



2017-2018 FULL DAY PRESCHOOL TUITION SCHEDULE

Thank you for choosing UCS Full Day Preschool program for your child's education and child care experience. The Full Day Preschool program is a self-supporting program. Tuition covers the cost of staff, teaching supplies, and all the costs associated with maintaining and operating a high quality early childhood program.

We are a year round program. Children may be scheduled for a minimum of 2 full days or 3 half days and up to 5 full days a week. Parents complete a form indicating a weekly schedule for their child prior to attending. Tuition is billed according to the schedule every Monday for that current week and must be paid no later than 4:00 pm on Monday.

If tuition is not paid, your child may not attend the program. All schedule changes must be made in writing and approved by the director. Fees for additional days must be paid in advance.

Summer Only Registration Fee: \$45 Child / \$70 Family

Annual Registration Fee: \$65 Child / \$90 Family

(Registration fee is non-refundable)

2017-2018 Tuition Rates

Full Day (more than 5 hours)	Half Day (5 hours or less)
1 full day - \$ 50	1 half day - \$ 40
2 full days - \$ 90	2 half days - \$ 75
3 full days - \$130	3 half days - \$100
4 full days - \$160	4 half days - \$125
5 full days - \$190	5 half days - \$145

If the Full Day Preschool program is not available due to Utica Community School closings, fees will be adjusted.

Fees:

- Late Pick Up Fee - \$15 will be charged every 15 minutes beginning at 6:01 pm
- Late Payment Fee - \$25 assessed after 4:00 pm every Monday
- Re-registration Fee - \$65 child / \$ 90 family re-enrolling
- Credit Card Decline Fee - \$5
- Non-Sufficient Fund (NSF) - \$25

NSF payments must be made with a money order, cashier's check or cash. A personal check or credit card WILL NOT be accepted.



Full Day Preschool & Infant/Toddler Early Learning & Care Enrollment Form

Early Childhood Programs Phone: 586-797-4660 or 586-797-6985

Child Information: How did you hear about the program: _____

Child's Name: _____ Date of Birth: _____ Male _____ Female _____

Home School: _____ Ethnicity: _____

Parent Information (responsible for child/account):

Parent/Guardian: _____ Relationship to Child: _____

Address: _____ City: _____ Zip: _____

Home: _____ Cell: _____ Work: _____

Email address: _____

Parent/Guardian: _____ Relationship to Child: _____

Address: _____ City: _____ Zip: _____

Home: _____ Cell: _____ Work: _____

Email address: _____

Program Information:

Program (check one): Full Day Preschool _____ Infant/Toddler _____ Start Date: _____

Classroom: _____ Location: _____ Director: _____

Sept. - June 2017-2018	Monday	Tuesday	Wednesday	Thursday	Friday
Arrival Time					
Departure Time					

Are you enrolling in the 2017 Summer Session? YES _____ NO _____

Registration/Payment Info: *Payment for registration fee is required to process this form.*

Summer Only Non-refundable Registration Fee: \$45 Child / \$70 Family

Annually Non-refundable Registration Fee: \$65 Child / \$90 Family Amount \$ _____

Payment Options: Visa, MasterCard, Discover or Check:

Credit Card #: _____ Name on Card: _____

Expiration: _____ Security Code: _____ or Check # _____ (Payable to UCS)

I understand this payment will be processed upon UCS receipt of this completed enrollment form.

X _____ Date: _____

(Authorized signature required to process enrollment)

(Required)



