3 SCHOOL

Help Me get to Know You!

What a blessing to have your child at Hudsonville Christian! We know that God has created every one of His children specially and with their own gifts and challenges. In order to work together for the BEST initial school experience possible, please fill out this form below to help us get to know your family and preschooler better. We pray that we get to know your child genuinely as we see him or her in God's image. **Return this form with your other enrollment forms by June 15!** Thank you for your help and for your trust in us as we partner together in raising your child.

Child's Name____**Male**____**Female**____
(First Middle Last)

Name they will use in school ____________________________**Child's birthdate**____________

Father's Name__________________________ **Mother's Name** __________________________

Father's Cell #__________________________ **Mother's Cell #** __________________________

Father's Email__________________________ **Mother's Email** __________________________

Address ____

City ______________________________ **State** Michigan ________________________ **Zip**__________

Race____

(African American / Asian / Hispanic / American Indian / White / Multi-Race / Hawaiian – Pacific Islander / Unknown)

Ethnicity ____________________Non Hispanic/Latino ______________________Hispanic/Latino

Sibling's Names and ages ____

What pets does your child have?____

Parent's Occupations ____

Present Church Affiliation ____

My child is allergic to____

I would describe my child as (circle all that apply):

Curious	Usually Cranky	Usually Smiling and Pleasant	Hesitant
Loving	Confident	Responds Positively to Affection	Prefers to be Alone
Intense	Demanding	Independent Anxious	Easily Frustrated

What are his/her preferred toys and activities? ____

____

My child plays with other children his/her own age... often sometimes never

My child can do the following things:

speak clearly	write their first name	color with crayons or markers	name 6 colors
play with others	sing the ABC song	shows bathroom independence	identify 6 shapes
cut with scissors	sit still for a short story	sing songs with a group	count to 5
categorize objects			

Has your child picked a hand preference? **RIGHT**__________ **LEFT**____________

My child is understood by others: ________**always** ________**sometimes** ________ **never**

Birth History...full-term pregnancy premature delivery developmental complications

adoption (at what age ____________)

My child has the following special needs ____

____

____

What public school district do you live in? ____

Something important that I would like you to know about my family is ______________________

____

____

Any other information ____

____

4 SCHOOL

Help Me Get to Know You!

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Child's Name____ **Male**____ **Female**____
(First Middle Last)

Name they will use in school ____________________ **Child's birthdate**__________

Father's Name____________________ **Mother's Name** ____________________

Father's Cell #____________________ **Mother's Cell #** ____________________

Father's Email____________________ **Mother's Email** ____________________

Address ____

City ____________________ **State** Michigan ____________________ **Zip**__________

Race____

(African American / Asian / Hispanic / American Indian / White / Multi-Race / Hawaiian – Pacific Islander / Unknown)

Ethnicity ____________Non Hispanic/Latino ____________Hispanic/Latino

Sibling's Names and ages ____

What pets does your child have?____

Parent's Occupations ____

Present Church Affiliation ____

My child is allergic to____

I would describe my child as (circle all that apply):

Curious	Usually Cranky	Usually Smiling and Pleasant		Hesitant
Loving	Confident	Responds Positively to Affection		Prefers to be Alone
Intense	Demanding	Independent	Anxious	Easily Frustrated

What are his/her preferred toys and activities? ______________________________

____

My child plays with other children his/her own age... often sometimes never

My child can do the following things:

speak clearly	write their first name	categorize objects	color with crayons or markers
play with others	count to 10	sing songs with a group	hold a writing utensil correctly
identify 6 shapes	name 6 colors	zip coat	use the bathroom **independently**
ride a bike	cut with scissors	sit still for a short story	hold scissors correctly

Has your child picked a hand preference? **RIGHT**__________ **LEFT**__________

My child is understood by others: ________**always** ________**sometimes** ________ **never**

Birth History...full-term pregnancy premature delivery developmental complications

adoption (at what age ____________)

My child has the following special needs ______________________________

____

____

What public school district do you live in? ______________________________

Something important that I would like you to know about my family is ______________

____

____

Any other information ____

____

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	Zip Code

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

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.

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	
OTHER Vaccines Specify Date & Type	Type of Vaccine(s)	Date of Vaccine(s)
	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.

HUDSONVILLE CHRISTIAN PRESCHOOL

I have read the information in the Hudsonville Christian Preschool Handbook and I understand the rules and guidelines for the Hudsonville Christian Preschool. I agree to support the preschool program, the teachers, and I agree to pay the fees that I agreed to at the time of admission.

- All childcare centers must maintain a licensing notebook, which includes all licensing inspection reports, special investigation reports and all related corrective action plans (CAP) for the last 5 years.
- The notebook will be available to parents for review during regular business hours.
- Licensing inspection reports, special investigation reports and all related corrective action plans (CAP) for the last 3 years are available on the department's childcare licensing website.
- Parents can access the childcare licensing rules on the department's child care licensing website. The website address is **www.michigan.gov/michildcare**.

Early Childhood Director

I have read the above statements issued by Hudsonville Christian School.

Child(ren)'s Names ______________________________

____

____

______________________________ Parent or Guardian Signature

__________ Date

Permission for Photos and Videos - 2023-2024

During the preschool year photos and videos may be taken by HCS staff of our Preschool programs in order to document our events and memories! We would like to request your permission, as parent, to take photos and videos that would include your child. These images may be included in print or electronic materials. Your child's name will never be associated with these images.

Do you give us permission to include your child in photos and videos that are taken this school year?

_____ Yes ______No

______________________________ Parent or Guardian Signature

__________ Date