ST. MARY CATHOLIC SCHOOL

220 N. Cedar Street • Williamston, MI 48895 • P(517) 655-4038

A Covenant Between
Parents of Children Attending Saint Mary School
and
Saint Mary School and Parish

As the Catholic Church teaches, parents are the primary educators of their children, charged to hand on the Faith to a new generation of Catholic Christian disciples. Saint Mary School is excited that parents have chosen the School as their partner in this vital undertaking. Parents and the School reinforce each other's efforts by manifesting the centrality of Christ through words and actions that are readily apparent to the children.

Thus, Saint Mary School and Parish commit themselves to:

- Undertake the sacred work of educating and forming disciples. To this end, school personnel will pray daily for students and parents, and will hold themselves to high standards of excellence.
- Guide students toward reaching their full academic, spiritual, physical, social, and emotional potential. The School will nurture habits of prayer, study, organization, work, service, kindness, joy, and virtue.
- Provide frequent Mass during the school week, as well as opportunities for Reconciliation, Eucharistic Adoration, Stations of the Cross, and Christian service.
- Communicate effectively with parents regarding student progress and school initiatives.

In return, parents of children attending Saint Mary School commit themselves to:

- Attend Mass with their children each week on Saturday afternoon or Sunday, similarly observe Holy Days of Obligation, and receive the Sacraments of Eucharist and Reconciliation on a regular basis. (Non-Catholic families commit themselves to weekly worship in their faith tradition.)
- Pray daily with their children. Spend time together as a family, making a significant effort to share at least one meal a day, and placing limits on the use of electronics during family times.
- Share generously their time, talent, and treasure with Saint Mary Parish and School, having due regard for the generous gifts that Almighty God has provided. Mindful that the School's per-pupil costs far exceed the required tuition and that the expense is borne by the whole parish community, school parents who are Catholic should (like all parishioners) register in the Parish and make a weekly contribution to the Parish through the use of envelopes or, preferably, make recurring contributions to the Parish through its secure on-line giving program.
- Promote growth in virtue, encourage strong study habits and wise use of electronics, maintain open and cordial communication with the principal and teachers, and follow the policies of the School.

_____ _____

parent signature date

_____ _____

parent signature date

SAINT MARY, PRAY FOR US!

CONCUSSION DANGER SIGNS

In rare cases, a dangerous blood clot may form on the brain in a person with a concussion and crowd the brain against the skull. An athlete should receive immediate medical attention if after a bump, blow, or jolt to the head or body s/he exhibits any of the following danger signs:

- One pupil larger than the other
- Is drowsy or cannot be awakened
- A headache that gets worse
- Weakness, numbness, or decreased coordination
- Repeated vomiting or nausea
- Slurred speech
- Convulsions or seizures
- Cannot recognize people or places
- Becomes increasingly confused, restless, or agitated
- Has unusual behavior
- Loses consciousness (even a brief loss of consciousness should be taken seriously)

WHAT SHOULD YOU DO IF YOU THINK YOUR ATHLETE HAS A CONCUSSION?

1. If you suspect that an athlete has a concussion, remove the athlete from play and seek medical attention. Do not try to judge the severity of the injury yourself. Keep the athlete out of play the day of the injury and until a health care professional, experienced in evaluating for concussion, says s/he is symptom-free and it's OK to return to play.
2. Rest is key to helping an athlete recover from a concussion. Exercising or activities that involve a lot of concentration, such as studying, working on the computer, and playing video games, may cause concussion symptoms to reappear or get worse. After a concussion, returning to sports and school is a gradual process that should be carefully managed and monitored by a health care professional.
3. Remember: Concussions affect people differently. While most athletes with a concussion recover quickly and fully, some will have symptoms that last for days, or even weeks. A more serious concussion can last for months or longer.

WHY SHOULD AN ATHLETE REPORT THEIR SYMPTOMS?

If an athlete has a concussion, his/her brain needs time to heal. While an athlete's brain is still healing, s/he is much more likely to have another concussion. Repeat concussions can increase the time it takes to recover. In rare cases, repeat concussions in young athletes can result in brain swelling or permanent damage to their brain. They can even be fatal.