2017-2018 FULL DAY PRESCHOOL PAYMENT AGREEMENT

1. I understand that Full Day Preschool is a non-profit, self-supporting program.
2. I understand that my child's Full Day Preschool account from previous school year and/or summer must be in good standing or I cannot register my child for the program.
3. I agree to pay **Registration Fee** \$65 child / \$90 family (non-refundable) or **Summer Only Registration Fee** \$45 child / \$70 family (non-refundable).
4. I agree to pay the weekly scheduled tuition when I receive my account statement every Monday.
5. I understand there will be a charged **Late Payment Fee** of \$25 accessed after 4:00 pm every Monday, **Credit Card Decline** of \$5, and **Non-Sufficient Fund (NSF)** of \$25. NSF payments must be made with a money order, cashier's check or cash. A personal check or credit card **WILL NOT** be accepted.
6. I understand that if my child's account is not at zero balance or in a credit status, my ProCare Log In code will be disabled and my child will be denied entry to the Full Day Preschool.
7. I understand my Payment Options are; **Online** using Tuition Express, **Phone** Early Childhood office 586.797.6985 or 586.797.4660 with credit card, **Mail** check, or **Bring** cash payment to Community Education Center.
8. I understand the parent that is listed on the Full Day Preschool registration form is considered to be the person responsible for full payment.
9. I understand that I will be emailed my account statement every Monday, if I fail to receive a statement I will contact my Full Day Preschool Director or the Early Childhood office.
10. I understand that if I have joint custody of my child and if I share financial responsibility for payments, I must work out the payment method with other parent. If I choose, I can have a separate Full Day Preschool account and I will register separately and pay a separate Registration Fee.
11. I understand that I will be charged a **Late Fee** of \$15 per 15 minutes increments starting at 6:01 pm. I understand that if I call and notify the Full Day Preschool that I will be late, it will **NOT** eliminate the late fee charge.
12. I understand that the Early Childhood office closes at 4:00 pm and to contact my program director with any questions and/or concerns.

I have received a copy of the current UCS Full Day Preschool program tuition rates and billing schedule.

In signing this I agree to comply with the terms outlined above.

Child's Name

Parent/Gaurdian Signature

Date

THIS FORM MUST BE SIGNED AND RETURNED WITH YOUR REGISTRATION



Utica Community Schools / Community Education

Full Day Preschool & Infant / Toddler Early Learning & Care Policy Agreement

(Parent's Name)

(Child's First Name)

(Child's Last Name)

Full Day Preschool and Infant / Toddler Early Learning and Care Programs:

- I agree to start the program within 30 days of registering with my child's program director.
- I agree to pay tuition billed every Monday according to the schedule submitted to the director and any late fees assessed. My Full Day Preschool and Infant/Toddler Early Learning and Care account will be at a zero balance or in a credit status OR my child may NOT attend. Late fees and/or outstanding tuition must be paid before child can attend program.
- If the Full Day Preschool and Infant/Toddler Early Learning and Care are closed due to low enrollment, weather or emergency related closings, you will not be charged. If you have pre-paid, fees will be adjusted.
- Regardless of my child's attendance (any absences), I agree to pay the weekly scheduled days of attendance I originally agreed to at the time of registration with my child's program director.
- I agree to request additional days by email to my child's program director for approval and pre-pay for days requested prior to my child attending the program.
- I agree to **schedule days off 2 weeks in advance by email** to my child's program director for approval. The maximum allowance of days off per school year is accordance with my weekly scheduled days of attendance. (Example: If your weekly schedule is 3 days, you will receive 3 days off per school year.)
- I understand extended days off of 30 days or more, I am required to re-register and pay the weekly scheduled days of attendance I originally agreed to at the time of registration with my child's program director.
- I agree to clock in/out my student each time I drop off and/or pick up my child.
- I will complete and submit all enrollment forms. I will keep all enrollment information current and up-to-date.
- I will read all communications from program Director and/or Teacher; (i.e. newsletters, emails, posters, and bulletin boards.)
- I will keep Director and/or Teacher informed of any changes or incidents at home that might result in a change in my child's behavior.
- I confirm that my child is in good health, able to participate in all activities unless otherwise indicated on enrollment forms.
- If a medical emergency arises, the Early Childhood program Director/Teacher will first attempt to contact me. If I cannot be reached, the staff will contact the person(s) on the Child Information Record. If the emergency is such that immediate hospital attention is necessary, appropriate emergency procedure will be followed.
- I agree that if the behavior or health of my child should necessitate sending him/her home, I (or someone on my Child Information Record) will IMMEDIATELY pick up my child from the program. I agree to keep my Child Information Record up-to-date.
- I have read, understand and agree to all the above. If I have any questions or concerns, I will contact my child's program Director.

All policies, procedures and staffing related to Full Day Preschool and Infant/Toddler Early Learning and Care programs are under the discretion of the Early Childhood Coordinator.

