



Community Education School Age Child Care Program

Child Information Form (One Form per Child)

Please Print

Date: _____

Child's Last Name

Child's First Name

DOB: _____
MM/DD/YYYY

Grade: _____

Age: _____

SCHEDULE – Please indicate when your child will be using the School Age Child Care

Before & After ___ Monday ___ Tuesday ___ Wednesday ___ Thursday ___ Friday

Before Only ___ Monday ___ Tuesday ___ Wednesday ___ Thursday ___ Friday

After Only ___ Monday ___ Tuesday ___ Wednesday ___ Thursday ___ Friday

School Age Child Care Director must be notified immediately of any changes to your child's schedule.

Parent(s) Name: _____
Mother / Last Name, First Name

Father / Last Name, First Name

Marital Status: ___ Single ___ Married ___ Divorced ___ Other

Siblings Names & Ages:

Custody Information: _____

1. Have there been any changes in your child's life recently? Yes No

If yes, please explain:

2. My child's greatest fears are: _____

3. When angry, my child will: _____

4. My child has difficulty with: _____

5. Please share any family traditions/holiday celebrations/heritage information:

Does your child receive any special support services during the school year? Yes____ No____

Including: Support for learning? Yes____ No____
Support for behavior? Yes____ No____
Support for communication? Yes____ No____
Support for health related issues? Yes____ No____

Please explain:

Please share strategies used at school and at home that are effective with your child:

Please share any additional information needed by our staff to plan for your child's success in our program:

Electronic Signature Agreement: By signing this Electronic Signature Agreement, I agree that my electronic signature is the legally binding equivalent to my handwritten signature. Whenever I execute an electronic signature, it has the same validity and meaning as my handwritten signature. I will not, at any time in the future, repudiate the meaning of my electronic signature or claim that my electronic signature is not legally binding.

Electronic Signature	
Electronic Signature:	
Please type your First and Last Name	Date
<input type="checkbox"/> I understand that checking this box constitutes a legal signature confirming that I acknowledge and warrant the truthfulness of the information provided in this document.	

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
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	

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Movie Release

I give my permission for my child/children to watch G and/or PG rated movies. On occasion a carefully selected G or PG movie will be shown.

1. _____ **G- Movies** Yes___No___ **PG – Movies** Yes___ No___
Child's Last Name Child's First Name
2. _____ **G- Movies** Yes___No___ **PG – Movies** Yes___ No___
Child's Last Name Child's First Name
3. _____ **G- Movies** Yes___No___ **PG – Movies** Yes___ No___
Child's Last Name Child's First Name

____ **YES**, I give permission

____ **NO**, I do not give permission

Parent Signature

Date



Community Education School Age Child Care Program

Media Release/Student Work Photograph Form

- | | | |
|----|-------------------|--------------------|
| 1. | _____ | _____ |
| | Child's Last Name | Child's First Name |
| 2. | _____ | _____ |
| | Child's Last Name | Child's First Name |
| 3. | _____ | _____ |
| | Child's Last Name | Child's First Name |

Periodically the media may be invited to visit School Age Child Care. I hereby give my permission for my child/children's projects, photographs, video images and/or voice recordings to be released to the paper, shown on the community channel or posted on the internet. I will immediately notify the Site Director and/or staff in writing should any of the above conditions change. There is no monetary compensation for the use of these projects and/or images.

____ **YES**, I give permission

____ **NO**, I do not give permission

Parent Signature

Date



Community Education School Age Child Care Program

Policy Agreement

1.	_____	_____
	Child's Last Name	Child's First Name
2.	_____	_____
	Child's Last Name	Child's First Name
3.	_____	_____
	Child's Last Name	Child's First Name

- I agree to keep my tuition payments current. My School Age Child Care account will be at a zero balance or in a credit status.
- I agree to clock in / out my student each time I drop off and / or pick up my child.
- I agree to provide the SACC Director my child's schedule a week in advance of my child SACC Program.
- I agree to call the SACC room to inform staff whenever my child will be absent. If my child is ill, I will not send my child to School Age Child Care and will make alternate arrangements.
- I will complete and submit all enrollment forms. I will keep all enrollment information current and up-to-date.
- I will read all communications from SACC Director, i.e., newsletters, e-mails, posters and bulletin boards.
- I will keep Director informed of any changes or incidents at home that might result in a change in my child's behavior or attitude.
- I confirm that my child is in good health, able to participate in all activities unless otherwise indicated on the Certificate of Good Health Form, and is up to date on his/her immunizations.
- I agree and assume full responsibility for any damage to person or property caused by my child.
- If a medical emergency arises, SACC staff will first attempt to contact me. If I cannot be reached, the staff will contact the person(s) on the Child Information Record. If the emergency is such that immediate hospital attention is necessary, appropriate emergency procedure will be followed.
- I agree that if the behavior or health of my child should necessitate sending him/her home, I (or someone on my Child Information Record) will IMMEDIATELY pick up my child from the program. I agree to keep my Child Information Record up-to-date.
- I understand that if my child has a persistent pattern of negative behavior and interventions have not been successful, I may be asked to remove my child from the SACC program.
- I understand that if I choose I will provide a nutritious snack for my child. Snacks will not be provided by the School Age Child Care program.
- I understand on any half days, there may be field trips or special activities, which I must sign up for and pay for in advance. NO REFUNDS will be issued for field trips.
- I have read, understood and agree to all of the above. If I have any questions or concerns I will contact School Age Child Care Coordinator, CJ Wajeeh at (586) 797-6984.

