Learn, Grow, Thrive

Parkwood YMCA Preschool: Registration 2024-25

Name of Child (Last, First, Middle)			Gender F ◯ M ◯	Date of Birth
Address (Number and Street, Building/Apartment Number)		City	State MI	Zip Code
Parent/Legal Guardian's Name	Cell # (required)	Parent/Legal Guardian's Name		Cell # (required)
Parent/Legal Guardian's Date of Birth	Parent/Legal Guardian's Gender M☐ F☐ NB☐	Parent/Legal Guardian's Date of Birth	Parent/Legal Guardian's Gender M☐ F☐ NB☐	
Home Address (if not child's address)		Home Address (if not child's address)		
City	State MI / Zip Code	City	State / Zip Code	
Email Address (required)		Email Address (required)		
Desired Start Date		Anticipated drop-off and pick-up times		

Enrollment Options

Ages	Select Schedule*:		Weekly Rate	Registration Fee
Junior Preschool (30 to 36 months)	☐	Full-time (4-5 days)	$250	A non-refundable $100/year registration fee is due at the time of registering for the Child Care Program. Your child is not enrolled or guaranteed a spot until this form and fee are returned.
	☐	Part-time (M-W-F)	$188	
	☐	Part-time (Tu-Th)	$150	
Preschool/Pre-K (36 to 60 months)	☐	Full-time (4-5 days)	$250	
	☐	Part-time (M-W-F)	$188	
	☐	Part-time (Tu-Th)	$150	
School-age Program (available June 9th – August 15th, 2025; post-kindergarten to age 11)	☐	Full-time (4-5 days)	$225	A non-refundable $50/week registration fee is due at the time of registering for the School-age Program.

** Schedules may not be altered.*

Credit Card Authorization

In filling out this form, you are providing permission to the Parkwood YMCA Preschool to charge your tuition payment weekly, one week in advance of care.

Circle credit card type:	☐ **Visa**	☐ **MasterCard**	☐ **American Express**	☐ **Discover**
Card Number:			Exp. Date:	CVV:
Cardholder Name:				
Authorized Signature:				

Parkwood YMCA Preschool: Agreement 2024-25

Please initial each item and sign/date form

_____ I have read the Parkwood YMCA Preschool Handbook and I agree to abide by all the terms stated in the handbook while my child receives care. The handbook included all the following information (R 400.8146 (1-2)):

- Criteria for admission and withdrawal
- Schedule of operation, denoting hours, days, and holidays during which the center is open, and services are provided.
- Fee policy
- Discipline policy
- Food service program
- Program philosophy
- Typical daily routine
- Parent notification plan for accidents, injuries, incidents, and illnesses.
- Medication policy
- Exclusion policy for child illnesses
- Notice that the center keeps a licensing notebook containing a summary sheet, all licensing inspections and special investigation reports, and related corrective action plans for the last five years. The licensing notebook is available to parents/guardians during regular business hours. Reports from at least the past three years are available at www.michigan.gov/michildcare.

_____ I understand that tuition is due weekly, one week in advance of care.

_____ I understand that I will be assessed a late payment fee if tuition payments fall behind, and a late pick-up fee for any day my child is not picked up on time.

_____ I will pay for my child's enrolled slot even if they are not present due to illness, time off, or vacation.

_____ I understand that I must give two weeks written notice to withdraw my child from the program, and that fees will be due through the end of the two-week period whether or not my child attends.

_____ I understand the Parkwood YMCA Preschool gives priority to full-time enrollment and if necessary I may be asked to rearrange my schedule to meet current vacancies.

_____ I understand the Parkwood YMCA Preschool is mandated to report to the Department of Health & Human Services any suspected case of child abuse or neglect.

Permissions

_____ I give permission to the Parkwood YMCA Preschool program staff to apply (twice daily prior to outdoor time) **sunscreen or bug repellant** that I have provided and labeled for my child.

_____ I give permission to the Parkwood YMCA Preschool program staff to apply (as needed) **lotion** that I have provided and labeled for my child.

_____ I give permission to the Parkwood YMCA Preschool program staff to apply **hand sanitizer** as needed.

_____ I give permission for my child (aged three years and older) to participate in **swimming activities**. I understand that I will be notified in advance to provide appropriate swimwear. I understand that the YMCA will assess each child's swimming ability prior to participation. I understand that non-swimmers and children under 3 years old will be engaged in supervised non-swimming activities away from the immediate swimming activity area during swim-time.

Parent Signature _____ Date _____

Director Signature _____ Date _____

Learn, Grow, Thrive

Parkwood YMCA Preschool: Photo/Media Consent and Release

Taking photographs of children at school is a common method of documenting their activities and development. Classroom staff at the Parkwood YMCA Preschool are trained to be discerning when photographing children, giving thought to its necessity and purpose in such documentation.

