

**Directions:** Please complete this form in its entirety. This form is kept on file in the school office for one year. You are responsible to complete and sign a new form every year that your child is enrolled in school. You have the right at any time during the school year to make changes to or update this form.

Student Name \_\_\_\_\_ School Year \_\_\_\_\_

Birthdate \_\_\_\_\_ Age \_\_\_\_\_ Sex \_\_\_\_\_

Date of Baptism \_\_\_\_\_ City & State of Baptism \_\_\_\_\_

Class

- preschool (child must be 3)  
 pre-kindergarten (child must be 4 by Sep 1)

Length

- half day (\$90/week) Select days: M T W R F  
 full day with after care (\$160/week)  
 full day without after care (\$135/week)

Parent/Guardian information:

Mother

Father

Name	_____	_____
Address	_____	_____
City	_____	_____
State	_____	_____
Zip	_____	_____
Phone	_____	_____
Email	_____	_____
Church membership	_____	_____
Denomination	_____	_____

Child resides with (check all that apply):  Mother  Father  Guardian

Billing address (if different from above) \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Parent Signature \_\_\_\_\_ Date \_\_\_\_\_

Parent Signature \_\_\_\_\_ Date \_\_\_\_\_

*ISJ Academy admits students of any race, color, national, or ethnic origin. All students are entitled to the rights, privileges, programs, and activities generally accorded or made available to students at the school. ISJ does not discriminate based on race, color, national or ethnic origin in the administration of its policies, admission policies, scholarship programs, athletic, and other school administered programs.*

**FOR OFFICE USE ONLY**

Received:  security deposit  registration fee  insurance fee  birth certificate  health appraisal form

## HEALTH OF CHILD & EMEGENCY CONTACT INFORMATION

State regulations require a completed health appraisal form for every child. This form is to be completed and signed by a physician or authorized medical professional. Your child's health appraisal must be completed and filed in the school office within ten days of the child's admittance into school or the child may be excluded from the program.

**Please check all that apply to your child's health and provide additional information if necessary:**

- My child is in good health and immunizations are up to date.
- My child has asthma.
- My child has a peanut allergy.
- My child has medication that is to be administered daily while at school. (Please complete the Medication Form)
- My child has the following allergies (please list): \_\_\_\_\_

- My child has the following restrictions placed on physical activity (please list): \_\_\_\_\_

## DOCTOR INFORMATION

Physician name \_\_\_\_\_ Phone \_\_\_\_\_

Address \_\_\_\_\_

Hospital preference \_\_\_\_\_

Date of last DTaP (Diphtheria, tetanus, pertussis) shot \_\_\_\_\_

Health Insurance Provider \_\_\_\_\_

Health Insurance Policy Number \_\_\_\_\_

Provide any special needs and/or instructions \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

*In case of an emergency, such as an accident or serious illness, I understand that the school shall attempt to contact the doctor listed above and follow the doctor's directions. If ISJ cannot contact the doctor, I authorize the school to take whatever steps deemed necessary.*

Initials \_\_\_\_\_

**ALTERNATE CAREGIVER:** If I am unable to pick up or drop off my child, I authorize the following person/s to drop off or to pick up my child on a regular basis.

Name \_\_\_\_\_ Phone \_\_\_\_\_

**EMERGENCY CONTACT INFORMATION:** In case I/we am unavailable during an emergency, please contact either of the following two people who will assume temporary care of my child until I am available.

	<u>Person 1</u>	<u>Person 2</u>
Name	_____	_____
Address	_____	_____
City	_____	_____
State	_____	_____
Zip	_____	_____
Phone	_____	_____
Email	_____	_____
Relationship	_____	_____

## ACKNOWLEDGEMENTS AND PERMISSIONS

Please read the following statements and policies, select an option when necessary to grant or deny permission, and initial each to indicate you have read each item.

### USE OF PESTICIDES

As part of ISJ's pest management program, pesticides are occasionally applied. You have the right to be informed of any pesticide application made to the school grounds or buildings. In certain emergencies, pesticides may be applied without prior notice, but you will be provided notice following any such application. **Please, select one:**

- I do want to be notified me prior to the use of pesticides
- I do not want to be notified prior to the use of pesticides

Initials \_\_\_\_\_

### RELEASE OF WRITTEN OR VISUAL ARTWORK

I/We being the parents/guardians of the student named above, hereby consent that the written or visual artwork of my child during the school year while enrolled as a student at ISJ Academy may be used as indicated in any of the following ways. The student's work may be used in the school newsletter, in local newspapers, school brochures, power point presentations, the school website, app, and on the official school Facebook pages. The work may be identified by the following **(please select one):**

- First name and grade
- First name only
- Grade only
- I DO NOT give my consent to have my child's written or visual artwork used by ISJ Academy. Initials \_\_\_\_\_

### PHOTO RELEASE

I/We, being the parents/guardians of the student named above hereby consent that the photographs or videos taken of my child during the school year while enrolled as a student at ISJ Academy may be used in the following ways. These pictures may be used on school bulletin boards, in the school newsletter, in local newspapers, school brochures, power point presentations, the school website, app, and the official school Facebook pages. When pictures of students are placed on the internet, there will be no personal identification of any student by name. **Please, select one:**

- I give my consent to have my child's photos to be used by ISJ Academy.
- I DO NOT give my consent to have my child's photos used by ISJ Academy.

