

## CHILD INFORMATION RECORD

State of Michigan - Department of Licensing and Regulatory Affairs - Child Care Licensing Bureau

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.

<b>For Provider Use Only:</b>		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	Primary Phone (    )	Parent/Legal Guardian's Name (Optional)	Primary Phone (    )
Home Address (if not child's address)	2 <sup>nd</sup> Phone (if applicable) (    )	Home Address (if not child's address)	2 <sup>nd</sup> Phone (if applicable) (    )
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/or Special Instructions? Yes <input type="checkbox"/> No <input type="checkbox"/> If yes, explain: (Attach additional sheets, if necessary.)			

CCL-3731 (Rev. 3/17/2022) Previous editions 7-18 & 4-21 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.	



## 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)	<b>Birth History:</b>  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 <b>Examiner's Initials:</b> _____
<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"/>	<input type="checkbox"/>	<input type="checkbox"/>	Does your child take any medication(s) regularly?	
			Reason for Medication	⇒
			_____ / /	
			<b>Parent/Guardian Signature</b>	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	⇒			
<input type="checkbox"/>	<input type="checkbox"/>	URINALYSIS Date: / /	Sugar Albumin Microscopic				<input type="checkbox"/>	<input type="checkbox"/>	BLOOD PRESSURE TUBERCULIN Date: / /	Reading: _____ Type: _____ Neg.: <input type="checkbox"/> Pos.: <input type="checkbox"/> _____ mm			
<input type="checkbox"/>	<input type="checkbox"/>	BLOOD LEAD LEVEL Date: / /	Level _____ ug/dl				<b>NOTE:</b> 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			Influenza (IIV/LAIV)	1
DTaP/DTP/DT/Td	1	4	2		4
	2	5	Meningococcal (MCV4 / MPSV4)	1	2
	3	6		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)	1	3	3		
	2	4	<i>Indicate and attach physician diagnosis or laboratory evidence of immunity as applicable</i>		
Rotavirus (RV1/RV5)	1	3	*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.		
	2		Parent/Guardian refused immunizations: <input type="checkbox"/>		
Measles, Mumps, Rubella (MMR)	1	2	History of Chickenpox Disease? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, date: _____		
Varicella (Chickenpox)	1	2	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: \_\_\_\_\_

child's name

\_\_\_\_\_ / \_\_\_\_ / \_\_\_\_

Dentist's Signature Date

**PHYSICIAN'S SIGNATURE**

\_\_\_\_\_ / \_\_\_\_ / \_\_\_\_

Examiner's Signature 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.

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.

**PARENT NOTIFICATION OF THE LICENSING NOTEBOOK**

Child Care Organizations Act, 1973 Public Act 116

**Michigan Department of Licensing and Regulatory Affairs**

**Child Care Licensing Bureau**

**CENTER MUST CHECK ONE**

The center keeps a licensing notebook containing a summary sheet, all licensing inspections and special investigations, and related corrective action plans for the last 5 years. The licensing notebook is available to parents/guardians during regular business hours. Reports from at least the past three years are available at [www.michigan.gov/michildcare](http://www.michigan.gov/michildcare).

The center does not keep a licensing notebook, but internet is available onsite. Reports from at least the last three years are available at [www.michigan.gov/michildcare](http://www.michigan.gov/michildcare).

I have read the above statement issued by \_\_\_\_\_

Name of Child Care Center

Child(ren)'s Name(s):	
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Parent Name \_\_\_\_\_

Parent Signature \_\_\_\_\_

Date \_\_\_\_\_

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## Walking Trip / Field Trip Permission

I understand walking trips and field trips are an integrated part of my child's program (Infants and Toddlers use the byebye buggy). I give permission for my child to participate in walking field trips with the understanding s/he is properly supervised, all safety precautions are taken, and that staff/child ratios are maintained on any outing. I also understand that for all field trips out of the neighborhood, I will receive a specific trip slip.

\_\_\_\_\_

Parent Signature

\_\_\_\_\_

Date

### AUTHORIZATION TO APPLY TOPICAL NON-PRESCRIPTION NON-MEDICATION OINTMENT or CREAM (i.e. diaper cream, sunscreen, Vaseline)

Child's Name \_\_\_\_\_ Date \_\_\_\_\_

The staff at EDWE has my permission to apply the following topical ointment/cream to my child,  
\_\_\_\_\_ as indicated below:

Child's First and Last Name \_\_\_\_\_

\_\_\_\_\_

Name of Ointment or Cream

To be used for: \_\_\_\_\_

Directions for use: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Parent's Name Printed

\_\_\_\_\_

Parent's Signature

\_\_\_\_\_

Date

Note: A label with your child's name will be made and placed on the container.