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.)				

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

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.

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

PERMISSIONS

TEDDY BEAR DAYCARE & PRESCHOOL 14TH STREET

Directions: Circle "I do" or "I do not" under every subject. The blank line must contain your child's first and last name.

SUNSCREEN

I DO or I DO NOT give permission for my child, _____to have sunscreen lotion that I have provided; to be applied by Teddy Bear Daycare and Preschool staff. I understand that my child will go without sunscreen if I do not have this permission slip on file and/or do not provide sunscreen.

DIAPER CREAM

I DO or I DO NOT give permission for my child, _____ to have the diaper cream applied to him/her, that I have provided, by Teddy Bear Daycare and Preschool staff.

BUG SPRAY

I DO or I DO NOT give permission for my child, _____ to have the bug spray I have provided applied by Teddy Bear Daycare and Preschool staff.

NEIGHBORHOOD WALKS

I DO or I DO NOT give permission for Teddy Bear Daycare and Preschool staff to take my child, _____ on periodic walks or short outgoings around the school and Tart Trail/Property (East).

PHOTOS FOR SCHOOL USE

I DO or I DO NOT give permission for the staff of Teddy Bear Daycare and Preschool to take pictures of my child, _____ for the school/classroom use. I understand that these photos will not be released or used for anything other than classroom materials or the schools use. School use may include Facebook.

WATER PLAY

I DO or I DO NOT give permission for the staff of Teddy Bear Daycare and Preschool to let my child, _____ engage in water play during the summer months. I understand that water play does not include pools or being submersed.

Parent/Guardian Signature: _____ **Date:** _____

Parent/Guardian Initials					
Date Reviewed					

Revised Annually

CHILD CARE FINANCIAL CONTRACT 2026-2027 (9/7/26 to 9/3/27)

TEDDY BEAR DAYCARE AND PRESCHOOL 14TH STREET LLC

Child's First and Last Name:	
Parent/Guardian Name:	
Parent/Guardian Name:	

Attendance Policy: You are required to provide an arrival and departure time for your child that is within a **9.5-hour timeframe**. You may change your child's arrival and departure time but must provide a minimum two-week notice. You may not change your child's schedule more than 2 times in a contract year. Children must be dropped off by 10am, and you must communicate before 9am if they will be arriving later than their contracted time. Late drop offs will not be accommodated unless in the case of an appointment or special circumstances.

Check Days of Care	Monday ⬜	Tuesday ⬜	Wednesday ⬜	Thursday ⬜	Friday ⬜
Arrival Time	: AM	: AM	: AM	: AM	: AM
Departure Time	: PM	: PM	: PM	: PM	: PM

Monthly Tuition Rates

Age	Full Time	M/W/F	T/TH
0-2.5 Years	$1750	$1100	$745
2.5-7 Years	$1450	$900	$615

Meal Plan

- Teddy Bear is not currently eligible to be enrolled in the Michigan Child and Adult Care Food Program (CACFP, income based). Teddy Bear charges $3 per day for children 12 months and up, on a monthly basis to account for food costs. The daily charge includes breakfast, morning and afternoon snacks. Parents will provide lunch. The meal fee may be waived on scheduled personal days. A late fee will be assessed as described below if payment is not made by the due date.

Discounts

- **Sibling Discount** A 10% sibling discount will be applied to the monthly tuition of the child with the lower tuition rate.
- **Personal Days** Families are allotted the following number of personal days per contract year, during which tuition will be waived as follows: Full Time: 7.5 Personal Days MWF: 4.5 Personal Days T/TH: 3 Personal Days
  Non-paid personal days may not be used during scheduled or unexpected closures. Personal days will not increase if your child's schedule changes in between contract renewals.
- **Short Term Withdrawal** If you wish to temporarily withdraw your child while maintaining their enrollment status, you may do so for a period of 14 to 60 operational days. During this time, a 50% tuition discount will be applied. A minimum of two weeks' written notice must be provided to Administration prior to the withdrawal period.

Policies & Terms

- Tuition is due by the 1st of each month.
- A late fee of $10 per day will be assessed on each day following the payment due date. If payment is not made within 5 days, your child's spot will be forfeited unless other payments have been made.
- If a paid holiday falls on a weekend, Teddy Bear will observe the day before or day after the weekend.
- Payment is required for closures outlined in our annual calendar unless otherwise specified.
- If you choose to withdraw your child from care at Teddy Bear, a minimum 30 day written notice is required and payment must be fulfilled regardless of circumstance.
- If your child arrives before their scheduled arrival time or is picked up more than 5 minutes past their scheduled departure time, a $10 initial fee will be charged, followed by an additional $1 per minute. A 5-minute grace period is provided only for late pickups.
- A $250 non-refundable **Annual Registration Fee** due upon contract renewal. If your child's start date is within 90 days prior to contract renewal, the annual fee will not be due again until the following contract renewal.

