

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
Parent/Legal Guardian's Name			Home Phone ()	Parent/Legal Guardian's Name (Optional)
Home Address (if not child's address)			Cell Phone ()	Home Address (if not child's address)
City	State	Zip Code	City	State
Email Address (optional)			Email Address	
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 Special Instructions (Attach additional sheets, if necessary.)				

BCAL-3731 (Rev. 7-18) Previous edition 6-17 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.	

BCAL-3731 (Rev. 7-18) Previous edition 6-17 may be used.



seeds
After School

PARENT/GUARDIAN HANDBOOK ACKNOWLEDGMENT

The SEEDS After School Program Parent/Guardian Handbook describes important information about SEEDS after school programming. I understand that I should consult the Site Coordinator regarding any questions not answered in the handbook.

Since the information, policies, and benefits described here are necessarily subject to change, I acknowledge that revisions to the handbook may occur. All such changes will be communicated through official notices, and I understand that revised information may supersede, modify, or eliminate existing policies.

I acknowledge that I have received SEEDS After School Program's Parent/Guardian Handbook and that I understand it is my responsibility to read and comply with the policies contained in this handbook, including any revisions.

Furthermore, I understand that SEEDS maintains a licensing notebook which includes all licensing inspection reports, special investigation reports and all related corrective action plans, and that this notebook is available for me to review. Licensing inspections and special investigation reports from at least the past two years are available on the child care licensing website at www.michigan.gov/michildcare

STUDENT'S NAME:	GRADE:
SCHOOL:	START DATE:
PARENT/GUARDIAN NAME (PRINTED):	
PARENT GUARDIAN SIGNATURE:	DATE:
PARENT/GUARDIAN EMAIL (REQUIRED):	



MEDICAL & ESSENTIAL HEALTH INFORMATION FORM

Student's Name:	
Date of Birth:	School:

GENERAL HEALTH ASSESSMENT

Is the child in good health?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Does the child have any activity restrictions?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Please note any activity restrictions:		
Does your student have any mental health concerns/diagnosis or special needs that we should be aware of?		
Please share any additional information about your student:		

IMMUNIZATIONS

I certify that all of my student's immunizations are complete and up to date	Yes <input type="checkbox"/>	No <input type="checkbox"/>
The immunization record is on file with the child's school	Yes <input type="checkbox"/>	No <input type="checkbox"/>
The appropriate immunization waiver is on file with the child's school	Yes <input type="checkbox"/>	No <input type="checkbox"/>

SERIOUS ILLNESS/SURGERY

Has your student suffered any serious illnesses?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Has your student suffered any chronic illnesses?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Has your student had any type of surgery?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
If you answered yes to any of the above questions, please describe the type of illness or surgery:		
Please Indicate any current complications from this illness or surgery:		



MEDICAL & ESSENTIAL HEALTH INFORMATION FORM CONTINUED

ALLERGIES & SPECIAL HEALTH CONCERNS

Does your student suffer from any allergies?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Does your student suffer from any other special health concerns?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
If you answered yes to any of the above questions, please describe the type of allergy or special health concern:		
What are the specific signs of the allergy or special health concern?		
What specifically should be done if these signs occur?		

MEDICATIONS

Is your student currently taking medication?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Will your student need medication during program hours?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
If you answered yes to either question, please describe the type of medication:		
SEEDS Staff do not regularly administer medication, except emergency medications such as EpiPens or inhalers or during overnight events. If your student needs these medications, see your Site Coordinator to complete the Medication Permission and Instructions (BCAL- 1243) for medication administration.		

I verify that my student is in good health and has no physical or emotional problems to restrict him/her from full participation in the program except where noted above, immunizations are up-to-date and that the immunization record or waiver is on file at the school. I verify that the above information is complete and accurate to the best of my knowledge.	
Parent Signature:	Date:



PERMISSIONS & WAIVERS

<p>School Records Consent I hereby authorize SEEDS' staff to have access to my child's Power School records for the purposes of program evaluation and student participation.</p>	<p>Initial Here</p>
<p>Photo Release Consent I hereby grant to SEEDS, SEEDS 21st Century Community Learning Centers, Youth Conservation Corps and to its employees, agents and assignees the right to photograph myself and/or my dependent listed below to use the photos and/or other digital reproductions and physical likeness for publication, marketing, and advertising purposes.</p> <p>If under eighteen; whether electronic, print and/or digital publishing via the Internet.</p>	<p>Initial Here</p>
<p>Swimming Consent I confirm that my child has basic swimming skills and has my permission to swim, if applicable, on field trip days</p>	<p>Initial Here</p>
<p>Topical Non-Prescription Medication Permission I give permission for SEEDS staff to apply the following non-prescription medication to my child, which I will supply and label with my child's name: <input type="checkbox"/> Sunscreen <input type="checkbox"/> Bug Repellent <input type="checkbox"/> Other _____</p> <p>In the event that sunscreen or insect repellent is needed and not sent from home, I give my permission for SEEDS staff to apply No Ad brand of sunscreen and/or Herbal Armor brand of insect repellent to my child.</p>	<p>Initial Here</p> <p>Initial Here</p>
<p>Hand Sanitization I understand that hand sanitizer may be used at the site in the absence of running water and soap.</p>	<p>Initial Here</p>

Liability Waiver

SEEDS and our employees respect you and your children. We take safety very seriously and follow protocols approved by the Department of Licensing and Regulatory Affairs when it comes to caring for students. Some of these protocols require us to require you to sign a variety of forms and waivers so that you understand the procedures we follow and the activities we do. Thank you for reading everything and trusting us with your children!

I, the undersigned, understand that SEEDS is doing due diligence when it comes to the safety and wellbeing of my child. I understand that SEEDS employees are never willfully negligent and that some events are simply out of anyone's control to avoid. Therefore, I will not hold SEEDS responsible for accidents of this nature. I further understand that SEEDS may engage in any of the activities listed in the Parent/Guardian Handbook.

<p>Parent/Guardian Signature:</p>	<p>Date:</p>
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seeds
After School

TRANSPORTATION PERMISSION FORM

I _____ (Parent/Guardian name) permit my child

_____ to (choose all that apply):

- walk** to SEEDS After School Program Field Trips.
- ride with a SEEDS After School representative** to SEEDS After School Program Field Trips.
- ride the school bus and/or public transportation** to SEEDS After School Program Field Trips
and/or as a means a transportation home if the service is provided by my students'
program.

I understand that Field Trips are part of the SEEDS After School and Summer Program and that they provide a learning experience of educational value to my child.

STUDENT'S NAME:	GRADE:
SCHOOL:	START DATE:
PARENT/GUARDIAN NAME (PRINTED):	
PARENT GUARDIAN SIGNATURE:	DATE:
PARENT/GUARDIAN EMAIL (REQUIRED):	