

welcome

to Climax-Scotts Pre-K 4's! It's easy to enroll...

Please return the following items in this envelope:

- Kalamazoo County Pre-K Application
- Proof of Income
- Legal copy of child's birth certificate
- Proof of Residency (driver's license, utility bill)
- Health Appraisal, completed by parent/guardian & a physician
- Up-to-date immunization record
- Proof of receipt of public assistance
- Child Information Record
- Pre-K Transportation Release Form
- Field Trip Release Form
- Picture & Technology Usage Release/Social Media
- Parent Notification of Licensing Notebook
- Questionnaire

Questions? Please contact the elementary office at (269) 497-2100 until June 7th OR after June 7th contact Central Office at (269) 746-2400.

2024-2025 KALAMAZOO COUNTY PRE-K APPLICATION



Dear pre-kindergarten family, we're so excited to be a part of your child's next adventure! A valuable Pre-K experience makes for a great start and a major difference in a child's kindergarten readiness and success.

If you answered "Yes" to the questions above, you are likely eligible for the Kalamazoo County Pre-K program. We encourage you to fill out the Kalamazoo County Pre-K application and submit it with all the required documents listed under the step-by-step instructions to determine eligibility.

Please contact us by email at hsenroll@kresa.org if you have any questions.

EASY AS 1, 2, 3...

Turn in the following three items with your child's application:

- 1. Child's birth record
- 2. Proof of yearly family income: work earnings (W-2, tax return, or check stubs), child support, unemployment, SSI, cash assistance and any other proof of income
- 3. Proof of current address: driver's license, rent receipt, utility bill, letter from shelter or host if between homes

Check out the step-by-step instructions for more detailed information.

KALAMAZOO RESA
INSPIRING EDUCATIONAL EXCELLENCE

KALAMAZOO COUNTY
PRE-K


KC Ready4s


GREAT START
COLLABORATIVE
Kalamazoo County


Great Start
Readiness Program
Michigan's Nationally Recognized Pre-K Program

 KALAMAZOO RESA
Head Start

Step-by-Step Instructions

Step 1: Pre-K Application

- 1a Fill out the Kalamazoo County Pre-K application, completely. Application is available in both English and Spanish. You can download a copy or fill out a digital form at DreamBigStartSmall.org.

Step 2: Required Documents

All applicants must send the following items with the Kalamazoo County Pre-K application. Eligibility cannot be determined unless all of the following required documents have been submitted.

 2a Proof of age. According to new guidelines, all children must be:

- 3 years old on or before December 1* in order to be age eligible for the 3-year-old programs
 - 4 years old on or before December 1* in order to be age eligible for the 4-year-old programs
- *Placement may be prioritized for children who will be 3 or 4 years old on or before September 1.

Submit one of the following:

- Birth certificate (preferred)
- Passport
- Affidavit of parentage/Hospital record
- Baptismal record
- Foster care emergency consent card
- Foster care placement letter
- Court order

 2b Proof of income. **Income is a primary qualifying factor.** You can check the charts available on kresa.org/qualifications for more details. You must submit documents for all sources of income over the last 12 months. These documents may include:

- Last year's tax return (first page), or pay stub with year-to-date listed, W2's, or written statement from employer if tax return is not available
- TANF/FIP
- Social security/SSI check stub or monthly statement
- Unemployment check stub or statement
- Financial aid (grants/scholarships)
- Child support/Alimony/Pension statement

 2c Proof of residency. Submit one of the following:

- Driver's license or County ID with correct address (preferred)
- Recent utility bill for your address
- Rental agreement/Mortgage/Deed to house
- Written letter from shelter, if between homes

 2d Additional documents:

- Current immunization record (prior to the child's first day of class)
- Health appraisal/Physical/Well-child exam within the past year (due within the first 30 days of the program year)
- Medicaid, or insurance card for child

Step 3: Submitting Your Documents 3a Once you have filled out the application completely and gathered all the required documents:

- Submit application and required documents online at DreamBigStartSmall.org
- Submit paper application and required documents at:
 - » Kalamazoo RESA Head Start/GSRP Administration Office, 422 E. South St., Kalamazoo, MI 49007
 - » Kalamazoo RESA Early Childhood Office, lower level of 4606 Croyden Ave., Kalamazoo, MI 49006
 - » Kalamazoo County Ready 4s Office, 161 E. Michigan Ave., Suite 600, Kalamazoo, MI 49006
 - » Any Kalamazoo County Pre-K provider
 - » Check with your local school district for location
- Email fillable form and required documents to hsenroll@kresa.org

For assistance, please call (269) 250-9333, Monday–Friday, 8:00 a.m.–4:00 p.m.

