



Utica Community Schools Community Education Early Childhood Programs 2012-2013

Early Childhood - Child Background Sheet

Please Print

Child's Name _____
(Last) (First) (Nickname)

Boy Girl Birthdate _____
(Circle One) (Month/Day/Year)

(Father/Legal Guardian's Name)

(Mother/Legal Guardian's Name)

Child lives with: (Please list parents, step parents, siblings (ages), grandparents, etc.)

Has your child had experiences away from home, such as; staying with a sitter, play groups, Sunday school? _____

Language spoken at home (if other than English): _____

Does your child have any fears or anxieties? _____

Is your child typically healthy? _____

Has your child experienced any serious accident, illness, or family difficulty (divorce, death, multiple moves, etc.)? _____

Does your child routinely drink from a cup? Yes _____ No _____

Does your child feed himself/herself with utensils (spoon, fork)? Yes _____ No _____

Does your child refuse any particular food? Yes _____ No _____

Does your child have a special security object or use a pacifier at home? Yes _____ No _____

If yes, explain. _____

How does your child let you know that he/she needs to use the bathroom? _____

What are your child's toileting routines? _____

How does your child challenge your patience? _____

How do you and other family members respond? _____

How does your child calm down or relax? _____

What do you and your child enjoy doing together? _____

What does your child enjoy doing alone? _____

Do you have any specific observations about your child's development that would help us understand your child? (List any evaluations or services your child had received.) _____

What are your expectations of the class? _____



Utica Community Schools

Community Education

Early Childhood Programs

Student Data Form

2012-2013

Please Print

School _____ Program _____ AM _____ PM _____

Child's Name _____
Last First

Address _____ City Zip

Male Female Birthdate Elementary School Attendance Area

Place of Birth _____
If USA - City/State If outside USA - Country Only

Phone No. _____
Home Cell Work

Email Address _____

Racial / Ethnic **(Check One)**

- | | |
|--------------------------------------|---------------------------------|
| _____ American Indian/Alaskan Native | _____ Asian American |
| _____ Black/African American | _____ Hispanic |
| _____ Caucasian/White | _____ Hawaiian/Pacific Islander |

Multi Racial (Specify) _____

PLEASE RETURN COMPLETED FORM TO YOUR CHILD'S TEACHER

**CHILD INFORMATION RECORD
STATE OF MICHIGAN**
Department of Human Services
Bureau of Children and Adult Licensing

Date of Admission		Allergies		CHILD INFORMATION RECORD STATE OF MICHIGAN Department of Human Services Bureau of Children and Adult Licensing					
Date of Discharge									
Name of Child (Last, First, Middle Initial)							Address (Number and Street, Building/Apartment Number)		
Child's Date of Birth		Home Phone ()					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
Employer/School Name							Employer/School Name		
Address (Employer/School)							Address (Employer/School)		
City	State	Zip Code					City	State	Zip Code
Employer/School Phone		Daily Work/School Times		Employer/School Phone ()		Daily Work/School Times			
Name(s) of Person other than Parent or Legal Guardian to whom child may be released									

BCAL-3731 (Rev. 9-09) Previous editions 3-08, 10-07, & 1-06 may be used.

See Reverse Side

I give permission to _____, licensed by the Department of Human Services (Provider's Name)			
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
Name of Child's Physician or Health Clinic		Physician's or Health Clinic's Phone Number ()	
Address of Child's Physician or Health Clinic		Name of Health Insurance Carrier	
Hospital Preferred for Emergency Treatment		Health Insurance Policy Number	
Special Needs:		Date of Last DTaP (Diphtheria, tetanus, pertussis) Shot	
Name of Local Person to be Notified in an Emergency When Parents Not Available		Local Address of Emergency Person	
Home and/or Cell Phone ()	Work Number ()	City, State	Zip code
Special Instructions:			
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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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)	WORK TELEPHONE NUMBER ()
			MI

SECTION I - HEALTH HISTORY

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)	Birth History: Are there any current or past diagnosis(es) <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, please describe: If yes, list medications: Was the health history reviewed by a health professional? <input type="checkbox"/> Yes <input type="checkbox"/> No Examiner's Initials: _____
<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 Exzema 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"/>	<input type="checkbox"/>	<input type="checkbox"/>	Does your child take any medication(s) regularly?	
			Reason for Medication	
			/ /	
			Parent/Guardian Signature _____ Date _____	

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 BLOOD PRESSURE	⇒			
<input type="checkbox"/>	<input type="checkbox"/>	URINALYSIS Date: / /	Sugar Albumin Microscopic				<input type="checkbox"/>	<input type="checkbox"/>	TUBERCULIN Date: / /	Type: _____ Neg.: <input type="checkbox"/> Pos.: <input type="checkbox"/> _____ mm			
<input type="checkbox"/>	<input type="checkbox"/>	BLOOD LEAD LEVEL Date: / /	Level _____ ug/dl				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 (Hep B)	1	3	Hepatitis A (Hep A)	1	2
	2			2	3
DTaP/DTP/DT/Td	1	4	Influenza TIV/LAIV	1	4
	2	5		2	4
	3	6			
Tdap	1		Meningococcal MCV4 / MPSV4	1	2
Haemophilus Influenzae type b (HIB)	1	3	Human Papillomavirus (HVP4/HPV2)	1	2
	2	4		2	3
Polio - IPV / OPV	1	3	OTHER Vaccines Specify Date & Type	Type of Vaccine(s)	Date of Vaccine(s)
	2	4		1	
				2	
Pneumococcal Conjugate (PCV7/PCV13)	1	3	3		
	2	4			
Rotavirus (RV1/RV5)	1	3	Indicate and attach physician diagnosis or laboratory evidence of immunity as applicable		
	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 child's school or local health department.		
Measles, Mumps, Rubella (MMR)	1	2	Parent/Guardian refused immunizations: <input type="checkbox"/>		
	2				
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	
<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 _____'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
 _____ 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 schedule of well-child care 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 and regular intervals based on age.

Developed in Cooperation with the Departments of Human Services, Education, Community Health, 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.



CREDIT CARD PAYMENT AUTHORIZATION FORM

_____ I authorize credit card payment for Nursery/Preschool on the first day of each month (7) times from October 2012 until April 2013 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 (7) times from October 2012 until April 2013 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 _____ Monthly Payment \$ _____
(Located on back of card)

_____ Initial here if you are authorizing first (September) & last months (May) payment now.

Cardholder Name (Print)

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 at:

**Community Education Center at Walsh
Early Childhood Accounting Office
38901 Dodge Park
Sterling Heights, MI 48312**

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**

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 required that the new media report to the 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 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**