | Height & Weight | Height | ☐ | ☐ | ☐ |
| | | | Weight | ☐ | ☐ | ☐ |
| ☐ | ☐ | Other | Other | ☐ | ☐ | ☐ |
| ☐ | ☐ | Hemoglobin/Hematocrit | ⇨ | ☐ | ☐ | ☐ |
| ☐ | ☐ | Blood Pressure | Reading | ☐ | ☐ | ☐ |

Complete pediatric tuberculosis risk assessment available at:
https://www.michigan.gov/documents/mdhhs/4._MI_Pediatric_TB_Risk_Assessment_661537_7.pdf **OR** feel free to use the attached QR code instead of the full link text.

**Examinations and/or Inspections**

Essential Findings Deviating from Normal — Exam Date

## SECTION 4 – IMMUNIZATIONS

Statements such as "UP-TO-DATE" or "COMPLETE" will not be accepted. Admission to school may be denied based on this information.*

| Vaccines (Select Type) | Date Administered (mm/dd/yy) | | |
|---|---|---|---|
| Hepatitis B (HepB) | 1. | 2. | 3. |
| | 4. | | |
| DTaP/DTP/DT/Td | 1. | 2. | 3. |
| | 4. | 5. | 6. |
| Tdap | 1. | | |
| *Haemophilus Influenzae* type b (HIB) | 1. | 2. | 3. |
| | 4. | | |
| Polio (IPV/OPV) | 1. | 2. | 3. |
| | 4. | 5. | |
| Pneumococcal Conjugate (PCV) | 1. | 2. | 3. |
| | 4. | | |
| Rotavirus (RV1/RV5) | 1. | 2. | 3. |
| Measles, Mumps, Rubella (MMR/MMRV) | 1. | 2. | 3. |
| Varicella (Chickenpox), (Var, MMRV) | 1. | 2. | |
| Hepatitis A (HepA) | 1. | 2. | 3. |

| | | | |
|---|---|---|---|
| Influenza (IIV/LAIV) | 1. | 2. | 3. |
| | 4. | | |
| Meningococcal (MCV4, MenABCWY ) | 1. | 2. | 3. |
| Meningococcal B (Bexsero, Trumenba, MenABCWY) | 1. | 2. | 3. |
| Human Papillomavirus (HPV) | 1. | 2. | 3. |

Additional Vaccines Specify Date & Type

| Type of Vaccine(s) | Date of Vaccine(s) |
|---|---|
| 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.

History of Chickenpox Disease? If yes, date

☐ Yes ☐ No

☐ Parent/Guardian refused recommended immunizations at visit.

I certify that the immunization dates are true to the best of my knowledge

Health Professional Signature Title Date

**SECTION 5 - RECOMMENDATIONS** (Required for Child Care and Head Start/Early Head Start)

Is there any defect of vision, hearing, or other condition for which the school could help by seating or other actions?

☐ Yes ☐ No

If yes, explain

Should the child's activity be restricted because of any physical defect or illness?

☐ Yes ☐ No

Check all that apply

☐ Classroom ☐ Playground ☐ Gymnasium

☐ Swimming Pool ☐ Competitive Sports ☐ Other

If yes, explain degree of restriction(s)

Other Recommendations

## SECTION 6 - DENTAL EXAM OR ASSESSMENT RECOMMENDATIONS

Child's Name

Type of Service
☐ Dental Exam ☐ Dental Assessment

Findings (Check all that apply)
☐ No findings ☐ Treated Decay ☐ Untreated Decay

Recommendations (Check one)
☐ Routine Care
☐ Referral for dental treatment
☐ Referral for urgent dental care

Provider Signature | Date

Check one
☐ Dentist ☐ Dental Therapist ☐ Dental Hygienist

## SECTION 7 - PHYSICIAN'S SIGNATURE

Examiner's Name (Print) | Degree or License | Telephone Number

Examiner's Signature | Date

Address | City | State MI | Zip Code

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 preventative and primary health care, including medical, dental, and mental health. The schedule must incorporate the well-childcare 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.

