HUDSONVILLE CHRISTIAN SCHOOL

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

----------PLEASE CONTINUE ON THE BACKSIDE----------

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 _____)

Has your child ever received any school based or community-based services (speech, occupational, therapy, counseling, social work)?

_____

Has your child utilized special programming (IEP, Early On, special education services)?

_____

My child has the following special needs _____

_____

_____

What public school district do you live in? _____

Any other information _____

_____

_____

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Father's Cell #_____ **Mother's Cell #** _____

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Address _____

City _____ **State** Michigan **Zip**_____

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----------PLEASE CONTINUE ON THE BACKSIDE----------

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 _____)

Has your child ever received any school based or community-based services (speech, occupational, therapy, counseling, social work)?

_____

Has your child utilized special programming (IEP, Early On, special education services)?

_____

My child has the following special needs _____

_____

_____

What public school district do you live in? _____

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.

›r 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 ☐ (If yes, explain below) No ☐ (Attach additional sheets, if necessary.)	

CCL-3731 (Rev. 3/17/2022) Previous editions 7-18 & 4-21 may be used

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__Hudsonville Christian___, 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.

CCL-3731 (Rev. 3/17/2022) Previous editions 7-18 & 4-21 may be used

HEALTH APPRAISAL

Michigan Department of Health and Human Services

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, dentist, dental therapist, and dental hygienist.
(**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/Cell Phone Number
Address (Number, Street, City, Zip Code)	Work Phone 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	Anaphylaxis
☐	☐		3	Does your child take any medication(s) regularly?
☐	☐	☐	4	Hay Fever, Asthma, or Wheezing
☐	☐	☐	5	Eczema or Frequent Skin Rashes
☐	☐	☐	6	Convulsions/Seizures
☐	☐	☐	7	Heart Trouble
☐	☐	☐	8	Diabetes
☐	☐	☐	9	Frequent Colds, Sore Throats, Earaches (4 or more per year)
☐	☐	☐	10	Trouble with Passing Urine or Bowel Movements
☐	☐	☐	11	Shortness of Breath
☐	☐	☐	12	Speech Problems
☐	☐	☐	13	Menstrual Problems
☐	☐	☐	14	Dental Problems Date of Last Exam _____ **OR** Date of Last Assessment _____
☐	☐	☐		Other (please describe) _____

Birth History
If yes, list medications
Are there any current or past diagnosis(es) ☐ Yes ☐ No
If yes, please describe

Reason for Medication		
Concussion History		
Parent/Guardian Signature	Date	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

Test and Measurements

Yes	No	Was child tested for	Tests and results		Normal	Referred	Under care
☐	☐	Vision Date _____	Visual Acuity				
			Muscle Imbalance				
			Other				
☐	☐	Hearing Date _____	☐ Audiometer	(R= Right, L=Left)	R/L	R/L	
			☐ OAE	(R= Right, L=Left)	R/L	R/L	
			☐ Other	(R= Right, L=Left)	R/L	R/L	
☐	☐	Urinalysis	Sugar				
			Albumin				
			Microscopic				
☐	☐	Blood Lead Level					
		Date _____	Level _____ug/dl				

Note: All children in Medicaid need to be tested at 1 and 2 years of age, or once between 3 and 6 years of age if not previously tested. All children, regardless of Medicaid status, should be tested at those same ages if they live in an area where lead risk is high.

☐	☐	Height & Weight	Height				
			Weight				
		Other _____	Other _____				
☐	☐	Hemoglobin/Hematocrit	⇨				
☐	☐	Blood Pressure	Reading _____				

Complete pediatric tuberculosis risk assessment available at:
https://www.michigan.gov/documents/mdhhs/4._MI_Pediatric_TB_Risk_Assessment_661537_7.pdf **OR** feel free to use the attached QR code instead of the full link text.

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 based on this information.*

Vaccines (Circle Type)	Date Administered mm/dd/yy		Vaccines (Circle Type)	Date Administered mm/dd/yy	
Hepatitis B (HepB)	1	3	Hepatitis A (HepA)	1	3
	2	4		2	
DTaP/DTP/DT/Td	1	4	Influenza (IIV/LAIV)	1	3
	2	5		2	4
	3	6	Meningococcal MenACWY (MCV4)	1	3
				2	
Tdap	1		Meningococcal B (Bexsero, Trumenba)	1	3
				2	
Haemophilus Influenzae type b (HIB)	1	3	Human Papillomavirus (9vHPV, 4vHPV, 2vHPV)	1	3
				2	
	2	4	Additonal Vaccines Specify Date & Type	Type of Vaccine(s)	Date of Vaccine(s)
Polio (IPV/OPV)	1	4		1	
	2	5		2	
	3			3	
Pneumococcal Conjugate (PCV7/PCV13)	1	3	Indicate and attach physician diagnosis or laboratory evidence of immunity as applicable.		
	2	4			
Rotavirus (RV1/RV5)	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				
Measles, Mumps, Rubella (MMR/MMRV)	1	3			
	2				
Varicella (Chickenpox), (Var, MMRV)	1	2			
History of Chickenpox Disease? ☐ Yes ☐ No If yes, date _____			Parent/Guardian refused recommended immunizations at visit: ☐		

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)

Yes	No	
☐	☐	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 EXAM OR ASSESSMENT REQUIREMENTS

Child's Name	Has received ☐ Dental Exam	☐ Dental Assessment
Findings and Recommendation (Check all that apply) ☐ No Urgent Needs	☐ Routine Care Needed	☐ Treated Decay
☐ Restorative/Urgent Needs for Dental Care	☐ Untreated Decay	☐ Further Referral for Specialist
Signature		Date
Check One ☐ Dentist	☐ Dental Therapist	☐ Dental Hygienist

PHYSICIAN'S SIGNATURE

Examiner's Signature	Date	Examiner's Name (Print)		Degree or License
Number & Street	City	MI	Zip Code	Telephone Number

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 preventative and primary health care, including medical, dental, and mental health. The schedule must incorporate the well-childcare 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**.

Konni Lubbers

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 - 2025-2026

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