

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) | TODAY'S DATE (mm/dd/yy) / / |
| PARENT/GUARDIAN (Last, First, Middle) | | | HOME TELEPHONE NUMBER () |
| ADDRESS (Number & Street) | (City) | (ZIP Code) | 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 | 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 | | | |
| | 3 | 6 | Human Papillomavirus (HPV9/HPV4/HPV2) | 1 | 3 |
| Tdap | 1 | | | 2 | |
| <i>Haemophilus Influenzae</i> 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 | |
| | 2 | 4 | 3 | | |
| Pneumococcal Conjugate (PCV7/PCV13) | 1 | 3 | <i>Indicate and attach physician diagnosis or laboratory evidence of immunity as applicable</i> | | |
| | 2 | 4 | *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. | | |
| Rotavirus (RV1/RV5) | 1 | 3 | | | |
| | 2 | | Parent/Guardian refused immunizations: <input type="checkbox"/> | | |
| 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 | | | | | |
| _____ / _____ / _____ <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"/> | <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 | | |
| _____ | | |

| 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 |
| _____ / _____ / _____ 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.

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 (optional) | | 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 (optional) | | | |
| Allergies, Special Needs and Special Instructions (Attach additional sheets, if necessary.) | | | |

BCAL-3731 (Rev. 6-17) Previous editions 4-16, 6-15 and 7-12 may be used until September 30, 2018.

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 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 | |

BCAL-3731 (Rev. 6-17) Previous editions 4-16, 6-15 and 7-12 may be used until September 30, 2018.

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. |
|--|

Return this completed form to: *(insert institution's name, address & telephone number)*

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

USDA Nondiscrimination Statement

In accordance with federal civil rights law and U.S. Department of Agriculture (USDA) civil rights regulations and policies, this institution is prohibited from discriminating on the basis of race, color, national origin, sex (including gender identity and sexual orientation), disability, age, or reprisal or retaliation for prior civil rights activity. Program information may be made available in languages other than English. Persons with disabilities who require alternative means of communication to obtain program information (e.g., Braille, large print, audiotape, American Sign Language), should contact the responsible state or local agency that administers the program or USDA's TARGET Center at (202) 720-2600 (voice and TTY) or contact USDA through the Federal Relay Service at (800) 877-8339. To file a program discrimination complaint, a Complainant should complete a Form AD-3027, USDA Program Discrimination Complaint Form which can be obtained online at: [USDA Program Discrimination Complaint Form](#), from any USDA office, by calling (866) 632-9992, or by writing a letter addressed to USDA. The letter must contain the complainant's name, address, telephone number, and a written description of the alleged discriminatory action in sufficient detail to inform the Assistant Secretary for Civil Rights (ASCR) about the nature and date of an alleged civil rights violation. The completed AD-3027 form or letter must be submitted to USDA by: **mail:** U.S. Department of Agriculture, Office of the Assistant Secretary for Civil Rights, 1400 Independence Avenue, SW, Washington, D.C. 20250-9410; or **fax:** (833) 256-1665 or (202) 690-7442; or **email:** program.intake@usda.gov

This institution is an equal opportunity provider.

USDA Civil Rights Complaint Link:
<https://www.usda.gov/sites/default/files/documents/USDA-OASCR%20P-Complaint-Form-0508-0002-508-11-28-17Fax2Mail.pdf>

Privacy Act Statement

The Richard B. Russell National School Lunch Act requires the information on this application. You do not have to give the information, but if you do not, we cannot approve the participant for free or reduced-price meals. You must include the last four digits of the Social Security Number of the adult household member who signs the application. The Social Security Number is not required when you apply on behalf of a foster child or you list a Food Assistance Program (FAP), Family Independence Program (FIP), or Food Distribution Program on Indian Reservations (FDPIR) case number for the participant or other FDPIR identifier or when you indicate that the adult household member signing the application does not have a Social Security Number. We will use your information to determine if the participant is eligible for free or reduced-price meals, and for administration and enforcement of the Program.

USDA Nondiscrimination Statement

In accordance with federal civil rights law and U.S. Department of Agriculture (USDA) civil rights regulations and policies, this institution is prohibited from discriminating on the basis of race, color, national origin, sex (including gender identity and sexual orientation), disability, age, or reprisal or retaliation for prior civil rights activity.

Program information may be made available in languages other than English. Persons with disabilities who require alternative means of communication to obtain program information (e.g., Braille, large print, audiotope, American Sign Language), should contact the responsible state or local agency that administers the program or USDA's TARGET Center at (202) 720-2600 (voice and TTY) or contact USDA through the Federal Relay Service at (800) 877-8339.