_____

STUDENT-ATHLETE NAME PRINTED

_____

STUDENT-ATHLETE NAME SIGNED

_____

DATE

_____

PARENT OR GUARDIAN NAME PRINTED

_____

PARENT OR GUARDIAN NAME SIGNED

_____

DATE

JOIN THE CONVERSATION ↳ www.facebook.com/CDCHeadsUp

HEADS UP

TO LEARN MORE GO TO >> WWW.CDC.GOV/CONCUSSION

Content Source: CDC's Heads Up Program. Created through a grant to the CDC Foundation from the National Operating Committee on Standards for Athletic Equipment (NOCSAE).

ST. MARY SCHOOL STUDENT INFORMATION & FIELD TRIP PERMISSION FORM (2021—2022)

(Please complete both sides)

STUDENT NAME_____
(Last) (First) (Middle)

START DATE_____ MALE____ FEMALE____ BIRTHDATE_____

HOME
ADDRESS_____ CITY/STATE/ZIP_____

PHONE_____ E-MAIL_____

E-MAIL_____

How is your child transported home?

CAR (Parent) _____ CAR (Other) _____ BUS #_____ S.M.A.R.T._____ OTHER_____

My child's name, address and phone number ☐may ☐may not be published in the St. Mary School Directory. (The directory is given to all school families.)

Our family e-mail address ☐may ☐may not be published in the St. Mary School Directory.

NAME OF MOTHER OR GUARDIAN_____

HOME ADDRESS_____CITY/STATE/ZIP_____

PHONE
NUMBERS_____
(Home #) (Work #) (Cell #)

EMPLOYER_____ADDRESS_____
(City) (State) (Zip)

NAME OF FATHER OR GUARDIAN_____

HOME ADDRESS_____CITY/STATE/ZIP_____

PHONE
NUMBERS_____
(Home #) (Work #) (Cell #)

EMPLOYER_____ADDRESS_____
(City) (State) (Zip)

NAME OF PERSON TO BE NOTIFIED IN AN EMERGENCY WHEN PARENT IS NOT AVAILABLE:

_____
(Name) (Home Phone #) (Work Phone #)

_____
(Name) (Home Phone #) (Work Phone #)

NAME(S) OF PERSON(S) OTHER THAN PARENT OR LEGAL GUARDIAN TO WHOM CHILD MAY BE RELEASED:

_____

_____

NAME(S) AND AGE(S) OF OTHER SIBLINGS OR CHILDREN AT HOME

_____

NAME OF CHILD'S PHYSICIAN/HEALTH CLINIC_____

ADDRESS_____ CITY/STATE/ZIP_____

PHONE_____ HEALTH INSURANCE POLICY NAME/POLICY NUMBER_____

HOSPITAL PREFERRED FOR EMERGENCY TREATMENT_____

ALLERGIES AND/OR HEALTH CONDITIONS, IF ANY_____

_____

_____

Please list any SPECIAL NEEDS of child_____

_____

_____

I give permission to St. Mary School personnel to secure emergency medical and/or emergency treatment for my child, _____.

_____ _____

Signature of Parent or Guardian *Date Signed*

Please include any other information that you think is important for us to know. This information will be kept CONFIDENTIAL and will ONLY be shared with the teaching staff.

_____

_____

_____

_____

_____

_____

WALKING FIELD TRIP PERMISSION:

I give my permission for my child, _____, to participate in walking field trips when supervised by St. Mary School personnel. Such trips might include McCormick Park or St. Mary Church or the surrounding areas. You will be notified before most walking trips.

_____ _____

Signature of Parent or Guardian *Date Signed*

FOR OFFICE USE ONLY

ENROLLMENT DATE_____ ***INITIAL***_____

CATHOLIC DIOCESE OF LANSING

WWW.DIOCESEOFLANSING.ORG

PHOTO RELEASE

_____ Yes, I hereby grant St. Mary School, their legal representative, or those for whom they are acting, the absolute right and permission to copyright and use photo-graphic portraits or pictures of my child for display during the 2021-2022 school year. Photos may be used for marketing purposes such as in the church bulletin, displays, diocesan or school websites, FAITH magazine, etc.

I hereby waive any right I may have to inspect or approve the finished product or products.

I hereby release St. Mary School, their representative, or those for whom they are acting, from any liability for any violation of any person or proprietary right I may have in connection with the use of the above stated images.

I state further that I have read the above authorization, release and agreement and that I am fully familiar with its contents.