(Parent/Guardian Signature)

(Date)

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
			Zip Code	
Father/Legal Guardian's Name		Home Phone ()	Mother/Legal Guardian's Name	
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 (optional)	
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. 6-15) Previous edition 7-12 only 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 must initial one of the following:

_____ I give permission to _____, licensed by the Department of Licensing and Regulatory Affairs to secure emergency medical and/or emergency surgical treatment for the above named minor child while in care.

_____ I do not give permission to _____, licensed by the Department of Licensing and Regulatory Affairs to secure emergency medical and/or emergency surgical treatment for the above named minor child while in care. I understand I assume responsibility for all emergency medical care.

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. Auxiliary aids, services and other reasonable accommodations are available upon request to individuals with disabilities.

AUTHORITY: 1973 PA 116
COMPLETION: Required
PENALTY: Rule Violation Citation.

BCAL-3731 (Rev. 6-15) Previous edition 7-12 only may be used.

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)			TODAY'S DATE (mm/dd/yy)
			MI
PARENT/GUARDIAN (Last, First, Middle)			HOME TELEPHONE NUMBER
ADDRESS (Number & Street) (City) (ZIP Code)			() ()
			MI
			WORK TELEPHONE NUMBER
			() ()

SECTION I - HEALTH HISTORY

<table style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 5%; text-align: center;">Yes</td> <td style="width: 5%; text-align: center;">No</td> <td style="width: 5%; text-align: center;">Resolved</td> <td style="width: 85%;"># is your child having any of the problems listed below?</td> </tr> <tr> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> <td>1 Allergies or Reactions (for example, food, medication or other)</td> </tr> <tr> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> <td>2 Hay Fever, Asthma, or Wheezing</td> </tr> <tr> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> <td>3 Eczema or Frequent Skin Rashes</td> </tr> <tr> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> <td>4 Convulsions/Seizures</td> </tr> <tr> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> <td>5 Heart Trouble</td> </tr> <tr> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> <td>6 Diabetes</td> </tr> <tr> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> <td>7 Frequent Colds, Sore Throats, Earaches (4 or more per year)</td> </tr> <tr> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> <td>8 Trouble with Passing Urine or Bowel Movements</td> </tr> <tr> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> <td>9 Shortness of Breath</td> </tr> <tr> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> <td>10 Speech Problems</td> </tr> <tr> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> <td>11 Menstrual Problems</td> </tr> <tr> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> <td>12 Dental Problems: Date of Last Exam / /</td> </tr> <tr> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> <td>Other (please describe): _____</td> </tr> <tr> <td colspan="4" style="padding-top: 10px;"> <input type="checkbox"/> Does your child take any medication(s) regularly? Reason for Medication _____ </td> </tr> <tr> <td colspan="4" style="padding-top: 10px;"> _____ / / Parent/Guardian Signature _____ Date _____ </td> </tr> </table>	Yes	No	Resolved	# is your child having any of the problems listed below?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	1 Allergies or Reactions (for example, food, medication or other)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	2 Hay Fever, Asthma, or Wheezing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	3 Eczema or Frequent Skin Rashes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	4 Convulsions/Seizures	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	5 Heart Trouble	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	6 Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	7 Frequent Colds, Sore Throats, Earaches (4 or more per year)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	8 Trouble with Passing Urine or Bowel Movements	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	9 Shortness of Breath	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	10 Speech Problems	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	11 Menstrual Problems	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	12 Dental Problems: Date of Last Exam / /	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Other (please describe): _____	<input type="checkbox"/> Does your child take any medication(s) regularly? Reason for Medication _____				_____ / / Parent/Guardian Signature _____ Date _____				<p>Birth History:</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>Are there any current or past diagnosis(es) <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>If yes, please describe:</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>If yes, list medications:</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>Was the health history reviewed by a health professional? <input type="checkbox"/> Yes <input type="checkbox"/> No Examiner's Initials: _____</p>
Yes	No	Resolved	# is your child having any of the problems listed below?																																																														
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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	No	Yes	Was child tested for:	Test results:	Normal	Referred	Under Care
<input type="checkbox"/>	<input type="checkbox"/>	VISION Date: / /	Visual Acuity Muscle Imbalance Other: _____				<input type="checkbox"/>	<input type="checkbox"/>	HEIGHT & WEIGHT Other: _____	Height Weight Other: _____			
<input type="checkbox"/>	<input type="checkbox"/>	HEARING Date: / /	Audiometer Other: _____				<input type="checkbox"/>	<input type="checkbox"/>	HEMOGLOBIN / HEMATOCRIT	→			
<input type="checkbox"/>	<input type="checkbox"/>	URINALYSIS Date: / /	Sugar Albumin Microscopic				<input type="checkbox"/>	<input type="checkbox"/>	BLOOD PRESSURE	Reading: _____			
<input type="checkbox"/>	<input type="checkbox"/>	BLOOD LEAD LEVEL Date: / /	Level _____ ug/dl				<input type="checkbox"/>	<input type="checkbox"/>	TUBERCULIN	Type: _____ Neg.: <input type="checkbox"/> Pos.: <input type="checkbox"/> _____ min			

