Early Childhood Program

9123 George Avenue
Berrien Springs, MI 49103
daycare@trinityberrien.org
(269) 473-1811

Registration Packet

Welcome to Trinity Lutheran's Early Childhood Program. We offer daycare options for children 6 weeks to 12 years old. There are also Preschool options for children 3-5 years old. Our programs encourage your child to develop socially, emotionally, physically, intellectually and spiritually with Christ at the center of everything we do.

Our program is licensed by the State of Michigan.

Registration Materials

Included in this packet you will find the following forms that must be completed and returned before entry into our programs:

1. Program Offerings - A detailed list of our program offerings with rates.
2. Registration Form - Completed form and non-refundable registration fee must be submitted to the office in order to reserve the child's place in the program.
3. Child Information Record - This is **required** by the State of Michigan. You must complete every section of this form.
4. Health Appraisal - Must be completed by a physician. School Age Health Records Statement may be completed in lieu of the Health Appraisal for school age children.
5. Trinity Lutheran Publicity Release
6. Permission for Topical Nonperscription Medication

Daycare Only

7. Daycare Agreement
8. Parent Provided Food Agreement
9. School Age Notice of Playground Usage

If you have any questions, feel free to contact the school office or schedule an appointment.

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Program Offerings

Preschool Classes

A non-refundable Registration Fee of $100.00 must be submitted to the office in order to reserve the child's place in class.

First and last month's tuition will be due before school begins. Monthly payments are due on the first of each month and considered late after the 15th. After the 15th, a late fee of $25 will be assessed.

Registration will be opened to returning families first. After that time period, registration will become open to new families on a first come first serve basis.

CLASS	TUITION	AGE	CLASS TIME
AM - 5 Day Class	$190/month $1,710/year	4 and 5 year olds (4 by September 1st)	Monday - Friday 8:45am - 11:30am
PM - 3 Day Class	$140/month $1,260/year	3 and 4 year olds (3 by September 1st)	Tues, Wed, Thurs 12:45pm - 3:15pm

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Program Offerings

Daycare

A non-refundable Registration Fee of $80.00 (Child), $125.00 (Family) is required at time of enrollment. The fee must be paid again each year as we update all paperwork.

Infant /Toddler (Under 35 Months)

Full Time (4-5 Days)	$185.00 per week
Part Time (3 Days)	$160.00 per week
Daily	$70.00 per day

3 and 4 Year Olds

Full Time (4-5 Days)	$160.00 per week
Part Time (3 Days)	$125.00 per week
In 5 Day Preschool	$125.00 per week
In 3 Day Preschool	$135.00 per week
In 2 Day Preschool	$145.00 per week
Hourly - When no preschool Example: School Holidays	$8.00 per hour additional for hours normally in preschool
Daily	$60.00 per day
Half Day - Only when enrolled in Preschool for the other half of the day	$35 per day

When determining open slots, full time attendees will be given priority over part time. If your child attends preschool and is in daycare all day on days there is no preschool, additional charges will be accessed.

See reverse side for School Age rates.

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Registration Form - Preschool & Daycare

Choice of Program:
(Check all that apply)

- ❑ Daycare: _____
  (Specify Age Group)
- ❑ ~~PM - 2 Day Preschool~~
- ❑ PM - 3 Day Preschool
- ❑ AM Preschool

For Office Use Only
Date Received:_____
Reg. Fee Received:_____
Initials of Staff:_____

Full Legal Name:_____
(Last) (First) (Middle)

Name with which to address child:_____*(James goes by Jimmy)*

Date of Birth:_____ Has this child been baptized? Y or N Date:_____
Church Affiliation: _____

Has this child previously attended a preschool or daycare center? Y or N
If so, where? _____

Name of Mother:_____ Phone Number:_____

Mother's Mailing Address: _____
(Number) (Street) (City, State & Zip)

Mother's Email Address:_____

Name of Father:_____ Phone Number:_____

Father's Mailing Address: _____
(Number) (Street) (City, State & Zip)

Father's Email Address:_____

_____
(Signature of Parent or Guardian)

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

Parent/Legal Guardian's Name	Home Phone ( )	Parent/Legal Guardian's Name (Optional)	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	
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. 7-18) 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 6-17may 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) MI	TODAY'S DATE (mm/dd/yy) / /
PARENT/GUARDIAN (Last, First, Middle)			HOME TELEPHONE NUMBER ( )
ADDRESS (Number & Street)	(City)	(ZIP Code) MI	WORK TELEPHONE NUMBER ( )

SECTION I - HEALTH HISTORY

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

No	Yes	Was child tested for:	Test results:	Normal	Referred	Under Care
☐	☐	HEIGHT & WEIGHT	Height			
			Weight			
☐	☐	Other: _____	Other			
☐	☐	HEMOGLOBIN / HEMATOCRIT	⇨			
☐	☐	BLOOD PRESSURE	Reading: _____			
☐	☐	TUBERCULIN Date: / /	Type: _____ 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 _____ (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.