To file a program discrimination complaint, a Complainant should complete a Form AD-3027, USDA Program Discrimination Complaint Form which can be obtained online at: [USDA Program Discrimination Complaint Form](#), from any USDA office, by calling (866) 632-9992, or by writing a letter addressed to USDA. The letter must contain the complainant's name, address, telephone number, and a written description of the alleged discriminatory action in sufficient detail to inform the Assistant Secretary for Civil Rights (ASCR) about the nature and date of an alleged civil rights violation. The completed AD-3027 form or letter must be submitted 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; or 2. **fax:** (833) 256-1665 or (202) 690-7442; or **email:** program.intake@usda.gov

This institution is an equal opportunity provider.

USDA Civil Rights Complaint Link:

<https://www.usda.gov/sites/default/files/documents/USDA-OASCR%20P-Complaint-Form-0508-0002-508-11-28-17Fax2Mail.pdf>

Consent for Disclosure of Personally Identifiable Information and Immunization Information to Local and State Health Departments

Immunizations are an important part of keeping our children healthy. Schools and State and Local health departments must monitor immunization levels to ensure that all communities are protected from potentially life-threatening diseases and, if necessary, respond promptly to an emerging public health threat. It is important that disease threats be minimized through the monitoring of students being immunized.

Sharing immunization and personally identifiable information including the student's name, Date of Birth, gender, and address with local and state health departments will help to keep your child safe from vaccine preventable diseases. The Family Educational Rights and Privacy Act (FERPA), 20 U.S.C. § 1232g, requires written parental consent before personally identifiable information and immunization information from your child's education records is disclosed to the health department. If your child is 18 or over, he or she is an "eligible student" and must provide consent for disclosures of information from his or her education records.

You may withdraw your consent to share this information in writing at any time.

I authorize Bradford Academy to release my child's immunization record and personally identifiable information to the Michigan Department of Health and Human Services and Local Health Department. I understand this information will be used to improve the quality and timeliness of immunization services and to help schools comply with Michigan Law. This includes any immunization information and limited personally identifiable information from the school.

Student's Name: _____

Date of Birth: __/__/__

Signature of Parent/Guardian
or Eligible Student:: _____

Date of Birth: __/__/__

Printed Parent/Guardian Name: _____



GSRP Media Release

Please be advised that your child, _____ may be photographed or videotaped during the school day, field trips, or other school events. These photos may be posted on our website, in the building, or in the classroom for public view.

- I hereby grant permission to GSRP to photograph/video my child.

- I do not grant permission to GSRP to photograph/video my child.

Parent Signature

Date

Getting to Know More about Your Child

Tell us more about your child to help us support the transition into school. Enrollment is not determined based on responses to these questions.

Please circle the interest areas in our classroom that you think your child will enjoy the most:

| | | |
|------------------|--------------------------|---------------------|
| Block Area | House Area | Art Area |
| Toy Area | Reading and Writing Area | Sand and Water Area |
| Woodworking Area | Movement & Music Area | Computer Area |
| | Outdoor Area | |

Experiences with Language(s)

What language(s) does your family speak? _____

How much experience (exposure) has your child had with the(se) languages? _____

Is your child growing up with two languages? _____ If so, what are the languages? _____

Can you tell me about your child's use of English (if at all)? _____

Experiences:

What are some of the ways your child plays at home? _____

Does your child play with children from other households? _____ If yes, how? _____

Has your child ever used: scissors? _____ Glue? _____ Crayons? _____ Paint? _____ Pencil? _____

What other school-type experience has your child had? _____

Approximately how many hours does your child spend daily watching TV? _____

Approximately how many hours does your child spend daily playing video games? _____

Approximately how many hours does your child spend daily on the computer or a tablet? _____

Eating Habits:

At what time does your child eat breakfast? _____ Lunch? _____ Dinner? _____

Between meal snacks? _____ Does your child feed himself/herself? _____

Food Favorites: _____

Food Dislikes: _____

Food Allergies: _____

What foods does your child eat at home? _____

Sleep Habits:

Does your child have his/her own room? ____ Shares room with: _____ (other children, parents)

At night sleeps from _____ to _____ Average hours of sleep per night: _____

Does your child sleep through the night? ____ Naps from _____ to _____ Average Hours of Naps: ____

Toilet Habits:

Can your child use the bathroom independently? _____

Does your child tell you when he/she needs to go? _____

What words does your child use for urinating and bowel movements? _____

If you have further questions please call the Preschool Programs office at _____