



Little Treasures

Early Childhood Center

Registration Checklist

- _____ Child Information Record
- _____ Tuition Agreement Contract
- _____ HEIS Food Forms
- _____ Health Appraisal Form
- _____ Immunizations
- _____ Screening Consent Form
- _____ First Week's Tuition
- _____ Enrollment Fee
- _____ Child Pilot Sign Up

As of _____, Little Treasures Early Childhood Center agrees to provide childcare services for the following named child(ren):

Name of Child: _____

Date of Birth: _____

Name of Child: _____

Date of Birth: _____

Name of Child: _____

Date of Birth: _____

My child(ren) will be attending the:

- 4196 Airport Road Location
- 3525 Elizabeth Lake Road Location



Little Treasures
Early Childhood Center

CHILD INFORMATION RECORD

State of Michigan - Department of Licensing and Regulatory Affairs - 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)				Date of Birth	
Address (Number and Street, Building/Apartment Number)			City	State	Zip Code
Parent/Legal Guardian's Name		Home Phone ()	Parent/Legal Guardian's Name (Optional)		Home Phone ()
Home Address (if not child's address)		Cell Phone ()	Home Address (if not child's address)		Cell Phone ()
City	State	Zip Code	City	State	Zip Code
Email Address			Email Address		
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					
Allergies, Special Needs and Special Instructions (Attach additional sheets, if necessary.)					

BCAL-3731 (Rev. 7-18) Previous edition 6-17 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.	

BCAL-3731 (Rev. 7-18) Previous edition 6-17 may be used.

Tuition Agreement Contract

Thank you for selecting Little Treasures to be your childcare provider! We are excited for a fun year ahead. In order to provide a safe, quality learning experience and plan for needed resources and teachers for the children at Little Treasures, payment is expected regardless of absence.

Payment obligations are based on the days that you agree to use Little Treasures, not on actual attendance to ensure a spot for your child. Two methods of payments are required to be kept on file using our Child Pilot software. Automatic billing will occur on every Friday for the upcoming week.

I understand:

- **Payments will occur every Friday for the upcoming week.**
- **Payment will be due weekly or monthly based upon agreed tuition amount regardless of absence, school closings or holiday breaks.**
- **There will be no reduction/adjustment in tuition for sickness, holidays, school closings, student absences, vacations, or snow days.**
- **If my child attends part time and will be absent, they may make up a day on a future date of parent's choice within the next ninety days.**
- **If I do not bring my child on their scheduled days, my weekly tuition amount will still be the same.**
- I must call or message Little Treasures if my child will be absent.
- Little Treasures will sometimes close for inclement weather. Please have alternate care in case of a snow day.
- If payment is late, a \$10.00 late fee will be added everyday payment is not made.
- If there are no sufficient funds on either form of payment, a \$25.00 fee will be added to the current balance.
- I must give a written notice of one week to begin the withdrawal period. If no notice is given, payment is still due for the one week.
- If I do not show respect to staff and students, my child may be withdrawn, and the contract will be terminated. Payment will still be due.
- After 2 weeks of non-attendance/non-payment, your child may be withdrawn from Little Treasures if you have not spoken with staff.

I understand and agree to the terms of the Little Treasures Early Childhood Center Tuition Agreement Contract.

Parent Signature: _____

Date: _____

Expected Hours of Care Needed

MON.	TUES.	WED.	THURS.	FRI.

\$75 ANNUAL ENROLLMENT FEE

\$100 ANNUAL ENROLLMENT FEE FOR FAMILIES

_____ PER WEEK

_____ PER MONTH**

_____ TOTAL FIRST PAYMENT DUE BEFORE START DATE

ONLY AN OPTION IF CHILD(REN) ATTEND FULL TIME

Licensing Rules Disclosure Form 2023-2024

Little Treasures Early Childhood Center is required to inform you that Pursuant to rule 146 (i) (III) of the Licensing Rules for Child Care Center for the State of Michigan:

The licensing notebook contains all of the inspections, investigation reports and corrective action plans. The licensing notebook is available to all parents during regular business hours.