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		VACCINES (Circle Type)	DATE ADMINISTERED MM/DD/YYYY	
Hepatitis B (HepB)	1	3	Hepatitis A (HepA)	1	2
	2			1	3
DTaP/DTP/DT/Td	1	4	Influenza (IIV/LAIV)	2	4
	2	5		1	2
	3	6	Meningococcal (MCV4 / MPSV4)	1	2
Tdap	1		Human Papillomavirus (HPV9/HPV4/HPV2)	1	3
Haemophilus Influenzae type b (HIB)	1	3	OTHER Vaccines Specify Date & Type	Type of Vaccine(s) Date of Vaccine(s)	
	2	4		1	
Polio (IPV/OPV)	1	3		2	
Pneumococcal Conjugate (PCV7/PCV13)	2	4	3		
	1	3	Indicate and attach physician diagnosis or laboratory evidence of immunity as applicable		
Rotavirus (RV1/RV5)	2		*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.		
	1	3			
Measles, Mumps, Rubella (MMR)	1	2	Parent/Guardian refused immunizations: <input type="checkbox"/>		
Varicella (Chickenpox)	1	2			
History of Chickenpox Disease? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, date: _____					
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	Question
<input type="checkbox"/>	<input type="checkbox"/>	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:
<input type="checkbox"/>	<input type="checkbox"/>	Should the child's activity be restricted because of any physical defect or illness? If yes, check and explain degree of restriction(s): <input type="checkbox"/> Classroom <input type="checkbox"/> Playground <input type="checkbox"/> Gymnasium <input type="checkbox"/> Swimming Pool <input type="checkbox"/> Competitive Sports <input type="checkbox"/> 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.

Notice to Parents

Often, our students are involved in interviews by the local media, reporting on the positive instructional programs of the district. These interviews can include, but are not limited to, classroom activities, concerts and musical programs. The Utica Community Schools Board of Education has approved a policy regarding media relations, which affects students. The policy requires that the news media report to the Office of School/Community Relations or the building principal for prior approval before interviewing students involved in instructional programs.

District employees may release student information to the media only in accordance with applicable provisions of the Family Education Rights and Privacy Act (FERPA) and Board of Education Policy 5124 - Release of Directory Information. (See reference in Student/Parent Handbook.)

By completing the form below, you will give the school district, including the Utica Community Schools cable access TV education station, and the new media permission to interview your child in connection with activities involving the Utica Community Schools for as long as your child is a student of the district. Please complete the form and return it to your building principal. The completed form will be kept in the school office.

Media Release Form

The person named below gives the Utica Community Schools (UCS) permission to allow the news media and/or the school district to photograph, video and/or audio tape his or her child in connection with news events and activities involving the Utica Community Schools. I also give permission to reproduce and record my child's voice. I consent to the use of his/her name and/or the recordation and reproduction of him/her in connection with the production, exhibition, distribution and promotion or other use of any photographs, photo play, audio plays or otherwise. I agree that his/her participation is voluntary and without consideration or compensation. If, at any time, I do not want my child to participate in media interviews, I will notify the building principal in writing.

Please Print Information

I agree to the above release language as parent or legal guardian of:

(child's name)

Date: _____

Name: _____

Relationship: _____

Signature: _____

Must be filled out. If you do not agree, fill out and write "NO" across the top

Use of Student Work/Photograph

Dear Parents:

As part of the communication process, the Utica Community Schools maintain web pages on the Internet. These pages provide information about the activities of the Utica Community Schools, its employees and students, and can be viewed globally.

