Registration Packets
For Additional child forms

CHILD INFORMATION RECORD

One form per child

State of Michigan Department of Human Services - Bureau of Children and Adult 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.

SCHOOL	GRADE

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 Phone ( )
Home Address (if not child's address)	Cell Phone ( )	Home Address (if not child's address)		Cell Phone ( )
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 Special Instructions (Attach additional sheets, if necessary.)				

BCAL-3731 (Rev. 7-12) previous editions 9-09, 3-08, 10-07, & 1-06 may be used until 12/31/13. **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.	( )

I give permission to Utica Community Schools (Provider's Name), licensed by the Department of Human Services to secure emergency medical and/or emergency surgical treatment for the above named minor child while in care.

Signature of Parent or Guardian	Date Signed
Department of Human Services (DHS) will not discriminate against any individual or group because of race, religion, age, national origin, color, height, weight, marital status, sex, sexual orientation, gender identity or expression, political beliefs or disability. If you need help with reading, writing, hearing, etc., under the Americans with Disabilities Act, you are invited to make your needs known to a DHS office in your area.	AUTHORITY: 1973 PA 116 COMPLETION: Required PENALTY: Rule Violation Citation.

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Community Education

School Age Child Care Program

Child Information Form

(One Form per Child)

Please Print

Date _____ **School**_____

Child's Last Name: _____ **Child's First Name:** _____

DOB _____ Age_____ Any Nick Names_____
MM/DD/YYYY

SCHEDULE – Please indicate when your child will be using the School Age Child Care

☐ **Before & After** ____**Monday** ____**Tuesday** ____**Wednesday** _____**Thursday** _____**Friday**

☐ **Before Only** ____**Monday** ____**Tuesday** ____**Wednesday** _____**Thursday** _____**Friday**

☐ **After Only** ____**Monday** ____**Tuesday** ____**Wednesday** _____**Thursday** _____**Friday**

School Age Child Care Director must be notified immediately of any changes to your child's schedule.

Parent(s) Name: _____ _____
Mother / Last Name, First Name Father / Last Name, First Name

Marital Status: __ Single __ Married __ Divorced __ Other

Siblings Names & Ages

_____

_____

Custody Information_____

1. Have there been any changes in your child's life recently? ☐ Yes ☐ No

If yes, please explain

_____

_____

2. My child's greatest fears are: _____

3. When angry, my child will: _____

4. My child has difficulty with: _____

5. Please share any family traditions/holiday celebrations/heritage information:

_____

_____

6. Does your child receive services from UCS Special Services Department/MISD? ☐ Yes ☐ No

If you answered yes, please complete the following.

Child has an IEP? ☐ Yes ☐ No

Child has a 504 Plan? ☐ Yes ☐ No

Child has any other specialized education plan on file with the school? ☐ Yes ☐ No

Does your child need assistance with ☐ Yes ☐ No
(i.e. going to the bathroom, following directions, etc?)

If yes, please
explain_____

_____

_____

7. Other helpful information:

_____

_____

_____

Community Education

School Age Child Care Program

Child/ Parent Behavior Contract

(one form per child)

Child's Last Name:_____ Child's First Name: _____

- I will report directly to School Age Child Care room immediately after school is dismissed and follow specified check-in procedures
- I will listen to staff and follow directions
- I will respect other people's belongings by not touching/using their belongings without permission
- I will respect School Age Child Care property and help clean up personal messes and assist in leaving an area better than I found it
- I will be responsible for all my actions
- I will respect others personal space by keeping my hands and feet to myself
- I will not have any physical contact with other people
- I will not raise my voice while inside the building and will use my inside voice when speaking
- I will use appropriate language and not use negative remarks
- I will ask staff for permission to leave the room/area
- I will respect others feelings by having a positive attitude when talking to them

School Age Child Care operates with a "**ZERO TOLERANCE"** policy towards bullying

Not abiding by these rules may result in suspension and /or termination from the School Age Child Care. All incidents will be handled on a Three Incident System, except physical contact. If physical contact occurs it will be an Immediate One Day Suspension from the School Age Child Care.

All other incidents will be handled as follows:

1st Incident	**Verbal Warning**
2nd Incident	**Written Warning / Parent Meeting / Child Coaching Plan**
3rd Incident	**1-Day Suspension from School Age Child Care**

Student Signature: _____ Date: _____

Parent/Guardian Signature: _____ Date: _____

Community Education

School Age Child Care Program

Good Health Certificate

(one form per child)

Has your child been diagnosed with any of the medical conditions or problems listed below?	**Yes**	**No**
Allergies		
Hay Fever		
Asthma		
Eczema or frequent skin rashes		
Convulsions/Seizures		
Heart Trouble		
Diabetes		
Frequent colds, sore throats, earaches (4 or more per year)		
Trouble passing urine or bowel movements		
Shortness of breath		
Menstrual problems		
Dental problems: date of last exam		
Reactions to food, medication or other that has not been diagnosed by a Doctor as an allergy		
Other		

Child's Last Name: _____

Child's First Name: _____

Please explain any problem identified above: _____

_____

_____

Does your child take any medications regularly? ☐ Yes ☐ No

If yes, what medication? _____

Reason(s) for medication: _____

I hereby certify that my child is in good health and that his/her immunizations are current.

Parent/Guardian Signature:_____ Date: _____