Licensing inspection and special investigation reports from at least the past 2 years are available on the childcare licensing website at www.michigan.gov/michildcare

If at any time you would like to see this notebook it is available during regular business hours.

Picture/Video Release Form

Little Treasures would like to take pictures and videos of the students throughout the day. These pictures will be used to show learning activities. The pictures will be used to send to parents, in newsletters, and on our website for school purposes. Little Treasures would like your permission to post your reviews from social media to our website.

- I give permission to Little Treasures to take and use pictures/videos of my child. I release Little Treasures from any claims arising out of the use of pictures/videos that I, or my child may have.

- I give permission to Little Treasures to post reviews or statements I make about Little Treasures on their website and social media.

- I do not give Little Treasures my permission to take and use pictures/videos of my child (This does not include the use of security cameras). I release Little Treasures from any claims arising out of the use of pictures/videos that I, or my child may have.**

Parent Signature: _____

Date: _____

Sunscreen and Topical Creams

I give the staff at Little Treasures permission to apply sunscreen and topical creams/lotions. I will send all topical items and sunscreen from home (labeled with my child's name), if I would like it to be applied on my child while at school.

Parent Signature: _____

Date: _____

Planned Food Service Program Policy

Meals are eaten family style with staff sitting with the children. **Children may bring food from home for lunch or may eat breakfast, lunch and snack provided by Little Treasures.** You may provide a snack from home or we will have snacks available. If your child has any allergies, please notify us and provide a doctor's note that states the allergy name and reaction that can occur.

If students require special milk, parents may send in milk labeled with child's first name, last name and date. They will be discarded 7 days after opening and new milk will need to be sent in.

Infants-Enough bottles for the day must be prepared at home by parent and labeled with first, last name and date. New premade bottles must be sent each day. They must have cover on each bottle. You may also send in unopened commercially prepared liquid formula that is already mixed with bottles. Bottles will be refrigerated and warmed in bottle warmer. Center is not allowed to mix formula per licensing rules.

Diapers

Children will need to have the proper size of diapers left at school for changing purposes. Children will be changed every two hours per licensing rules. We ask that your child comes with a sufficient number of diapers, wipes, and diaper cream for the month. Communication will be passed on to the parents or guardians if a child needs more supplies. We understand that it may be difficult to find the time to obtain these supplies, so Little Treasures does offer a monthly fee of \$45.00 to ensure your child has diapers, wipes, and diaper cream. If this is something you would like to utilize, please check the box below.

- I would like Little Treasures to supply proper diapering materials for my child(ren)**

Discipline Policy Form

Staff will support children as they begin to understand their behavior choices and learn acceptable ways of interaction with others. The approach we use promotes and encourages self-regulation, self-direction, self-esteem, and a spirit of cooperation. We use a six-step process to resolve conflicts.

The steps are:

1. Approach children calmly and stop any hurtful actions
2. Acknowledge children's feelings
3. Involve children in identifying the problem by gathering information
4. Restate the problem in children's vocabulary
5. Ask children for solutions and encourage them to choose one together
6. Give follow-up support when children act on their decisions

Teachers at Little Treasures will utilize respectful and positive methods of discipline, so that each child is provided with a safe and nurturing learning environment. Students will learn to develop self-control and how to take responsibility for their own actions. Expectations will be clear and consistent.

Kicking, spitting, hitting, disrespectful verbal behavior, and other behaviors that will put your child or another child in danger are not permitted. Age-appropriate behavior will be modeled and taught. Logical consequences and a calm tone will be used for discipline.

Students will discuss their emotions and feelings in order to solve the behavior issue and may be redirected to a new activity.

If a certain behavior (excessive or aggressive) continues to become harmful to others, a parent meeting will be held to come up with a plan to resolve the concern privately. Parents will be provided with a behavior notice. If necessary, families will be connected with community resources for support.

If families are unable to follow the rules and agreements set by Little Treasures, the child will be withdrawn. If families and students are unable to speak/treat staff members with respect, their contract will be terminated immediately, and payment will still be due for the withdrawal period of two weeks after withdrawal date/notice. Based on the severity or danger of the situation, Little Treasures reserves the right to immediately exclude a child from the program permanently.