_____ No, I decline to have my child's photograph displayed; however, I do allow my child to be in unidentified group pictures with no names mentioned.

Printed Name of Child: _____ Grade: _____

Printed Name of Parent/Guardian: _____

Signature of Parent/Guardian: _____ Date: _____

PHYSICAL EDUCATION FORM

Dear Parents,

It is very important for your child's physical education teacher to be aware of any injury, illness or operation your child has had that may affect his/her performance in class (allergies, a broken arm that did not heal properly, asthma, etc.).

Please complete this form and return it to your child's classroom teacher. We appreciate your cooperation.

_____ *My child does not have any physical problems or illness that will prevent his/her participation in regular physical education classes.*

_____ *My child does have a problem that may hinder his/her participation which is described below.*

Type of Injury, Illness or Operation	*Date*	*Prognosis*

*Special Considerations*_____

_____

_____

_____ _____

Student's Name *Grade*

_____ _____

Signature of Parent or Guardian *Date Signed*

Once again, thank you for your cooperation.

2021-2022 Family-School Agreement
Diocese of Lansing

As parents/guardians, we ask ___St. Mary Classical School___ to help us in educating and forming our child(ren). We understand and agree that our child(ren) will be taught the teachings of the Catholic Church in their fullness. Our intention is to respect and cooperate with school policies and with those providing a Catholic-based education to our child(ren)—the priests, principal, teachers, parishioners, and all school personnel. We pledge our full cooperation with the school to prepare our child(ren) to be disciple(s) of Jesus Christ. We will make every effort to supervise our child(ren)in accordance with this agreement.

Name of Father/Legal Guardian _____ Signature: _____

Name of Mother/Legal Guardian _____ Signature: _____

Name(s) of Child(ren): _____ Grade: _____

_____ _____

_____ _____

_____ _____

_____ _____

_____St. Mary Classical School_____ accepts your request and commitment for a Catholic education and formation for your child(ren). We acknowledge our obligation to assist you in your responsibility of educating your child(ren). We will make our best effort to form your child(ren) as disciple(s) of Jesus Christ, according to the teachings of the Catholic Church.

Principal's Signature: _____ Date: _____

St. Mary Catholic School

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 St. Mary Catholic School 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:__/__/__

Printed Parent/Guardian Name: _____

ST. MARY WILLIAMSTON

IMPORTANT IMPORTANT IMPORTANT IMPORTANT

Dear Parents,

With the start of the new school year we are informing parents of our lunch and snack routines, and our birthday celebration policy, in an effort to keep St. Mary a safe environment for students with food allergies and other health concerns. Please know that among our students we have students with **fatal allergies**. You should know that, for whatever the reason, the increase in allergy diagnossis among young children nationwide, elementary schools, both public and private, are swiftly moving in this direction. As has been the policy for many years, our classrooms will continue to be peanut/tree nut free.

NO PEANUTS(PEANUT BUTTER) OR TREE NUTS WILL BE ALLOWED IN THE CLASSROOMS.

"Nut Free Zone" signs will be posted outside of each of the classrooms as well as the library, art, music, and CGS rooms (Most of these have been there already.)

A tree nut is any nut other than a peanut. This is includes walnuts, cashews, almonds, macadamia nuts, pralines, pecans, as well as many others. Please read labels carefully. Any product processed in a facility with nuts may contain traces of nuts. Please refer to the link below which includes a list of safe snacks.

During lunch and snack times, grades PK-8 will follow the same procedure:

- Children, teachers, and lunch duty supervisors will do their best to review all food to determine if there are any peanut/tree nut products present.
- Lunch supervising volunteer parents will be made aware of these routines.
- We will have a peanut free designated zone with a separate table set up in the lunch room.
- We ask that you please help your child be aware of the items in his or her lunch.
- It would help us greatly, if you could please label all non-nut butters in your child's snack or lunch, ie: sunflower seed, apple, pumpkin, and those resembling peanut butter.
- Encouraging your child to get in the habit of washing hands after lunch reduces the chance that the fatal oils can be spread and cause a fatal reaction.

Please contact your child's home room teacher one week in advance to schedule a treat and get pre-approval and suggestions for treats.

Please refer to **http://snacksafely.com/safe-snack-guide/** as a guide. **Thank you** for your support and understanding in providing a healthy and safe learning environment for all students.