All policies, procedures and staffing related to the School Age Child Care Programs are under the discretion of the School Age Child Care Coordinator.

Parent Signature: _____

Date: _____



Community Education School Age Child Care Program

Child/ Parent Behavior Contract (one form per child)

Child's Last Name

Child's First Name

- I will report directly to School Age Child Care room immediately after school is dismissed and follow specified check-in procedures
- I will listen to staff and follow directions
- I will respect other people's belongings by not touching/using their belongings without permission
- I will respect School Age Child Care property and help clean up personal messes and assist in leaving an area better than I found it
- I will be responsible for all my actions
- I will respect others personal space by keeping my hands and feet to myself
- I will not have any physical contact with other people
- I will not raise my voice while inside the building and will use my inside voice when speaking
- I will use appropriate language and not use negative remarks
- I will ask staff for permission to leave the room/area
- I will respect others feelings by having a positive attitude when talking to them

School Age Child Care operates with a **"ZERO TOLERANCE"** policy towards bullying

Not abiding by these rules may result in exclusion and /or termination from the School Age Child Care. All incidents will be handled on a Three Incident System, except physical contact. If physical contact occurs it will be an Immediate One Day Exclusion from the School Age Child Care.

All other incidents will be handled as follows:

1 st Incident	Verbal Warning
2 nd Incident	Written Warning
3 rd Incident	Parent meeting and possible 1 day exclusion and/or termination from School Age Child Care

Student Signature: _____

Date: _____

Parent Signature: _____

Date: _____



Community Education School Age Child Care Program

Handbook Notification

1.	_____	_____
	Child's Last Name	Child's First Name
2.	_____	_____
	Child's Last Name	Child's First Name
3.	_____	_____
	Child's Last Name	Child's First Name

- I have received a copy of the UCS, School Age Child Care parent handbook.
- I understand that the School Age Child Care Parent Handbook may not cover every issue that arises and as a result creates the need for communication between the SACC staff and myself.
- I understand that I am held accountable for these policies until my child is no longer enrolled.
- I understand that SACC reserves the right to change these policies and will notify me in writing as soon as possible after any changes have been made.
- I have read and agree to all the terms and conditions set forth in the SACC Parent Handbook.
- I have reviewed and discussed any pertinent information with my child.

This form must be completed and returned to your Director within five days of receiving this book.

Parent Signature: _____

Date: _____



Community Education School Age Child Care Program

Good Health Certificate (one form per child)

Child's Last Name

Child's First Name

Has your child been diagnosed with any of the medical conditions or problems listed below?	Yes	No
Allergies		
Hay Fever		
Asthma		
Eczema or frequent skin rashes		
Convulsions/Seizures		
Heart Trouble		
Diabetes		
Frequent colds, sore throats, earaches (4 or more per year)		
Trouble passing urine or bowel movements		
Shortness of breath		
Menstrual problems		
Dental problems: date of last exam		
Reactions to food, medication or other that has not been diagnosed by a Doctor as an allergy		
Other		

Please explain any problem identified above:

Does your child have allergies? Yes _____ No _____

If yes, please list allergies: _____

List all medications your child takes: _____

Please note any illnesses, accidents or hospitalizations your child has experienced:

I hereby certify that my child is in good health and that his/her immunizations are current.

Parent Signature: _____

Date: _____



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ELECTRONIC FUNDS TRANSFER AUTHORIZATION FOR BANK ACCOUNT and CREDIT CARD

I (we) hereby authorize (business name) _____ to initiate credit card charges to the below-referenced credit card account (Section A) OR, initiate debit entries to my (our) checking or savings account, indicated below (Section B). To properly affect the cancellation of this agreement, I (we) are required to give 10 days written notice.

____ (initial) Credit union members: please contact your credit union to verify account and routing numbers for automatic payments. Check with the center for accepted credit card types.

COMPLETE ONE SECTION ONLY

SECTION A (Credit Card)

_____		_____	
Cardholder Name		Phone #	
_____		_____	_____
Cardholder Address		City	State Zip
_____		_____	
Account Number		Expiration Date	
_____		_____	
Cardholder Signature		Date	

SECTION B (Bank Account)

_____		_____	
Your Name		Phone #	
_____		_____	_____
Address		City	State Zip
_____		_____	
Bank or Credit Union Name	Bank or Credit Union Address	City	State Zip
_____		_____	
Routing Transit Number (see sample below)	Account Number (see sample below)	<input type="checkbox"/> Checking	<input type="checkbox"/> Savings
_____		_____	
Authorized Signature		Date	

For Official Use Only

Date Received

Employee Signature



A service of

