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

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

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)			Child's 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 Do Not _____ 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 6-17may be used.

Tuition Agreement Contract 1

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**. Payments may be paid by check, cash, credit card, money order, Cash App, on the website, through the invoice sent to your email or with PayPal.

I understand:

- **Payments must be made on Friday, prior to the start of the upcoming week or monthly on the first school day of the month, if paid monthly.**
- **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. If my child attends full time and will be missing 5 consecutive days, 50% of tuition will be due for the week absent. (If notified ahead of time) Ex: Tuition=$200.00 50%=$100.00**
- If I do not bring my child on their scheduled days, my weekly tuition amount will still be the same. There will be no refunds/credits for missed days of care.
- 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.
- Little Treasures reserves the right to immediately withdraw a child and terminate contracts when they deem necessary.

- Children must be fever free without medicine for a full 24 hours, the next day, before returning to school. If children have thrown up, fever or had severe diarrhea, other contagious illness, they may not return to school the next day. They must wait one school day/24 hours before returning to school. They must stay home for a full 24 hours the next day, not 24 hours from the last illness incident. Ex: Vomited on Tuesday at 9am, must stay home Wednesday and ,may return on Thursday if no symptoms present. Children who live in same household with similar symptoms must go home with sick child.

- I must give a written notice of one week to begin the withdrawal period. If withdrawing with no notice, payment is still due for the one week.
- If I do not show respect to staff and students, my child may be withdrawn immediately and the contract will be terminated. Payment will still be due for the two-week withdrawal period.
- After 2 weeks of non-attendance/non-payment, your child may be withdrawn from Little Treasures if you have not spoken with Stephanie Medina.

Tuition deposit will be put towards last week before withdrawal. Families must give at least one week notice and make payments for the last week. You may either put a credit card on file or pay one week of tuition deposit at enrollment. If no deposit has been given, credit card on file will be charged for last week if payment has not been made and no notice has been given when withdrawing. If credit card is not valid or does not go through. Payment will be referred to a debt collection agency.

****Parent Signature:**_____ **Date:**_____

Expected Care Hours For Child

Monday	Tuesday	Wednesday	Thursday	Friday
Am				
Pm				

If you are in of need before and after school care, please also write the times needed above, so I am able to make sure you are accommodated and I am in ratio. Please let me know schedule changes at least a week in advance. I understand changes may come up and I will do my best to accommodate day of or day before changes, if possible, if you need your child to stay later than scheduled times.

☐ **$70.00 Annual Enrollment Fee per child/$100 per Family**

☐ Weekly Amount Paid $_____

Payments will be made ☐ Weekly ☐ Monthly

Licensing Rules Disclosure Form 2021-2022

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 child care 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.**

Sunscreen and Topical Creams

I give the staff at Little Treasures 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/Guardian Signature_____

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 requires 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 that wear diapers or pull ups must have enough diapers/wipes at school to last at least a week or more. Children are changed every two hours or more as needed per licensing. **(20-25 diapers/week depending on the child)** We will store them safely in a bin with your child's name to make changing quick and easy. When you are running low, we will send a note to ask you to send more in to leave at school. We thank you for your cooperation.

If you would like Little Treasures to provide diapers and wipes for your child instead of you sending them in, there will be a fee of $45.00/month. This breaks down to $2.25/day.

Payment must be made for the month in total. Please pay by the beginning of each month.

☐ I would like Little Treasures to provide diapers and wipes for my child.

Discipline Policy Form

Teachers at Little Treasures will utilize 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. We know that conflicts will arise. We will work with children to solve their problems and create a positive learning situation. Children will learn conflict resolution skills and will be respected.

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/parents are unable to follow the rules and agreements set by Little Treasures, the child will be withdrawn. If families/parents 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/the child may be withdrawn and contract terminated.

Parents have the right to expect that their children will have proper supervision. A child who consistently needs the attention of the staff because of behavior 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 a specific behavior do not work and other students are constantly put in danger.

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 Learning Center agree to abide by all of the policies contained in this contract and within the parent handbook.

_____ _____

Parent/Guardian's 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)

Required

Return this completed form to: *(Little Treasures, 3525 Elizabeth Lake Road, Suite C, Waterford, MI 48328 & 248-270-5158)*

Household Income Eligibility Statement – Child Care Institutions

Part 1 – Households Receiving Food Assistance Program (FAP), Family Independence Program (FIP), or Food Distribution Program on Indian Reservations (FDPIR)

If any member of your household receives FAP, FIP, or FDPIR, provide the name and case number for the person who receives the benefits.

Name:____**Case Number:** ___ ___ ___ ___ ___ ___ ___ ___ ___

Part 2 – Household Information

First and Last Names of All Household Members, Related and Unrelated	Enrolled for Child Care (x)	Age	Birth Date	Foster Child (x)	Amount of Earnings from Work (before deductions)	How Often? (x) Annually	Monthly	2x Month	BI Weekly	Weekly	Amount of Welfare, Child Support, or Alimony	How Often? (x) Annually	Monthly	2x Month	BI Weekly	Weekly	Amount of All Other Income (Indicate source and amount)	How Often? (x) Annually	Monthly	2x Month	BI Weekly	Weekly	Mark if No Income (x)
	☐			☐		☐	☐	☐	☐	☐		☐	☐	☐	☐	☐		☐	☐	☐	☐	☐	☐
	☐			☐		☐	☐	☐	☐	☐		☐	☐	☐	☐	☐		☐	☐	☐	☐	☐	☐
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Part 3 – All Households: Signature and Last Four (4) Digits of Adult Social Security Number (Adult household member MUST sign and date)

I certify that all information on this form is true and that all income is reported. I understand that the center or day care home will receive federal funds based on the information I give. I understand that CACFP officials may verify the information. I understand that if I purposely give false information, the participant receiving meals may lose the meal benefits, and I may be prosecuted.