This form officially documents that you are willing to release your child's projects, photographs, video images and/or voice recordings into the public domain. They can be viewed by anyone with access to the Internet. Group photographs may be used on a web page, however, your child's name and/or individual photograph will not appear on the Internet. There is no monetary compensation for the use of these projects and/or images.

Release

I give my permission for my child's computer projects, photographs, images and/or voice recordings, to be used as described above and are willing to release this for use in the Utica Community Schools web pages on the internet. I understand no monetary compensation will be given for use of the materials.

Student Name (Signature)

Parent/Guardian (Signature)

Address

Parent/Guardian name (Printed)

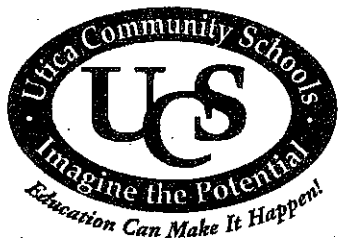
City, State, Zip

Date

Phone number with area code

Please sign and return to the building principal

**Must be filled out.
If you do not agree, fill out and
write "NO" across the top**



Utica Community Schools

Community Education Early Childhood Programs

Full Day Preschool

Dear Full Day Preschool Parents,

In accordance with Michigan Licensing for Child Care Centers, a statement needs to be on file stating you are packing a nutritious lunch and beverage for your child.

Please fill out the bottom portion of this sheet and return it to your child's teacher as soon as possible. Please indicate below any additional information we should be aware of, i.e., food allergies, medical concerns, etc.

Should you need additional information, please contact your Director.

TO: Full Day Preschool Director

I agree to pack a nutritious lunch and beverage. I will label it daily with my child's name and date _____

Child's Name

Does your child have any food allergies or sensitivities or special dietary considerations?

Yes _____ No _____

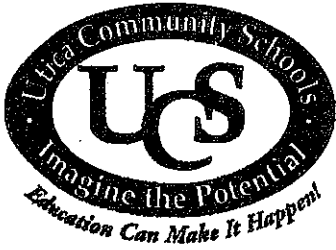
If Yes, please elaborate:

Does your child have any medical concerns regarding diet or food intake that the staff should be aware of? Yes _____ No _____

If Yes, please elaborate:

Parent/Guardian

Date



Utica Community Schools
Community Education
Early Childhood Programs
FULL DAY PRESCHOOL

Permission to administer external topical ointments:

Child's Name: _____

I give the Full Day Preschool staff permission to administer the following external, topical ointments. I agree to provide and label these items with my child's name. The products must be in original containers and used according to package directions.

_____ Flushable Wipes

_____ Lotion

_____ Non-prescription ointment (Chapstick, Vaseline, etc.)

_____ Sunscreen

_____ Other – Please specify:

Parent Signature

Date



CREDIT CARD PAYMENT AUTHORIZATION FORM

_____ I authorize credit card payment for **Nursery or Preschool** on the first day of each month (8) times from September 2017 until April 2018 or until account is paid in full for my child's tuition in the Utica Community Schools Early Childhood program.

_____ I authorize credit card payment for **Montessori or Come Play With Me** on the 15th day of each month (8) times from September 2017 until April 2018 or until account is paid in full for my child's tuition in the Utica Community Schools Early Childhood program.

_____ I authorize credit card payment for **Full Day Preschool or Infant/Toddler Early Learning and Care** weekly payments for 2017-2018 school year or until account is paid in full for my child's tuition in the Utica Community Schools Early Childhood program.

Child's Name _____ Phone # _____

Credit Card # _____ Expiration Date _____

3 Digit Security Code _____
(Located on back of card)

Nursery/Preschool/Montessori/CPWM
Monthly Payment \$ _____



Full Day Preschool/Infant/Toddler Early Learning & Care
Weekly Payment \$ _____

Cardholder Name (Print) _____

Cardholder Billing Address _____

Cardholder Signature _____ Date _____

This document will be kept in a secure location during the school year and will be shredded at the conclusion of the program. In the event your child discontinues the program during the year, this agreement will terminate. Please let us know if there are any changes regarding the credit card used for the authorization period.