If needed, a behavior plan will be implemented. If efforts to correct inappropriate behavior are unsuccessful, your child may be suspended from care for a specific amount of time or withdrawn. Parents have the right to expect that their children will have proper supervision. A child who consistently needs the attention of the staff is taking away the rights and learning experiences of the other children and not allowing the needs of all children to be met.

Children may be withdrawn if efforts to control behavior do not work and other students are constantly put in danger.

The director has the right to request withdrawal of a child for reasons such as:

- Failure to provide the requirements listed above for admission-
- Non-payment of fees or tuition-
- Parental failure to follow school policies-
- Parental failure to show respect to staff members-
- Non-attendance of at least two weeks-
- Behavior-

Additional techniques to be used with my child:

Receipt of Parent Handbook Policies

I certify that I have received and understand the handbook, food service, discipline policy, licensing rules, and other school policies.

Upon signing this agreement, the parent or guardian and Little Treasures Early Childhood Center agree to abide by all the policies contained in this contract and within the parent handbook.

Parent Signature: _____

Date: _____

Screening Consent Form

The Ages and Stages Questionnaire-3 (ASQ-3) is a screening tool that asks questions about your child's overall and social emotional development, looking at how children are doing in the important areas of communication, physical ability, problem solving, and personal-social skills.

These screens can help identify your child's strengths as well as any areas where your child may need support. The screening should take about 10-20 minutes to answer questions about your child.

Your individual information is protected to ensure confidentiality. Information is entered on a web-based database that is secure and password protected. Identifying information from the screen will be seen only by the developmental screening specialist, who scores your screening and provides the results to you and the teacher.

General information about the ages and results of children's screening scores are computed at the Oakland Intermediate School District in order to better understand the strengths and challenges of the children living in Oakland County.

I have read the above description and give Great Start Oakland and Little Treasures consent to screen my child(ren).

Yes, I do wish to participate

No, I do NOT wish to participate

Parent/Guardian Signature

Date

Child's Name

Child's Name (if applicable)

Participant Enrollment Form

Instructions:

1. List full name of participant enrolled in care
2. Circle the typical days each participant is in care
3. List times each participant is in care
4. Circle the meals and snacks each participant typically receives while in care
5. Select the ethnicity of each participant using the following codes: H = Hispanic or Latino, N = Not Hispanic or Latino*
6. Select one or more racial designations of each participant using the following codes: A/I = American Indian or Alaskan Native, A = Asian, B = Black or African American, H/PI = Native Hawaiian or Pacific Islander, W = White*
7. Sign and date the form and return to your care center

Participant's First and Last Name	Typical Days in Care (circle all that apply)	List Times in Care	Meals/Snacks Received (circle all that apply)	Ethnicity	Race
	Mon Tues Wed Thu Fri Sat Sun		Breakfast AM Snack Lunch PM Snack Supper Evening Snack		
	Mon Tues Wed Thu Fri Sat Sun		Breakfast AM Snack Lunch PM Snack Supper Evening Snack		
	Mon Tues Wed Thu Fri Sat Sun		Breakfast AM Snack Lunch PM Snack Supper Evening Snack		
	Mon Tues Wed Thu Fri Sat Sun		Breakfast AM Snack Lunch PM Snack Supper Evening Snack		

* This information is voluntary. This will assist us in assuring the Child and Adult Care Food Program is administered in a nondiscriminatory manner.

Adult/Parent/Guardian's Address

Signature of Adult/Parent/Guardian

Adult/Parent/Guardian's Phone Number

Date Signed

Non-Discrimination Statement

In accordance with Federal civil rights law and U.S. Department of Agriculture (USDA) civil rights regulations and policies, the USDA, its Agencies, offices, and employees, and institutions participating in or administering USDA programs are prohibited from discriminating based on race, color, national origin, sex, disability, age, or reprisal or retaliation for prior civil rights activity in any program or activity conducted or funded by USDA. Persons with disabilities who require alternative means of communication for program information (e.g. Braille, large print, audiotape, American Sign Language, etc.), should contact the Agency (State or local) where they applied for benefits. Individuals who are deaf, hard of hearing or have speech disabilities may contact USDA through the Federal Relay Service at 800-877-8339. Additionally, program information may be made available in languages other than English.