Signature: ____ Print Name:____ Date: __________________

Last four digits of Social Security Number: XXX-XX-_ _ _ _ ☐ I do not have a Social Security Number

For Institution Use Only:

For Institution Use Only		
Total Household Members:	Total Income: $ ____ Annually ____ Monthly ____ 2x Month ____ Bi-Weekly ____ Weekly	APPROVED CATEGORY Categorical Eligibility (A/Free): Foster FIP FAP FDPIR Other Household Children: A (Free) B (Reduced) C (Paid)
Institution Official Signature: ______________________________________ Approval Date: _____________		

This form is valid for 12 months from the date of institution signature. Approval date and institution signature are required.

Return this completed form to: (*Little Treasures, 3525 Elizabeth, Lake Road, Suite C, Waterford, MI 48327, 248-270-5158)*

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

_____ Adult/Parent/Guardian's Phone Number

_____ Signature of Adult/Parent/Guardian

_____ 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, (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.

MICHIGAN Department of Education

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?
☐	☐	☐	1 Allergies or Reactions (for example, food, medication or other)
☐	☐	☐	2 Hay Fever, Asthma, or Wheezing
☐	☐	☐	3 Eczema or Frequent Skin Rashes
☐	☐	☐	4 Convulsions/Seizures
☐	☐	☐	5 Heart Trouble
☐	☐	☐	6 Diabetes
☐	☐	☐	7 Frequent Colds, Sore Throats, Earaches (4 or more per year)
☐	☐	☐	8 Trouble with Passing Urine or Bowel Movements
☐	☐	☐	9 Shortness of Breath
☐	☐	☐	10 Speech Problems
☐	☐	☐	11 Menstrual Problems
☐	☐	☐	12 Dental Problems: Date of Last Exam / /
☐	☐	☐	Other (please describe): _____
☐	☐		Does your child take any medication(s) regularly?
Reason for Medication			

Birth History:

Are there any current or past diagnosis(es) ☐ Yes ☐ No

If yes, please describe:

If yes, list medications:

_____ / /
Parent/Guardian Signature Date

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

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
☐	☐	VISION Date: / /	Visual Acuity			
			Muscle Imbalance			
			Other:			
☐	☐	HEARING Date: / /	Audiometer			
			Other:			
☐	☐	URINALYSIS Date: / /	Sugar			
			Albumin			
			Microscopic			
☐	☐	BLOOD LEAD LEVEL Date: / /	Level _____ ug/dl ⇨			

No	Yes	Was child tested for:	Test results:	Normal	Referred	Under Care
☐	☐	HEIGHT & WEIGHT	Height			
			Weight			
		Other: _____	Other			
☐	☐	HEMOGLOBIN / HEMATOCRIT	⇨			
☐	☐	BLOOD PRESSURE	Reading: _____			
☐	☐	TUBERCULIN Date: / /	Type: _____ Neg.: ☐ Pos.: ☐ _____ mm			

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	
Hepatitis B (HepB)	1	3
	2	
DTaP/DTP/DT/Td	1	4
	2	5
	3	6
Tdap	1	
Haemophilus Influenzae type b (HIB)	1	3
	2	4
Polio (IPV/OPV)	1	3
	2	4
Pneumococcal Conjugate (PCV7/PCV13)	1	3
	2	4
Rotavirus (RV1/RV5)	1	3
	2	
Measles,Mumps, Rubella (MMR)	1	2
Varicella (Chickenpox)	1	2

History of Chickenpox Disease? ☐ Yes ☐ No If yes, date:

VACCINES (Circle Type)	DATE ADMINISTERED MM/DD/YYYY	
Hepatitis A (HepA)	1	2
Influenza (IIV/LAIV)	1	3
	2	4
Meningococcal (MCV4 / MPSV4)	1	2
Human Papillomavirus (HPV9/HPV4/HPV2)	1	3
	2	
	Type of Vaccine(s)	Date of Vaccine(s)
OTHER Vaccines Specify Date & Type	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.

Parent/Guardian refused immunizations: ☐

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

_____ _____ ___/___/___

Health Professional's Signature Title Date

SECTION IV - RECOMMENDATIONS

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

No	Yes	
☐	☐	Is there any defect of vision, hearing or other condition for which the school could help by seating or other actions? If yes, please explain:
☐	☐	Should the child's activity be restricted because of any physical defect or illness? If yes, check and explain degree of restriction(s): ☐ Classroom ☐ Playground ☐ Gymnasium ☐ Swimming Pool ☐ Competitive Sports ☐ Other

Other Recommendations

SECTION V - DENTAL EXAMINATION AND RECOMMENDATIONS (OPTIONAL)

I have examined _____ '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

_____ _____ 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.

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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.