Accepted ONLY by mail or drop-off at:

**Community Education Center
Early Childhood Accounting Office
38901 Dodge Park
Sterling Heights, MI 48312
Office Hours: 8:00 am – 4:00 pm**

TuitionExpress.com Information for Parents

Automatic Payment Processing

Safe – Convenient – Easy

Day by Day Child Development Center, Inc. is excited to offer you the convenience of Tuition Express – an automated payment processing system that is intergraded into the ProCare Child Care Management System that allows you to pay your tuition and fees four ways:

- Recurring credit card payments
- Recurring bank-to-bank transactions (EFT)
- POS/Credit Card Swipe
- Online Payments - *NOTE: At this time, Day by Day Child Development Center, Inc. has decided not to offer this option.*

Tuition Express is a Payment Card Industry Level 1 Service Provider and it is the premier payment processing solution in the childcare/early education industry. It will allow parents the ability to check their balance online, receive Email Payment Notifications, and the ability to print reports regarding their account.

Since 2003, Tuition Express has safely and conveniently processed billions in tuition and fee payments. Your account information is safe. Write checks no more. And easily make your tuition payment on time, every time. Saving your childcare provider time and money, since they no longer need to go to the bank or hunt down parents regarding past due payments and fees.

What is TuitionExpress.com?

At TuitionExpress.com you may register to check your balance, sign up for email notifications, sign up for receipt notification when a payment has been processed, etc. Some services, such as the ability to make online payments, or use a credit card to make online payments, are at the discretion of your child care provider and may or may not be available.

NOTE: At this time, Day by Day Child Development Center, Inc. has decided not to offer this option. This may be available in the future depending on how the transition goes to TuitionExpress.com. Please keep in mind that this is a huge step and learning curve for our center as we transition to a computer based childcare management system.

Is it free?

Yes. All services are free to parents and guardians whose child care provider uses Tuition Express®.

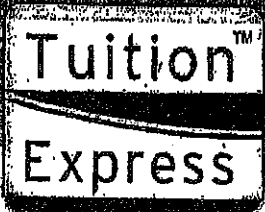
Do I need to complete an Authorization Form?

Yes. If your child care provider will be collecting automatic payments from your bank account or credit card you must complete an authorization form available through your child care provider.

ID Number, Bank Account or Registration Number

You'll need two numbers to register the very first time at TuitionExpress.com.

1. The first number is your unique Tuition Express ID number which will be given to you by your child care provider. This will be provided once you return your TuitionExpress Registration Form.
2. The second number you'll need will be the last 4 digits of the bank account (or credit card number) from which you have agreed to pay your provider.



Automated Payment Processing
Safe - Convenient - Easy

We are excited to offer the safety, convenience and ease of Tuition Express™ - an automatic payment processing system that allows on-time tuition and fee payments to be made from your bank account.

ELECTRONIC FUNDS TRANSFER AUTHORIZATION FOR BANK ACCOUNT AUTHORIZATION

I (we) hereby authorize Utica Community Schools (business name) to initiate debit entries to my (our) Checking or Savings Account indicated below. To properly affect the cancellation of this agreement, I (we) are required to give 10 days written notice.

Credit Union Members: Please contact your Credit Union to verify account and routing numbers for automatic payments.

Your Name _____ Phone # _____

Address _____ City _____ State _____ Zip _____

Bank or Credit Union Name _____

Bank or Credit Union Address _____ City _____ State _____ Zip _____

Checking Savings

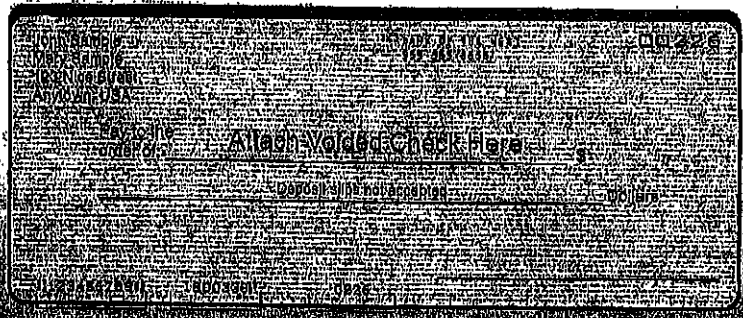
Routing Transit Number (see sample below) _____ Account Number (see sample below) _____