Step 4: Application Processing Time 4a Please allow two to four weeks for processing your application. Once your application is processed, you will receive an email or a phone call regarding eligibility. Please make sure you enter a valid email address and phone number in the "Parent or Legal Guardian Information" section so you get notified of your eligibility.

Complete this application and email it to hsenroll@kresa.org with supporting documents, directly to preschool provider, at a location listed in step 3, or apply online at dreambigstartsmall.org.

CHILD INFORMATION

Child's Legal Name: _____ Date of Birth: ____ / ____ / ____
Last Name First Name Middle Initial mm dd yyyy

Sex Assigned at Birth: Male Female Ethnicity: Hispanic or Latino Not Hispanic or Latino

Race (Check all that apply): Black or African American Asian White or Caucasian
 American Indian or Alaska Native Native Hawaiian or other Pacific Islander

Program Preference (Full day not available in all programs): Full Day Part Day (If part day, Morning Afternoon Either)

Based on availability, do you have a program location preference? _____

How did you hear about Kalamazoo County Pre-K? Previous Experience (Pre-K programs) Previous Experience (Early On or Seeds) Radio
 Flyer Social Media Family/Friends — Full Name: _____ Other: _____

FAMILY INFORMATION

Child Lives with: Both Parents Mother Father Joint Custody (If joint, Physical or Legal) Legal Guardian
 Grandparent(s) Foster Care Other, Explain: _____

Family Language: Primary _____ Secondary _____ Family Needs an Interpreter

PARENT OR LEGAL GUARDIAN INFORMATION

PARENT OR LEGAL GUARDIAN INFORMATION

<p>Full Name: _____</p> <p>Date of Birth: _____</p> <p>Parent Address: _____</p> <p>Email: _____</p> <p>Legally Responsible for Financial Support: <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Phone Type: _____ Phone Number with Area Code: _____ <input type="checkbox"/> Home <input type="checkbox"/> Work <input type="checkbox"/> Cell <input type="checkbox"/> Text _____ <input type="checkbox"/> Home <input type="checkbox"/> Work <input type="checkbox"/> Cell <input type="checkbox"/> Text _____</p> <p>Relationship: <input type="checkbox"/> Birth or Adoptive or Step Parent <input type="checkbox"/> Foster Parent <input type="checkbox"/> Grandparent <input type="checkbox"/> Other Relative <input type="checkbox"/> Other Caregiver</p> <p>Education (Check the highest level): <input type="checkbox"/> No High School Diploma or Highest Grade: <input type="checkbox"/> 9 <input type="checkbox"/> 10 <input type="checkbox"/> 11 <input type="checkbox"/> High School Diploma or <input type="checkbox"/> GED <input type="checkbox"/> Associate Degree <input type="checkbox"/> Bachelor's Degree <input type="checkbox"/> Master's Degree <input type="checkbox"/> Doctoral Degree</p> <p>Employment or Other (Check all that apply): <input type="checkbox"/> Employed Part-time (Less than 35 hours per week) <input type="checkbox"/> Employed Full-time (More than 35 hours per week) <input type="checkbox"/> Attends School or College <input type="checkbox"/> Home by Choice <input type="checkbox"/> Unemployed</p>	<p>Full Name: _____</p> <p>Date of Birth: _____</p> <p>Parent Address: _____</p> <p>Email: _____</p> <p>Legally Responsible for Financial Support: <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Phone Type: _____ Phone Number with Area Code: _____ <input type="checkbox"/> Home <input type="checkbox"/> Work <input type="checkbox"/> Cell <input type="checkbox"/> Text _____ <input type="checkbox"/> Home <input type="checkbox"/> Work <input type="checkbox"/> Cell <input type="checkbox"/> Text _____</p> <p>Relationship: <input type="checkbox"/> Birth or Adoptive or Step Parent <input type="checkbox"/> Foster Parent <input type="checkbox"/> Grandparent <input type="checkbox"/> Other Relative <input type="checkbox"/> Other Caregiver</p> <p>Education (Check the highest level): <input type="checkbox"/> No High School Diploma or Highest Grade: <input type="checkbox"/> 9 <input type="checkbox"/> 10 <input type="checkbox"/> 11 <input type="checkbox"/> High School Diploma or <input type="checkbox"/> GED <input type="checkbox"/> Associate Degree <input type="checkbox"/> Bachelor's Degree <input type="checkbox"/> Master's Degree <input type="checkbox"/> Doctoral Degree</p> <p>Employment or Other (Check all that apply): <input type="checkbox"/> Employed Part-time (Less than 35 hours per week) <input type="checkbox"/> Employed Full-time (More than 35 hours per week) <input type="checkbox"/> Attends School or College <input type="checkbox"/> Home by Choice <input type="checkbox"/> Unemployed</p>
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LIST OTHER CHILDREN AND OTHER FAMILY MEMBERS SUPPORTED BY INCOME (IF YOU NEED EXTRA SPACE, ATTACH A SHEET OF PAPER)