Classroom staff are prohibited from using their personal cell phones and other electronic devices for photographing or recording children's activities. Any photos of children must be taken using only YMCA-issued devices, which are accessible only to center personnel.

Photographs and video of children are intended for educational and communication purposes only. Photographs of an individual child may be shared with that child's family only. Photographs may be displayed in the classroom, especially to indicate allergies to new staff. Group photographs are sometimes used on the YMCA Parkwood Kid's Time Preschool's *private* Facebook page to convey activities and development, but they are not made public.

On rare occasions, the YMCA of the USA seeks photographs from its association members of people and programs, including children. The Parkwood YMCA Preschool will release to the YMCA of the USA only photographs of children whose family has given explicit consent on this form.

Please initial only those items to which you consent:

_____ I understand that photographs will be taken of my child by staff at the Parkwood YMCA Preschool to document his/her activities and development.

_____ I give permission to the Parkwood YMCA Preschool to use my child's photograph within the classroom.

_____ I give permission to the Parkwood YMCA Preschool to use my child's photograph on the center's private Facebook page.

_____ I give permission to the Parkwood YMCA Preschool to release my child's photograph to the YMCA of the USA for their exhibition in promotions, advertising, education, and legitimate business uses. Such use includes reproductions in any form and media, adaptations and/or revisions, throughout the world and forever. I understand and agree there may be no compensation for this, and I will not make any claim for payment of any kind. My child may or may not be identified in such reproductions; however, my child's name will not be used to endorse any particular commercial products or commercial services.

Parent Signature _____ Date _____

Director Signature _____ Date _____

CHILD INFORMATION RECORD

State of Michigan - Department of Lifelong Education, Advancement, and Potential - 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 MI	Zip Code

Parent/Legal Guardian's Name	Cell Phone	Parent/Legal Guardian's Name (Optional)	Cell 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 MI / Zip Code		City / State / Zip Code	
Email Address (required)		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:	

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 **Parkwood YMCA Kids Time Preschool**, licensed by the Department of Lifelong Education, Advancement, and Potential, 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

MiLEAP 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 (due within 30 days of enrollment)

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)			CELL PHONE
ADDRESS (Number & Street)	(City)	(ZIP Code) MI	WORK TELEPHONE NUMBER

SECTION I - HEALTH HISTORY (to be completed by parent/guardian)

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	Visual Acuity			
			Muscle Imbalance			
		Date: ___/___/___	Other:			
☐	☐	HEARING	Audiometer			
			Other:			
		Date: ___/___/___				
☐	☐	URINALYSIS	Sugar			
			Albumin			
		Date: ___/___/___	Microscopic			
☐	☐	BLOOD LEAD LEVEL	Level _____ ug/dl ⇨			
		Date: ___/___/___				

No	Yes	Was child tested for:	Test results:	Normal	Referred	Under Care
☐	☐	HEIGHT & WEIGHT	Height			
			Weight			
		Other: _____	Other			
☐	☐	HEMOGLOBIN / HEMATOCRIT	⇨			
☐	☐	BLOOD PRESSURE	Reading: _____			
☐	☐	TUBERCULIN	Type: _____			
		Date: ___/___/___	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	
	Type of Vaccine(s)	Date of Vaccine(s)
OTHER Vaccines Specify Date & Type	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 _____ 's teeth. As a result of this examination, my recommendation for treatment is: _____

child's name

_____ ___/___/___

Dentist's Signature Date

PHYSICIAN'S SIGNATURE

_____ ___/___/___ _____ _____

Examiner's Signature Date ***Examiner's Name (Print or Type)*** Degree or License

_____ _____ MI _____ (_____) _____

Number & Street City 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.

REQUIRED

Learn, Grow, Thrive

Family Structure and Child Development

The purpose of this questionnaire is to allow the teaching staff a better understanding of your child and your family. All information is confidential.

GENERAL INFORMATION

Child's full name_____Nickname _____ DOB_____

Race/ethnicity_____Nationality _____ Religion_____

Person providing this information:_____ Relationship to child_____

Is child your: □ biological child □ adopted child □ foster child □ other:_____

FAMILY STRUCTURE & LIVING SITUATION

Father's Name_____ Occupation_____ Highest education: _____

Mother's Name_____ Occupation_____ Highest education: _____

Guardian's Name_____ Occupation_____ Highest education: _____

With whom does child live *at least half* the time? (Check all that apply)

□ both parents in the same home □ mother's home □ father's home

□ other's home (specify) _____

List all people living in household (indicate which household if child lives in multiple homes):

Name	Age	Relationship to child	Which home? (Leave blank if N/A)

Any pets? (Indicate type, name, household)_____

Language(s) spoken at home _____ Primary language at home _____

List all locations (city, state, and/or country) that your child has lived:

1. Birthplace _____ Moved at age _____
2. _____ Moved at age _____
3. _____ Moved at age _____

Are parents of child currently:

□ unmarried, living together
□ married
□ separated
□ divorced
□ never married, not living together

If separated, divorced, or never married and not living together, who has *legal* custody?

