Cherry Hill United Presbyterian Preschool (CHUP)
TEACHER'S PERSONAL INFORMATION SHEET

Child's Name: _____ Preferred Name:_____
Parent's Name: _____ Home Phone: _____
Child's Birthdate: _____ Business Phone: _____ Mom/Dad

Person other than parent to contact in case of emergency:_____ Phone: _____
Who does child live with? _____
Names/ages of other children in the family: _____
_____
What is the primary language spoken in the home? _____
Does your child speak English? _____

Does your child have any fears, allergies or health problems the teacher should be aware of? _____
If yes, please explain: _____
How does your child react when upset? _____
_____
Are there any special needs, behavior problems, learning disabilities, difficulties with speech, walking, etc that the teacher should be aware of?_____
_____

Do you have any special talents such as musical ability or hobbies, etc that you are willing to contribute?
Mother _____ Father _____
Collections such as dolls, shells, postcards, and/or equipment you are willing to bring on the days you work
_____
Do you know someone who is in a special profession (fireman, nurse, etc) who would be willing to share their job experience and duties with the children? _____
_____
Are you interested in substitute teaching? _____
Qualifications? _____
Are you Pediatric CPR certified? _____ OSHA/Universal Precaution trained? _____

Why are you sending your child to nursery school? _____
_____
Have you worked in a co-op nursery before? If yes, which one? _____

Please put additional comments on the back.

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.

CO-OP DUTIES PREFERENCE FORM

WE'RE LOOKING FOR...

At a cooperative preschool we keep costs down by participating in different aspects of the classroom. Please let us know what type of job you prefer. We'll do our best to accommodate everyone's preference.

Thanks for helping to keep CHUP running!

Please number the job area you would like like to participate in from 1 to 5, 1 being the most preferred:

_____ Babysitting Help
_____ Memory Books/Photography
_____ Librarian/Scholastic Books
_____ Aquarium Help
_____ Social Chair/Party Planning
_____ Storage/Organization/Cleaning
_____ Scheduling
_____ Website Design/Publicity
_____ Fundraising

Student Name_____Class_____

Michigan Licensing Requirement

_____
Child's Name

After reading the statements, please check the boxes and sign your name at the bottom.

- ☐ To comply with the Michigan Bureau of Children and Adult Licensing, all CHUP licensing documentation is located in the cabinet above the OSHA equipment in the Quiet Room.
- ☐ The center maintains a licensing notebook of all licensing inspection reports, special investigation reports and all related corrective action plans.
- ☐ The notebook will be available to parents for review during regular business hours.
- ☐ Licensing inspection and special investigation reports from the past two years are available on the Bureau of Children and Adult Licensing website at **www.michigan.gov/michchildcare.**

_____

Parent/Guardian Signature Date

March 2013

Cherry Hill United Presbyterian Preschool (CHUP)
PHOTO WAIVER

Throughout the year, photos are taken at holiday parties, field trips, "special days", etc.

Occasionally these photos are posted on the CHUP website, in the local paper and on the websites of visitors (the Dearborn Animal Shelter, for example).

We also use photos to update the school scrapbook. The scrapbook is used during the open houses.

Names of children are not posted on the website or in the scrapbook.

Please indicate below if you give permission to include photos of your child(ren) and other family members:

CHUP Website

☐ Yes, photos of or including my child/children and other family members that may be in the photo may be used on the CHUP website.

☐ No, please do not include photos of my child/children on the CHUP website.

Local Paper (Dearborn Press & Guide, for example)

☐ Yes, photos of or including my child/children and other family members that may be in the photo may be used in articles published in local papers.

- No, please do not include photos of my child/children in articles published in local papers.

Other Websites (Dearborn Animal Shelter, for example)

☐ Yes, photos of or including my child/children and other family members that may be in the photo may be used on the websites of official CHUP visitors.

☐ No, please do not include photos of my child/children on the websites of official CHUP visitors.

_____

Parent/Guardian Signature **Date**

CHERRY HILL UNITED PRESBYTERIAN
COOPERATIVE PRESCHOOL
HEALTH INFORMATION RELEASE FORM

I will inform Cherry Hill United Presbyterian Cooperative Preschool of any communicable disease my child or children may have.

I give Cherry Hill United Presbyterian Cooperative Preschool permission to notify the preschool families of any communicable disease my child or children may have. The school will report only number and type of occurrences.

Student Name: _____
(Please Print)

Signed: _____ Date: _____
(Mother or Guardian)

Signed: _____ Date: _____
(Father or Guardian)

We ask for this release, as it is a part of the Department of Social Services licensing requirement.

AIDS, HIV, and ARC are not included in the list of communicable diseases to be reported in accordance with the law.

INFORMATION FOR COMPLETING HEALTH APPRAISAL FORM

PERSONAL

- Fill in the Child's Full Name (Last, First & Middle as indicated)
- Sex (Fill in Male or Female)
- Date of Birth (Please list as in this format: 00/00/0000)
- Fill in your Complete Address
- Today's Date (The date you are filling out the form in the 00/00/0000 format)
- Parent or Guardian Name (Fill in Full Name)
- Telephone Number (Home & work if applicable–if no work number write NONE)
- Address of Parent (Fill in complete address even if it is the same as child's)

SECTION I – History

- Answer all questions in the first box yourself. If any are YES, you need to list detailed explanations in the sections provided.
- Under No.12 – Please list child's date of last dental examination.
- If you have answered YES under the medication section, you need to list ALL medications by their complete name and the reason for the medication.

SECTION II – Immunization

- You can either fill in each immunization from you child's medical records or attach a listing of the immunization record from your child's physician/medical records. Your physician's office will give you a copy of them if you ask for it at the time of the health examination.

**** This section also needs to be signed by the physician's office as to the validity of this information. Make sure it is also dated on the date of the examination.**

SECTION III – Physical Examination, Inspection, Tests & Measurements

- The first section is only to be completed if there is a (DEVIATION FROM NORMAL AND/ OR RECOMMENDATIONS). Physician needs to complete this section.

Tests and Measurements

- This should be completed by the physician/nurse at the time of the examination.
- TB test is only required to be filled in **if applicable.**

SECTION IV – Recommendations

- First section – needs to be checked if the child has vision or hearing problems, otherwise check **NO.**
- Section regarding restriction of activity needs to be checked. If **NO,** then no further information is required. If it is **YES,** physician must fill in what the restriction is and why.
- **PRINT NAME OF PHYSICIAN, COMPLETE ADDRESS AND TELEPHONE NUMBER**

Dental Examination (Optional but NOT REQUIRED)

THIS INFORMATION NEEDS TO BE COMPLETED BEFORE THE ORIENTATION MEETING. IF THE HEALTH APPLRAISAL INFORMATION IS NOT COMPLETE, IT WILL DELAY THE ADMISSION OF YOUR CHILD TO THE PROGRAM.

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			

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?

Parent/Guardian Signature Date ☐ 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 _____ '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.

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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.