Last Name	First Name	Attended Head Start?	Date of Birth (mm/dd/yyyy)	Sex Assigned at Birth	Relationship	If child, age of parent when child was born
		<input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> M <input type="checkbox"/> F		
		<input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> M <input type="checkbox"/> F		
		<input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> M <input type="checkbox"/> F		
		<input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> M <input type="checkbox"/> F		

Please list school(s) where siblings currently attend: _____

FAMILY'S CURRENT LIVING SITUATION

The family currently lives: in a home you rent or own in a temporary housing situation in a hotel/motel
 in a home owned or rented by someone else without a fixed nighttime residence in a shelter

ADDRESS INFORMATION (INCLUDE APARTMENT COMPLEX NAME, IF APPLICABLE.)

Address: _____ Street, Apt _____ City _____ State _____ Zip Code _____ County: _____

Child's Pick-up Address (If different): _____ Child's Drop-off Address (If different): _____

What school district do you live in: Climax-Scotts Comstock Galesburg-Augusta Gull Lake Kalamazoo Parchment Portage Schoolcraft Vicksburg Other: _____

INCOME OF FAMILY MEMBERS LEGALLY RESPONSIBLE FOR CHILD'S SUPPORT

Name: _____ Total Annual Income: \$ _____

Name: _____ Total Annual Income: \$ _____

Please select ALL sources of family income received in the last 12 months:

- Full-time Employment Cash Assistance (FIP) SSI Other: _____
 Part-time Employment Unemployment Child Care Reimbursement _____
 Social Security Child Support _____

SUPPLEMENTAL QUESTIONS

Emergency Contact Name: _____ Phone Number with Area Code: _____

Address: _____ Street/ Apt _____ City _____ State _____ Zip Code _____

Before or after School care needed? (Not available in all programs) Yes No Are you able to self-transport? Yes No

Please list any program or childcare that your child is currently attending: _____

CHILD (APPLICANT) DISABILITY STATUS

Does the child have an identified developmental delay? No Yes - Please describe: _____

Has your child participated with any of the following programs? Early On PET Home Visits - Contact: _____

Has your child received services for: Vision or Hearing Speech Early Childhood Special Education Occupational Therapy
 Physical Therapy IEP or IFSP