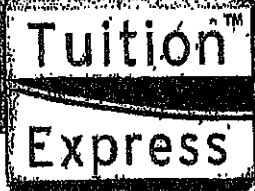
Signature _____ Date _____

Check if you wish to make online payments

Mall completed form to: Utica Community Schools
Community Education Center
Early Childhood Accounting Office
38901 Dodge Park
Sterling Heights, MI 48312

For Official Use Only
Date Received
Employee Signature





Automated Payment Processing
Safe - Convenient - Easy

We are excited to offer the safety, convenience and ease of Tuition Express Online Payments. You can process on-time tuition and fee payments with your credit card at www.tuitionexpress.com

TUITIONEXPRESS.COM REGISTRATION

As a customer of Utica Community Schools (business name), I (we) wish to register at www.tuitionexpress.com for the purpose of making Online Payments using a credit card.



PLEASE CONTACT CENTER REPRESENTATIVES FOR CREDIT CARD TYPES ACCEPTED BY CENTER.

Cardholder Name _____ Phone # _____

Cardholder Address _____ City _____ State _____ Zip _____

Cardholder Signature _____ Date _____

Website Registration Code: _____ (Please select a 4 digit PIN that will be used when you register at TuitionExpress.com)
4 digits

Please provide a 4-digit website registration code of your choice on the form. The Early Childhood Accounting office will enter your 4-digit code with Tuition Express. Once we set up your online account, we will notify you that the account is activated and you may begin using Tuition Express.

Mail completed form to: Utica Community Schools
Community Education Center
Early Childhood Accounting Office
38901 Dodge Park
Sterling Heights, MI 48312

For Official Use Only
Date Received
Employee Signature



Utica Community Schools/Community Education
Early Childhood Programs
Full Day Nursery/Preschool
Child Information Sheet

Start Date _____

Child's Name _____
First Middle Last

Birthdate ____/____/____ Age ____ Male _____ Female _____

Name your child is usually called _____

Parent/Guardian Name _____ Relationship to child _____

Age _____

Parent/Guardian Name _____ Relationship to child _____

Age _____

Parents are: Married _____ Divorced _____ Single _____ Living w/partner _____ Widowed _____

With whom does the child live?

Does the child have step-parents? Yes _____ No _____

Step-parent name(s) and age(s) _____

Step-parents(s) contact information _____

Please list the other children in the family and their ages

1. _____ Age _____ 3. _____ Age _____

2. _____ Age _____ 4. _____ Age _____

If the other children in the family do not live with you full time, please explain.

Besides child's parent, who has taken care of your child in the past, beginning at what age and for how long?

Does your child require any items such as glasses, hearing aids, footwear, etc. If so, for what purpose and at what age did they start? What is the current status of your child's needs?

Does your child have any fears? Yes _____ No _____ If yes, please explain.

Please describe any important events in your child's life. Examples would include family relocation, serious illness, divorce, or death of a loved one.

Sleeping/Eating

Does your child take a nap? _____ For how long? _____

Describe your child's nap routine. (Favorite toy, blanket, music etc?)

Where does your child sleep/nap at home?

What words do you or your child use for naptime?

Does your child feed himself/herself?

Do you have any concerns about your child's eating habits?

COMMUNICATION

Do you have any concerns about your child's ability to communicate?

What other languages are spoken in the home? _____

TOILET MASTERY

At what age did your child master toilet training? Age _____

Does your child wipe himself/herself? Yes _____ No _____

Does your child flush the toilet? Yes _____ No _____

What words or actions does your child use for a bowel movement? _____

What words or actions does your child use for urination? _____

Pull-ups and Diapers CANNOT be used appropriate clothing for childcare should be worn. Examples include clothing that can be easily pulled up/down, no belts, no overalls, etc.

*Children enrolled in the All Day Preschool program must be independently toilet trained.

SELF-CARE

Does your child wash his/her own hands/face? Yes _____ No _____

Does your child dress himself/herself? Yes _____ No _____

DISCIPLINE

How does your child challenge your patience?

What is your typical response to challenging behavior?

If "time out" is used, please elaborate.

OBSERVATION

Do you have any specific observations about your child's development that would help us understand your child?

Do you have any suggestions or additional information regarding your child, which might be helpful to our caregivers?

Please list any interests or hobbies, which you would be willing to share with us for the enhancement of the program.
