

St. Francis Xavier Child Development Center Contract

Preschool - Child Care - Latchkey - Infant Care

Child's Name: _____ Age: _____ D.O. B. _____

Parishioner: Yes _____ No _____ Parish _____

Address: _____ City: _____ State: _____

Phone Number: _____ E-Mail: _____

Preschool

2 Day(3 year olds) AM _____ PM _____

3 Day(4/5 year olds) AM _____ PM _____

Child Care/Infant/ or Latchkey Arrival and Departure Times

Monday- _____

Tuesday- _____

Wednesday- _____

Thursday- _____

Friday- _____

- Registration Fee of \$100.00
- Infant and Toddler and Childcare absences are at full rate
- Billing is done every two weeks. Preschool will be billed once a month
- A \$10.00 late pick up fee will be charged for every 10 minutes past 5:30pm
- An outstanding bill of \$500.00 or more will result in termination of services

Parents agree to:

- Notify the center of child's arrival and departure each day (time sheet)
- Must have and follow a weekly schedule – No Drop In's without seeking approval from staff member.
- Understand our Licensing Notebook is located in the CDC office and is available for your review at anytime
- Notify the center in advance of absences and any delay in pick up time.
- Keep your child home if they are ill. Must be fever free for 24 hours
- Comply with policies as stated in the handbook and have completed all necessary enrollment paperwork.
- Understand during the course of school, students may be photographed for various publications, website, facebook page, newsletters.
- Fill out medication permission slip required by the Department of Social Services
- Understands at the time your child turns 30 months they will move out of the infant and toddler room and into the CDC room.
- Understand at the time your child reaches 33 months of age they will be moved to a 1 to 10 ratio
- Understand children will be utilizing the pre-school playground. School age children will utilize the St. Francis School playground.
- Read and understand the Priority Enrollment agreement
- 3 Tickets for the St. Francis Gala Auction mandatory sale \$100.00 each

A parent or legal guardian must sign this agreement before attending any part of the center.

Parent/Guardian

Administration

Contract ___ Info Card ___ Health Form ___ Inventory Sheet ___ Registration Fee ___

DATE PAPERWORK RECEIVED: _____

VERIFIED PARISHIONER: _____

CHILD INFORMATION RECORD

State of Michigan - Department of Licensing and Regulatory Affairs - Child Care Licensing Bureau

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
Parent/Legal Guardian's Name			Primary Phone ()	Parent/Legal Guardian's Name (Optional)
Home Address (if not child's address)			2 nd Phone (if applicable) ()	Primary Phone ()
City			State	Zip Code
Email Address (optional)			Email Address (optional)	
Employer Name			Work Phone ()	Employer Name
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/or Special Instructions? Yes <input type="checkbox"/> No <input type="checkbox"/> If yes, explain: (Attach additional sheets, if necessary.)				

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See Reverse Side

Emergency Contact & Release of Child: List all individuals, including parents/legal guardians, in order of preference, to be contacted in an emergency. If possible, include at least one person other than the parents/legal guardians to be contacted in an emergency and to whom the child can be released. The second phone number column can be left blank. (If more individuals, attach additional sheets.)

1.	()	()
2.	()	()
3.	()	()

Release of Child Only: List all individuals, other than the parents/legal guardians, to whom the child may be released. (If more individuals, attach additional sheets.)

1.	()	2.	()
3.	()	4.	()

Parent/Legal Guardian Initials:

_____ I give permission to _____, licensed by the Department of Licensing and Regulatory Affairs to secure emergency medical treatment for the above named minor child while in care.

I certify that I accurately completed this form and if anything changes, I will notify the provider by updating this form.

Signature of Parent or Guardian _____ Date Signed _____

Date Card Reviewed	Parent or Legal Guardian Initials	Date Card Reviewed	Parent or Legal Guardian Initials	Date Card Reviewed	Parent or Legal Guardian Initials	Date Card Reviewed	Parent or Legal Guardian Initials
LARA is an equal opportunity employer/program.						AUTHORITY: 1973 PA 116 COMPLETION: Required PENALTY: Rule Violation Citation.	

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RATE SHEET

Registration Fee Fall Session: \$100.00/Family
Registration for Summer session: \$50.00/Family

Preschool Tuition

2-day- \$170.00/month

Tuesday and Thursday

8:00 am – 11:00 am OR 12:00 pm – 3:00 pm

3-Day- \$220.00/month

Monday, Wednesday and Friday

8:00 am - 11:00 am OR 12:00 pm – 3:00 pm

Childcare Rates

\$5.00

Latchkey Rates

\$14.25 day/child

Absent fees do not apply to latchkey

Summer Child Care

5.00 Hour (2 ½ to 12 years of age)

Infant and Toddler Rates

\$5.25 per hour

Acceptable forms of payment: cash, check, credit card

Tuition for Infant and Toddler room does not include diapers and formula

Absent Fees: Each family will receive 3 absent days a school year. After the 3 days you will be charged a half day of care. (4 Hours)

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 Date: / /	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	Human Papillomavirus (HPV9/HPV4/HPV2)	1	3
	3	6		2	
Tdap	1		OTHER Vaccines	Type of Vaccine(s)	Date of Vaccine(s)
<i>Haemophilus Influenzae</i> type b (HIB)	1	3	Specify Date & Type	1	
	2	4		2	
Polio (IPV/OPV)	1	3		3	
	2	4	<i>Indicate and attach physician diagnosis or laboratory evidence of immunity as applicable</i>		
Pneumococcal Conjugate (PCV7/PCV13)	1	3	*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.		
	2	4			
Rotavirus (RV1/RV5)	1	3	Parent/Guardian refused immunizations: <input type="checkbox"/>		
	2				
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	
<input type="checkbox"/>	<input type="checkbox"/>	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"/>	Should the child's activity be restricted because of any physical defect or illness? If yes, check and explain degree of restriction(s): <input type="checkbox"/> Classroom <input type="checkbox"/> Playground <input type="checkbox"/> Gymnasium <input type="checkbox"/> Swimming Pool <input type="checkbox"/> Competitive Sports <input type="checkbox"/> Other
Other Recommendations		

SECTION V - DENTAL EXAMINATION AND RECOMMENDATIONS (OPTIONAL)

I have examined _____'s teeth. As a result of this examination, my recommendation for treatment is: _____

child's name

_____/_____/_____
Date

Dentist's Signature

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.