OTHER CONFIDENTIAL INFORMATION THAT MAY PRIORITIZE PLACEMENT

- Does child's behavior ever prevent participation in other group settings? Yes No
Does anyone in the household speak a primary language other than English? Yes No
Has someone in the household been abused or neglected? Yes No
Does child live with one adult as result of divorce, separation, incarceration, military service or death? Yes No
Does child have a chronic illness or medical considerations (asthma, feeding tube, allergies, frequent ear infections, etc.) Yes No
Is the child in foster care? Yes No
Does any sibling have a chronic illness, behavior issue, disability or has died? Yes No
Was either parent under 20 years old when first child was born? Yes No
Is family without stable housing or is family homeless? Yes No
Does family live in high-risk neighborhood? (Unsafe due to crime, drug abuse, pollution, insect infestation, etc.) Yes No
Was child exposed to toxic substances before or after birth? (Alcohol, drugs, lead poisoning, nicotine, etc.) Yes No

PARENT/GUARDIAN SIGNATURE

Information on this application is confidential. Your child's pre-kindergarten program will not discriminate against any family on the basis of race, color, national origin, sex (including sexual orientation or sexual identity), disability, age, religion, height, weight, marital or family status, military status, ancestry, genetic information or any other legally protected category.

I certify that the information, including income, provided in this application is accurate and truthful to the best of my knowledge. I understand that it is my responsibility to inform my child's pre-kindergarten program if I move, or if I have any other changes in circumstances that could affect my child's enrollment or placement. I understand that by participating in the pre-kindergarten program, my child's learning and development will be assessed and monitored to support further growth; and that some results may be reported as scores and combined with other children's scores for future research related to the general level of impact of kindergarten readiness across the county.

I understand that this information will be entered into a confidential central database system that may be accessed by Kalamazoo RESA Head Start, Great Start Readiness Programs and Kalamazoo County Ready 4s in an effort to correctly place my child into a Kalamazoo County Pre-K Program and effectively analyze Kalamazoo County services to families and children. My signature below constitutes consent to disclose the information in this application to the listed entities and obtain any relevant information from them.

Signature* of Parent/Guardian: _____ Date (mm/dd/yyyy): _____

* If information is given verbally, staff will print the parent/guardian name above with the date, check this box, and initial _____ (Revised 2/6/2024)

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)	Birth History: Are there any current or past diagnosis(es) <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, please describe: If yes, list medications: Was the health history reviewed by a health professional? <input type="checkbox"/> Yes <input type="checkbox"/> No Examiner's Initials: _____
<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	
			_____ / /	
			Parent/Guardian Signature _____ 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"/>	HEIGHT & WEIGHT Other: _____	Height Weight Other: _____			
<input type="checkbox"/>	<input type="checkbox"/>	HEARING Date: / /	Audiometer Other: _____				<input type="checkbox"/>	<input type="checkbox"/>	HEMOGLOBIN / HEMATOCRIT BLOOD PRESSURE	Reading: _____			
<input type="checkbox"/>	<input type="checkbox"/>	URINALYSIS Date: / /	Sugar Albumin Microscopic				<input type="checkbox"/>	<input type="checkbox"/>	TUBERCULIN Date: / /	Type: _____ Neg.: <input type="checkbox"/> Pos.: <input type="checkbox"/> _____ mm			
<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: / /

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		VACCINES (Circle Type)	DATE ADMINISTERED MM/DD/YYYY	
Hepatitis B (HepB)	1	3	Hepatitis A (HepA)	1	2
	2		Influenza (IIV/LAIV)	1	3
				2	4
DTaP/DTP/DT/Td	1	4	Meningococcal (MCV4 / MPSV4)	1	2
	2	5	Human Papillomavirus (HPV9/HPV4/HPV2)	1	3
	3	6		2	
Tdap	1		OTHER Vaccines Specify Date & Type	Type of Vaccine(s)	Date of Vaccine(s)
Haemophilus Influenzae type b (HIB)	1	3		1	
	2	4		2	
Polio (IPV/OPV)	1	3		3	
	2	4	Indicate and attach physician diagnosis or laboratory evidence of immunity as applicable		
Pneumococcal Conjugate (PCV7/PCV13)	1	3	*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.		
	2	4	Parent/Guardian refused immunizations: <input type="checkbox"/>		
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

Health Professional's Signature

Title

Date

SECTION IV - RECOMMENDATIONS

(Required for Child Care and Head Start/Early Head Start)

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		

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

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.