To file a program complaint of discrimination, complete the [USDA Program Discrimination Complaint Form](http://www.ascr.usda.gov/complaint_filing_cust.html), (AD-3027) (http://www.ascr.usda.gov/complaint_filing_cust.html) online, and at any USDA office, or write a letter addressed to USDA and provide in the letter all of the information requested in the form. To request a copy of the complaint form, call 866-632-9992. Submit your completed form or letter to USDA by: (1) mail: U.S. Department of Agriculture, Office of the Assistant Secretary for Civil Rights, 1400 Independence Avenue, SW, Washington, D.C. 20250-9410; (2) fax: 202-690-7442; or (3) email: program.intake@usda.gov. This institution is an equal opportunity provider.

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	Resol ed	# Is your child having any of the problems listed below?	
<input type="checkbox"/>	<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"/>	<input type="checkbox"/>	2 Hay Fever, Asthma, or Wheezing	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	3 Eczema or Frequent Skin Rashes	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	4 Convulsions/Seizures	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	5 Heart Trouble	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	6 Diabetes	
<input type="checkbox"/>	<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"/>	<input type="checkbox"/>	8 Trouble with Passing Urine or Bowel Movements	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	9 Shortness of Breath	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	10 Speech Problems	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	11 Menstrual Problems	
<input type="checkbox"/>	<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"/>	<input type="checkbox"/>	Other (please describe): _____	
<input type="checkbox"/>	<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	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	HEIGHT & WEIGHT Other: _____	Height	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>		Muscle Imbalance	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		Weight	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>		Other: _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		Other: _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	HEARING Date: ___/___/___	Audiometer	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	HEMOGLOBIN / HEMATOCRIT BLOOD PRESSURE	Reading: _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>		Other: _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		Type: _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	URINALYSIS Date: ___/___/___	Sugar	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	TUBERCULIN Date: ___/___/___	Neg.: <input type="checkbox"/> Pos.: <input type="checkbox"/> _____ mm	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>		Albumin	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>					
<input type="checkbox"/>	<input type="checkbox"/>		Microscopic	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>					
<input type="checkbox"/>	<input type="checkbox"/>	BLOOD LEAD LEVEL Date: ___/___/___	Level _____ ug/dl	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	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)
Hepatitis B (HepB)	1	3	Hepatitis A (HepA)
	2		
DTaP/DTP/DT/Td	1	4	Influenza (IIV/LAIV)
	2	5	
	3	6	2
Tdap	1		Meningococcal (MCV4 / MPSV4)
<i>Haemophilus Influenzae</i> type b (HIB)	1	3	Human Papillomavirus (HPV9/HPV4/HPV2)
	2	4	
Polio (IPV/OPV)	1	3	OTHER Vaccines Specify Date & Type
	2	4	
Pneumococcal Conjugate (PCV7/PCV13)	1	3	
	2	4	Date of Vaccine(s)
Rotavirus (RV1/RV5)	1	3	1
	2		2
Measles, Mumps, Rubella (MMR)	1	2	3
Varicella (Chickenpox)	1	2	
History of Chickenpox Disease? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, date: _____		Parent/Guardian refused immunizations: <input type="checkbox"/> h	
I certify that the immunization dates are true to the best of my knowledge			
_____		_____	_____
<i>Health Professional's Signature</i>		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:	
<input type="checkbox"/> h	<input type="checkbox"/> h		
<input type="checkbox"/> h	<input type="checkbox"/> h	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	

_____	_____ / _____ / _____
<i>Dentist's Signature</i>	Date

PHYSICIAN'S SIGNATURE			
_____	_____ / _____ / _____	_____	_____
<i>Examiner's Signature</i>	Date	<i>Examiner's Name (Print or Type)</i>	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.

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.