# WRITTEN INFORMATION PACKET DOCUMENTATION

Michigan Department of Licensing and Regulatory Affairs
Child Care Licensing Bureau

| Child(ren)'s Name(s) (Last, First) | Facility's Name and License Number |
|---|---|
| | |

A written information packet has been provided at the time of enrollment. The packet included all the following information *(R 400.8146 (1-2)):*

- Criteria for admission and withdrawal.
- Schedule of operation, denoting hours, days, and holidays during which the center is open, and services are provided.
- Fee policy.
- Discipline policy.
- Food service program.
- Program philosophy.
- Typical daily routine.
- Parent notification plan for accidents, injuries, incidents, and illnesses.
- Transportation policy, if applicable.
- Medication policy.
- Exclusion policy for child illnesses.
- Notice of the availability of the center's licensing notebook. (CENTER MUST CHECK ONE)

  ☐ The center keeps a licensing notebook containing a summary sheet, all licensing inspections and special investigation reports, and related corrective action plans for the last 5 years. The licensing notebook is available to parents/guardians during regular business hours. Reports from at least the past three years are available at www.michigan.gov/michildcare.

  ☒ The center does not keep a licensing notebook, but internet is available onsite. Reports from at least the last three years are available at www.michigan.gov/michildcare.

- Other _____

I certify that I received all of the above items.

_____ _____

**Parent/Guardian Signature** **Date**

**Note:** A single CCL-4340 form may be used for all children in the same family.

LARA is an equal opportunity employer/program.

## Recall List

By signing this document, I acknowledge that I have been notified of the Recall List provided by the State of Michigan and I have the right to access the link to their website at any time.

_____ _____

Parent Signature Date

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## Licensing Rulebook

By signing this document, I acknowledge that I have been notified of the Licensing Rulebook provided by the State of Michigan and I have the right to access the link to their website at any time.

_____ _____

Parent Signature Date

# Volunteer and Background Check Form

Volunteers are a vital part of our preschool program at New Era Christian School. For the safety of our children, as well as being required by the State of Michigan, our volunteers agree to a criminal background check through a system called ICHAT. Volunteers must also be checked through the Public Sex Offender Registry.
Anyone listed on the Registered Sex Offender list for any reason are not allowed to be in contact with children in our care.

Please complete both sections to provide us with the necessary information.

_____ I give New Era Christian School permission to submit my information for a criminal background check through ICHAT.

- Full Legal Name_____
- Date of Birth_____

_____ I do NOT give New Era Christian School permission to submit my information for a criminal background check through ICHAT. By selecting NO, I will not be allowed to volunteer in the preschool classroom.

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Have you ever been convicted of any civil or criminal offense other than a minor traffic violation?

_____Yes _____ No

Have you ever been involved in a substantiated case of abuse or neglect of children or adults with any local Family Independence Agency (social services) or other similar agency?

_____ Yes _____ No

If you answered yes to either question above, please explain.

- I understand that abuse and neglect of children is against the law.
- I have been informed of the Center's policies on child abuse and neglect.
- I understand that caregivers are mandated by law to report suspected abuse and neglect of children.

_____ _____

Signature Date

New Era
Christian School

New Era
Christian School

## Preschool NECS Field Trip Permission Slip

I give permission for my child to participate in field trips planned and organized by New Era Christian Preschool. I also give permission for my child to be transported in a vehicle to and from the destination.

I give permission for my child to do unplanned or spontaneous walking trips in the neighborhood. The teacher will contact parents if a learning opportunity arises.

_____ _____

Parent Signature Date

_____

Printed Name

_____

Child's Name

## Preschool NECS Permission for Topical, Non-Prescription Meds

I give permission to NECS staff to apply topical, non-prescription medications to my child. (this list includes, but is not limited to sunscreen, insect repellent, diaper cream) as needed. I also understand that I am responsible for providing topical medications for the center to apply.

_____ _____

Parent Signature Date

_____

Child's Name

New Era Christian School