By signing this document, you agree to the terms and policies described above and in the Parent Handbook.

Parent/Guardian Signature: _____ **Date Signed:** _____

MDHHS-3305, HEALTH APPRAISAL

Michigan Department of Health and Human Services (MDHHS)
(Revised 7-24)

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 1. Section 4 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).

SECTION 1 – 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 2 – HEALTH HISTORY

Yes	No	Resolved	Is your child having any of the problems listed below?	Birth History
☐	☐	☐	1. Allergies or Reactions (for example, food, medication or other)	
☐	☐	☐	2. Anaphylaxis	
☐	☐	☐	3. Does your child take any medication(s) regularly?	If yes, list medications
☐	☐	☐	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)	Are there any current or past diagnosis(es) ☐ Yes ☐ No
☐	☐	☐	10. Trouble with Passing Urine or Bowel Movements	If yes, describe

☐	☐	☐	11. Shortness of Breath	
☐	☐	☐	12. Speech Problems	
☐	☐	☐	13. Menstrual Problems	
☐	☐	☐	14. Dental Problems Date of Last Exam OR Date of Last Assessment	
☐	☐	☐	15. Other (describe)	

Reason for Medication

Concussion History

Parent/Guardian Signature Date

Was the health history reviewed by a health professional? Examiner's Initials

☐ Yes ☐ No

SECTION 3 - PHYSICAL EXAMINATION, INSPECTION, TESTS AND MEASUREMENTS

Required for Child Care and Head Start / Early Head Start

Test and Measurements

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

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 4 – IMMUNIZATIONS

Statements such as "UP-TO-DATE" or "COMPLETE" will not be accepted. Admission to school may be denied based on this information.*****

Vaccines (Select Type)	Date Administered (mm/dd/yy)		
Hepatitis B (HepB)	1.	2.	3.
	4.		
DTaP/DTP/DT/Td	1.	2.	3.
	4.	5.	6.
Tdap	1.		
Haemophilus Influenzae type b (HIB)	1.	2.	3.
	4.		
Polio (IPV/OPV)	1.	2.	3.
	4.	5.	
Pneumococcal Conjugate (PCV)	1.	2.	3.
	4.		
Rotavirus (RV1/RV5)	1.	2.	3.
Measles, Mumps, Rubella (MMR/MMRV)	1.	2.	3.
Varicella (Chickenpox), (Var, MMRV)	1.	2.	
Hepatitis A (HepA)	1.	2.	3.

Influenza	1.	2.	3.
(IIV/LAIV)	4.		
Meningococcal (MCV4, MenABCWY)	1.	2.	3.
Meningococcal B (Bexsero, Trumenba, MenABCWY)	1.	2.	3.
Human Papillomavirus (HPV)	1.	2.	3.

Additional 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.

History of Chickenpox Disease? If yes, date

☐ Yes ☐ No

☐ Parent/Guardian refused recommended immunizations at visit.

I certify that the immunization dates are true to the best of my knowledge

Health Professional Signature Title Date

SECTION 5 - RECOMMENDATIONS (Required for Child Care and Head Start/Early Head Start)

Is there any defect of vision, hearing, or other condition for which the school could help by seating or other actions?

☐ Yes ☐ No

If yes, explain

Should the child's activity be restricted because of any physical defect or illness?

☐ Yes ☐ No

Check all that apply

☐ Classroom ☐ Playground ☐ Gymnasium

☐ Swimming Pool ☐ Competitive Sports ☐ Other

If yes, explain degree of restriction(s)

Other Recommendations

SECTION 6 - DENTAL EXAM OR ASSESSMENT RECOMMENDATIONS

Child's Name

Type of Service
☐ Dental Exam ☐ Dental Assessment

Findings (Check all that apply)
☐ No findings ☐ Treated Decay ☐ Untreated Decay

Recommendations (Check one)
☐ Routine Care
☐ Referral for dental treatment
☐ Referral for urgent dental care

Provider Signature | Date

Check one
☐ Dentist ☐ Dental Therapist ☐ Dental Hygienist

SECTION 7 - PHYSICIAN'S SIGNATURE

Examiner's Name (Print) | Degree or License | Telephone Number

Examiner's Signature | Date

Address | City | State **MI** | Zip Code

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.