Initials \_\_\_\_\_

**TUITION**

Parental/guardian commitment to their tuition and fee obligations is crucial to the school’s continued operation and vitality. In order to meet our financial obligations, tuition and fees must be paid in a timely manner. The following is a summary of the tuition policy set in the ISJ Policy & Procedures Handbook:

- Tuition includes a non-refundable registration fee of \$50 and a \$10 insurance fee; neither qualifies for any discount.
- A \$10 late fee will be charged for each day tuition is late.
- Any check returned for non-sufficient funds will be charged a \$25 fee.
- ISJ requires a 30-day notice for withdrawal.
- If payments are 14 days overdue, the account will be classified as outstanding/bad debt and the process outlined in the Policy & Procedures Handbook applies.
- Account balances must be current for your child to begin the school year. If balances are outstanding, your child will not be allowed to enroll.

**Initials** \_\_\_\_\_

**RECEIPT OF HANDBOOK**

I acknowledge that I have received a copy of ISJ Academy’s policy and procedures manual. I understand that it provides guidelines and summary information about ISJ’s personnel policies, procedures, benefits, and rules of conduct. I also understand that I am responsible to read, understand, become familiar with, and comply with the standards that I have been established. I further understand that ISJ reserves the right to modify, supplement, rescind, or revise any provision, benefit, or policy from time to time, with or without notice, as it deems necessary or appropriate.

**Initials** \_\_\_\_\_

**STATEMENT OF ABUSE & NEGLECT**

I acknowledge that I have been informed of, read, and understand ISJ’s policy on child abuse and neglect as stated in the handbook. I am aware that abuse and neglect of children is against the law. I know that Michigan law mandates that caregivers and teachers report abuse and neglect.

**Initials** \_\_\_\_\_

**WALKING FIELD TRIPS**

Occasionally, we at ISJ ECC like to take walking trips around our campus and in the neighborhood to nearby locations such as St. James Church, Briggs Park, Frosty Boy Ice Cream Shop, and the like. When we take trips off campus to other locations you will be notified in advance of days and times. By initialing below, you give permission for your child to attend these walking trips unless you notify us in writing that permission has been revoked for a particular trip.

**Initials** \_\_\_\_\_

**PERMISSION TO APPLY OTC TOPICAL OINTMENTS**

By initialing below give permission for ISJ Staff to apply any of the following OTC topical ointments (check all that apply) to my child as needed. I also understand that I am responsible for supplying these products and making sure that instructions on frequency of use are provided.

- Sunscreen
- Insect repellent
- Hand lotion
- other please specify \_\_\_\_\_

**Initials** \_\_\_\_\_

# 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.

<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		Primary Phone ( )	Parent/Legal Guardian's Name (Optional)		Primary Phone ( )
Home Address (if not child's address)		2 <sup>nd</sup> Phone (if applicable) ( )	Home Address (if not child's address)		2 <sup>nd</sup> 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? Yes <input type="checkbox"/> No <input type="checkbox"/> 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.	( )

**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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PHYSICS DEPARTMENT

PHYSICS 551

NAME	
NUMBER	

DATE

TOPIC

PROBLEM

SOLUTION

ANSWER

DISCUSSION

CONCLUSION

REFERENCES

APPENDIX

NOTES

QUESTIONS

ANSWERS

EXERCISES

PROBLEMS

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## WRITTEN INFORMATION PACKET DOCUMENTATION

Michigan Department of Licensing and Regulatory Affairs

Child Care Licensing Bureau

<b>Child(ren)'s Name(s) (Last, First)</b>	<b>Facility's Name and License Number</b> Immanuel St. James Lutheran Preschool DC410017375
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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](http://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](http://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.





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

Form with fields for CHILD'S NAME, ADDRESS (Number & Street), CITY, (ZIP Code), DATE OF BIRTH, TODAY'S DATE, PARENT/GUARDIAN, HOME TELEPHONE NUMBER, WORK TELEPHONE NUMBER.

SECTION I - HEALTH HISTORY

Form with multiple rows for health history questions (Allergies, Hay Fever, Eczema, etc.), Birth History section, and medication information.

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

Tests and Measurements

Table with columns for tests (VISION, HEARING, URINALYSIS, BLOOD LEAD LEVEL, HEIGHT & WEIGHT, HEMOGLOBIN / HEMATOCRIT, BLOOD PRESSURE, TUBERCULIN) and checkboxes for results (Normal, Referred, Under Care).

Examinations and/or Inspections

Form with field for Essential Findings Deviating from Normal and Exam Date.

<b>SECTION III - IMMUNIZATIONS</b>					
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
DTaP/DTP/DT/Td	1	4		2	4
	2	5	Meningococcal (MCV4 / MPSV4)	1	2
	3	6	Human Papillomavirus (HPV9/HPV4/HPV2)	1	3
Tdap	1			2	
Haemophilus Influenzae type b (HIB)	1	3	OTHER Vaccines Specify Date & Type	Type of Vaccine(s)	Date of Vaccine(s)
	2	4		1	
Polio (IPV/OPV)	1	3		2	
Pneumococcal Conjugate (PCV7/PCV13)	2	4	3		
	1	3	Indicate and attach physician diagnosis or laboratory evidence of Immunity as applicable		
Rotavirus (RV1/RV5)	2		*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.		
Measles, Mumps, Rubella (MMR)	1	2			
Varicella (Chickenpox)	1	2	Parent/Guardian refused immunizations: <input type="checkbox"/>		
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

		<b>SECTION IV - RECOMMENDATIONS</b>			
		(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:			
<input type="checkbox"/>	<input type="checkbox"/>				
<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			
<input type="checkbox"/>	<input type="checkbox"/>				
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: _____
_____ Dentist's Signature	_____/_____/_____ Date

<b>PHYSICIAN'S SIGNATURE</b>			
_____ 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.