Sincerely,

Mr. Lomas, Teachers, and Staff

_____ _____

(PARENT/GUARDIAN SIGNATURE) (DATE)

220 North Cedar Street, Williamston, MI 48895
M(517) 655-4038 | F(517) 655-3933
stmarywilliamston.rj@gmail.com | www.stmaryschoolwilliamston.com

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

_____ / /
Parent/Guardian Signature Date

Birth History:

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

If yes, please describe:

If yes, list medications:

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 _____ (child's name)'s teeth. As a result of this examination, my recommendation for treatment is: _____

Dentist's Signature | Date

PHYSICIAN'S SIGNATURE

Examiner's Signature | Date | *Examiner's Name (Print or Type)* | Degree or License

Number & Street | City | MI ZIP Code | ( ) Telephone

Information required for:

Early On - Hearing and Vision Status; Diagnosis; Health Status

Child Care Licensing - Physical Exam, Restrictions, Immunizations

Head Start/Early Head Start - Determination that child is up-to-date on a schedule of age-appropriate preventive and primary health care, including medical, dental, and mental health. The schedule must incorporate the well-child care visit required by EPSDT and the latest immunizations schedule recommended by the Centers for Disease Control and Prevention, State, tribal, and local authorities. An EPSDT well-child exam includes height, weight, and blood tests for anemia at regular intervals based on age.

****

Developed in Cooperation with the Department of Health and Human Services, Education, Michigan American Association of Pediatrics, Early Childhood Investment Corporation, Child Care Licensing, Head Start, Michigan State Medical Society, Michigan Association of Osteopathic Physicians and Surgeons.

St. Mary/WCS Student Registration Form

Enrollment Date:_____

Student's Legal Name:_____ Birthdate:
Last Name, First, Middle Nickname

City & State of Birth: _____ Grade Entering: _____ Gender: M F

Home Address:
Street Apt/Lot # City ZIP

In which school district does the student reside? _____

Student's Ethnic Background: African American Asian Caucasian Hispanic Native American Pacific Islander

Parent/Legal Guardian Information

Name: Relationship

Address:
Street Apt/Lot # City ZIP
School District of Residence: _____

Name: Relationship

Address:
Street Apt/Lot # City ZIP
School District of Residence: _____

School Information

Name of Most Recent **School** Attended: _____

Name of Most Recent School **District** Attended (if public school): _____

Location of Most Recent School Attended (**city and state**) _____

Has the student ever attended Williamston Community Schools? Yes No

Has the student ever attended a public school? Yes No If yes, in which school district? _____

Parent Signature: _____ Date: _____

OFFICE USE ONLY

I verify the date of birth and city of birth of the student as listed above. I have reviewed the following documentation to support the date of birth being claimed:

Certified Birth Certificate Hospital-Issued Birth Certificate Passport Visa Other: _____

Please print legal, verified student name: _____

Office Staff Signature: _____ Date: _____

Revised form: November 14, 2019

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.)					

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

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
Bureau of Community and Health Systems

Child(ren)'s Name(s) (Last, First)	Center Name

A written information packet has been provided at the time of enrollment. The packet included all the following information:

- 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, illnesses.
- Exclusion policy for child illnesses.
- Notice of the availability of the center's licensing notebook.
  - The licensing notebook contains all the licensing inspection and special investigation reports and related corrective action plans since May 28, 2010.
  - The licensing notebook is available to parents during regular business hours.
  - Licensing inspection and special investigation reports from at least the past two years are available on the child care licensing website at **www.michigan.gov/michildcare.**
- Other _____

I certify that I received all of the above items.

_____ _____

Parent/Guardian Signature Date

Note: A single BCAL-4340 form may be used for all children in the same family.

PARENT NOTIFICATION OF THE LICENSING NOTEBOOK

Child Care Organizations Act, 1973 Public Act 116

Michigan Department of Licensing and Regulatory Affairs

All child care centers must maintain a licensing notebook which includes all licensing inspection reports, special investigation reports and all related corrective action plans (CAP). The notebook must include all reports issued and CAPs developed on and after May 27, 2010 until the license is closed.

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

I have read the above statement issued by _____.
Name of Child Care Center

Child(ren)'s Name(s) _____

_____

Parent Name _____

Parent Signature _____ Date _____

LARA is an equal opportunity employer/program.