Climax-Scotts Pre-K



TRANSPORTATION RELEASE FORM

CHILD'S NAME _____

PARENT/GUARDIAN NAME _____

I hereby give my child permission to use Climax-Scotts transportation, and ride the bus to and from Pre-K. I have read the Pre-K transportation policy and confirm my child's bus ride is less than one hour.

I also give permission for my child to be treated by a physician in case of an emergency according to the information filed on my child's CIR (Child Information Record).

I understand that in the event that my child is uncooperative on the bus and poses a safety concern, a child seat with safety belts may be required and will be used for their protection and the protection of everyone riding the bus.

A copy of the CIR will be kept on the bus.

Pick-up address _____

Drop-off address _____

Signature of Parent/Legal Guardian

Date



Climax-Scotts Pre-K



PICTURE & TECHNOLOGY USAGE RELEASE/SOCIAL MEDIA

CHILD'S NAME _____

PARENT/LEGAL GUARDIAN NAME _____

PICTURE RELEASE CONSENT

I give consent for my child's picture to be used in school/community publications as deemed appropriate by the school.

Yes _____ No _____

I give consent for my child's picture to be used in school projects (i.e. class book).

Yes _____ No _____

PERMISSION FOR TECHNOLOGY RESOURCES

From time to time the preschool students will use the internet with direct supervision for instruction purposes and will follow the district's technology code of ethics. I give my child permission to use the district's technology resources.

Yes _____ No _____

SOCIAL MEDIA

For the respect and privacy of each family, I agree NOT to copy photos from the classroom community pages onto other forms of social media.

Yes _____ No _____

Signature of Parent/Legal Guardian

Date



Climax-Scotts Pre-K



FIELD TRIP RELEASE FORM

CHILD'S NAME _____

PARENT/LEGAL GUARDIAN NAME _____

I hereby give my child permission to attend any and all field trips planned for educational purposes to meet classroom objectives. These objectives might include specific curricular activities and/or celebrations of accomplishments.

I also give permission for my child to be treated by a physician in case of an emergency according to the information filed on my child's CIR (Child Information Record).

The program will provide notification before each field trip, including maps and directions.

Signature of Parent/Legal Guardian

Date

PARENT NOTIFICATION OF THE LICENSING NOTEBOOK
Child Care Organizations Act, 1973 Public Act 116
Michigan Department of Licensing and Regulatory Affairs
Child Care Licensing Bureau

All child care centers must maintain a licensing notebook which includes all licensing inspection reports, special investigation reports and all corrective action plans for the last 5 years.

- This center maintains a licensing notebook of all licensing inspection reports, special investigation reports and all related corrective action plans.
- The notebook will be available to parents for review during regular business hours.
- Licensing inspection reports, special investigation reports, and corrective action plans from at least the past 3 years are available on the Child Care Licensing Bureau's website at www.michigan.gov/michildcare.

I have read the above statement issued by _____

Name of Child Care Center

Child(ren)'s Name(s):	
--------------------------	--

Parent Name _____

Parent Signature _____

Date _____

LARA is an equal opportunity employer/program.

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.

CHILD INFORMATION RECORD

State of Michigan - Department of Licensing and Regulatory Affairs - Child Care Licensing Bureau

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
Parent/Legal Guardian's Name			Primary Phone ()	Parent/Legal Guardian's Name (Optional)
Home Address (if not child's address)			2 nd Phone (if applicable) ()	Primary Phone ()
City	State	Zip Code	City	State
Email Address (optional)			Email Address (optional)	
Employer Name			Work Phone ()	Employer Name
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? Yes <input type="checkbox"/> No <input type="checkbox"/> If yes, explain: (Attach additional sheets, if necessary.)				

CCL-3731 (Rev. 3/17/2022) Previous editions 7-18 & 4-21 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.	()

Parent/Legal Guardian Initials:

_____ I give permission to _____, licensed by the Department of Licensing and Regulatory Affairs 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
LARA is an equal opportunity employer/program.						AUTHORITY: 1973 PA 116 COMPLETION: Required PENALTY: Rule Violation Citation.	

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