□ mother □ father □ both
□ other (specify): _____

If separated or divorced, how do you feel your child has adjusted to separation/divorce?

_____

_____

Are the other adults who have a *significant* part in raising your child? □Yes □No If so, please indicate name & relationship (i.e., step-parent, grandparent, etc.) _____

_____

SOCIAL-EMOTIONAL DEVELOPMENT

Has your child had previous experience with a fulltime babysitter/nanny, child care home/center, or other care outside your home? □Yes □No If so, when, with whom, and how often? _____

Have there been any significant changes in the home over the last few years? (i.e., new marriages, deaths, births, address changes, family separation/divorce, parent dating, money problems, etc.) _____

_____

What do you feel are your child's…
Strengths_____ Weaknesses_____

Reaction to strangers: _____ Able to play alone? _____

How much time each day does your child typically spend on the following electronic media?
Watching TV: _____ Playing video/computer/phone games: _____ Other_____

Does anyone read aloud to your child at home? □Yes □No If so, how often? _____

At what age did your child begin playing with other children? _____

What are your child's favorite activities? _____

Is your child affectionate? _____

Does your child celebrate holidays or special occasions? _____

Are there occasions in which you would rather your child not participate? _____

What are the things your child seems to fear? _____

Has your child had any frightening experiences? If so, describe briefly: _____

_____

What is the method of behavior management/discipline at home? _____

_____

HEALTH AND DEVELOPMENT

Any known complications at birth? _____

Serious illnesses and/or hospitalizations:_____

Special physical conditions, disabilities: _____

Is your child currently taking any medication? □ Yes □ No If yes, please list medication and uses: _____

Has your child ever been identified as having a disability? □ Yes □ No If so, by whom, what age, & what disability? _____

Has your child ever received psychological counseling? □ Yes □ No If yes, by whom (professional/ agency) and when: _____

During your child's first few years of life, were any of the following significantly present?

- □ Difficult to comfort
- □ Was not easily calmed by being held or stroked
- □ Colicky
- □ Excessive irritability
- □ Diminished sleep
- □ Difficult nursing
- □ Poor eye contact
- □ Did not respond to their name
- □ Fascination with certain objects
- □ Constantly head banging

* If you checked any of the above, please describe_____

PARENTING

Which adult would your child prefer to talk with about a problem? _____

Who is the family member with whom your child feels closest? _____

Who is primarily responsible for discipline at home? _____

What is the most effective way to deal with your child's behavior problems at home? _____

_____

How does your child respond to discipline at home? _____

List any responsibilities your child has at home: _____
Does your child do these regularly? □ Yes □ No
Does your child need frequent reminders? □ Yes □ No

SLEEPING HABITS

Indicate your child's… Bed time? _____ Wake time? _____ Do they sleep well? _____

Does your child sleep in a… Crib? _____ Bed? _____ Other? _____

Does your child sleep *in a room* alone? □ Yes □ No If not, with whom do they share? ___
_____

Does your child sleep *in a bed* alone? □ Yes □ No If not, with whom and how often? _____
_____

Does your child become tired or nap during the day (include when and how long)? _____
_____

Describe any special characteristics or needs (stuffed animal, story, mood on waking, etc.) _____
_____

How does your child fall asleep? (Check all that apply)
□ Rocking chair
□ Laying with someone
□ On their own
□ Other _____

EATING HABITS & NUTRITION

Is your child usually hungry at mealtime? □ Yes □ No Between meals? □ Yes □ No

Is your child able to eat with a…
Spoon? □ Yes □ No
Fork? □ Yes □ No
Hands? □ Yes □ No

At home, what time does your child eat breakfast? _____ Lunch? _____ Dinner? ____

Favorite foods: _____

Foods refused: _____

Eating problems or difficulties: _____

List foods your child may not eat: _____

TOILETING HABITS

Has toilet learning been attempted? □ Yes □ No

How does your child indicate toileting needs (include special words): _____

_____

Please describe any particular toileting procedure(s) to be used for your child at the center: _____

_____

What is used at home?

Pottychair?	□ Yes	□ No
Special child seat?	□ Yes	□ No
Regular seat?	□ Yes	□ No

Is your child ever reluctant to use the toilet? □ Yes □ No If yes, what are the circumstances? _

_____

Does your child have accidents? □ Yes □ No If yes, what are the circumstances? _____

_____

Are bowel movements regular? □ Yes □ No How many per day? _____

Is there a problem with diarrhea? □ Yes □ No If yes, what are the circumstances? _____

_____

Is there a problem with constipation? □ Yes □ No If yes, what are the circumstances? _____

_____

ADDITIONAL INFORMATION

Please provide us with any additional information that will help us care for your child.