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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.

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Publicity Release

Trinity Lutheran Church, School and Early Childhood Program is making a concentrated effort to promote the positive activities, honors and work of our faculty, staff and students. This includes working with the local newspapers, radio, television stations, our website and other online social networking platforms. These publications include information, likenesses and images which may appear on the website as well as in other publications. As we go through the year, there will be various opportunities for students to be interviewed and/or photographed and identified by name and classroom or school.

However, we understand that some parents may request that we do not identify their child(ren). Please fill out the information below to inform us of your wishes regarding publicity.

Please note that your child's image or likeness may appear in occasional candid photos without any type of name identification and the use of these candid photos of your child is permissible. This photo release form does not apply to photographs taken during extra-curricular activities. Students who attend extra-curricular activities forfeit their rights to retain authority over the publication of photos taken.

Please Print (Use a separate form for each child)

Student Name: _____

Parent/Guardian Name: _____

- ❑ I give permission for my child to be interviewed, identified and/or photographed/filmed for use in school publications, including, but not limited to publications via website or other technological publications, videos, newspaper, radio, televisions or social media.

- ❑ I request that you do not interview or photograph my child.

Parent/Guardian Signature: _____

Date: _____

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Permission for Topical Nonprescription Medication

The staff at Trinity Lutheran Daycare have my permission to apply

- ❑ Sunscreen (provided by parent)
- ❑ Insect Repellent (provided by parent)
- ❑ Diaper Ointment (provided by parent)

to my child, _____ while in their care.
(Name of Child)

_____ _____
Parent's Name - Printed Date

_____
Parent's Name - Signature

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Daycare Agreement

This Agreement is entered into on this _____ day of _____, 20___ with

Trinity Lutheran Daycare of Berrien Springs and _____
(Parent/Guardian Name)

Parent/Guardian of _____ DOB: _____
(Child's Name)

- ❑ **Registration Fee**
  Parent/Guardian agrees to pay a registration fee of $80 (child) or $125 (family).
  This is a non-refundable payment.
  Registration Fee: $_____ Paid: ( ) Yes ( ) No
  Cash: _____ Check #: _____ Date: _____
- ❑ **Weekly Rate**
  The weekly rate will be $_____ and is due and payable the week before services are rendered. Payment is expected even if the child is absent.
- ❑ **Days and Hours**
  The parties to this agreement have agrees to the following schedule of care:

	Monday	Tuesday	Wednesday	Thursday	Friday
Times					

I have agreed to the terms of this contract and will follow all of Trinity Lutheran Daycare's rules and regulations as listed in the parent handbook. I understand that this contract is binding starting on the date above. I will have two weeks to terminate my contract but payment will be paid for those two weeks and I will not be refunded any money.

By: _____ Date: _____
(Parent/Guardian Signature)

By: _____ Date: _____
(Director's Signature)

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Parent Provided Food Agreement

For all children over 1 year of age, an afternoon snack will be provided for your child by Trinity Lutheran Daycare. All other food/meals (breakfast and lunch) will be provided by the parents. This includes, but is not limited to, formula, milk and food. Lunch boxes/bags/containers must be labeled with first and last name. Food needs to be packed with ice packs so that it may hang on your child's hook. Meals must be nutritionally balanced and age appropriate. Children will never be deprived of a meal if parents do not provide one, but $7.00 per meal will be charged if we have to provide a meal. For children less than one year of age, parents will provide ALL formula and food for the entire day (breakfast, lunch and snack).

I _____ the parent/guardian of _____
(Parent's Name) (Child's Name)

have read and agree to the above policies and will provide adequate food for my child

on a daily basis.

_____ Date: _____
(Parent/Guardian Signature)

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School Age Notice of Playground Usage

This notice is to inform you that the school age children in child care will be using Trinity Lutheran School's outdoor play area. The school's outdoor play area does not comply with the State of Michigan Child Care Licensing Rules, but it is approved by the Michigan Department of Education.

I _____ have been informed in writing that my
(Parent's Name)

school age child _____ will be using Trinity Lutheran
(Child's Name)

School's outdoor play area.

_____ Date: _____
(Parent/Guardian Signature)