



Northside Child Development Center

Parents Name _____ Phone _____

Child's Name _____ Age _____

Y Membership Status ☐ Member ☐ Non-Member Employer _____

Ethnicity ☐ Caucasian ☐ African American ☐ Hispanic ☐ Asian or Pacific Islander ☐ Other

Admission Agreement *Please initial each line*

	POLICIES AND PROCEDURES – I have reviewed or will access the handbook online, including the discipline policy, and understand all policies and procedures therein. I further understand that 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 at least the past two years are available on the Bureau of Community and Health Systems website at www.michigan.gov/michildcare .
	PAYMENTS – I understand that payments that are more than one draft behind will result in your child being removed from child care. It is required to have an EFT on file in order to register for the program.
	MEDICAL INFORMATION – I certify that my child is in good health with activity restrictions noted and the documentation of physical examination and immunizations are up-to-date and in accordance with the public schools health requirements.
	MEDICATIONS – I understand that a Medication Form is required to be completed and signed by a parent/guardian should my child need any medication administered during the program. I further understand that we allow the self-carry of Emergency Medications ONLY for children diagnosed with asthma or other relevant conditions. Self-carry is only permitted with the prescribing physician's written permission.
	CUSTODY – YMCA requires a legal document or court decree, otherwise decisions regarding who is authorized to pick up a child will be governed by the Primary Parent/Guardian information listed on this document.
	PHOTO RELEASE – The YMCA is hereby granted permission to use any individual or group photograph and/or videotape showing my child in YMCA activities for use in public relations, promotional or advertising purposes
	YMCA PROGRAM CLOSURES – I understand, during inclement weather, the YMCA will not refund or pro-rate the fee. We will use an app to communicate closures.
	PLAYGROUND USE – I understand that this program uses the space available at our site locations, which meets the safety standards set by LARA.
	COVID-19 – I understand it is my responsibility to provide a mask for my child to comply with the state requirements according to the Governor's office and state reopening plan. I also understand the health risks.

I have read the **Admission Agreement** and fully agree to its terms. I have also read and accept the Policies and Procedures listed in the parent handbook and stated within this agreement. I also agree to keep all information as it relates to this paperwork, up to date for the safety of my child. By signing, I hereby release the YMCA of Greater Michiana, its officers and employees from responsibility of personal injury or personal property damage associated with the program or its property. I consent to full understanding and knowledge of inherent risks and voluntarily accept responsibility for any such occurrence not related to gross negligence.

Parent/Guardian Signature _____ Date _____

Please send completed form to Dr. Zech Hoyt, Executive Director of Youth Programs, at zhoyt@ymcagm.org.
The Y will then contact you to set up an intake appointment.

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.	

MEDICATION PERMISSION AND INSTRUCTIONS
CHILD CARE HOMES AND CENTERS
Department of Licensing and Regulatory Affairs
Bureau of Community and Health Systems
Child Care Licensing Division

If you are giving or applying any medication to a child in care, the following must be completed by the parent for **each** medication. An interruption in medication will require a new permission form.

TO BE COMPLETED BY PARENT

I give my permission for _____ to give or apply the medication
(Caregiver, Facility)
_____, to my child _____, as follows:
(Specify, prescribed medication/over the counter product) (Child's Name)

DIRECTIONS:

1. Date to Begin Giving Medication	2. Date to Stop Medication
3. Times Medication is to be Given	4. Amount (dosage) of Medication Each Time Given
5. Storage of Medication	
6. Other Directions, if Any	
Signature of Parent	Date

TO BE COMPLETED BY THE CAREGIVER GIVING THE MEDICATION:

DATE	TIME	AMOUNT GIVEN	CAREGIVER'S NAME	CAREGIVER'S SIGNATURE

It is recommended this form be reviewed with the parent every 3 months if the medication is ongoing.

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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) MI / /
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?	Birth History:
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	1 Allergies or Reactions (for example, food, medication or other)	
<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)	Are there any current or past diagnosis(es) <input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	8 Trouble with Passing Urine or Bowel Movements	If yes, please describe:
<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?	If yes, list medications:
Reason for Medication				
/ /				Was the health history reviewed by a health professional?
Parent/Guardian Signature _____ Date _____				<input type="checkbox"/> Yes <input type="checkbox"/> 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	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	Reading: _____			
<input type="checkbox"/>	<input type="checkbox"/>	BLOOD LEAD LEVEL Date: / /	Level _____ ug/dl				<input type="checkbox"/>	<input type="checkbox"/>	TUBERCULIN	Type: _____ Neg.: <input type="checkbox"/> Pos.: <input type="checkbox"/> _____ 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		VACCINES (Circle Type)	DATE ADMINISTERED MM/DD/YYYY	
Hepatitis B (HepB)	1	3	Hepatitis A (HepA)	1	2
	2			2	
DTaP/DTP/DT/Td	1	4	Influenza (IIV/LAIV)	1	3
	2	5		2	4
	3	6	Meningococcal (MCV4 / MPSV4)	1	2
Tdap	1		Human Papillomavirus (HPV9/HPV4/HPV2)	1	3
Haemophilus Influenzae type b (HIB)	1	3		2	
Polio (IPV/OPV)	1	3	OTHER Vaccines Specify Date & Type	Type of Vaccine(s)	Date of Vaccine(s)
	2	4		1	
Pneumococcal Conjugate (PCV7/PCV13)	1	3		2	
	2	4	3		
Rotavirus (RV1/RV5)	1	3	Indicate and attach physician diagnosis or laboratory evidence of immunity as applicable		
	2				
Measles, Mumps, Rubella (MMR)	1	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 provider office for medical waiver forms and through your local health department for nonmedical waiver forms.		
Varicella (Chickenpox)	1	2			
History of Chickenpox Disease? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, date: _____			Parent/Guardian refused immunizations: <input type="checkbox"/>		
I certify that the immunization dates are true to the best of my knowledge					
_____			_____		
<i>Health Professional's Signature</i>			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: _____	

<i>Dentist's Signature</i>	
_____ / _____ / _____ Date	

PHYSICIAN'S SIGNATURE

_____		_____		_____		_____	
<i>Examiner's Signature</i>		Date		<i>Examiner's Name (Print or Type)</i>		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.

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.

Billing Information

Bank Draft - Voided Check or Bank Verification Needed

☐ Checking ☐ Savings

Account Holder(s) _____

Routing Number _____

Last 4 digits of account number _____

Credit/Debit

☐ Visa ☐ Master Card ☐ Discover

Card Holder _____

Card Number _____ - _____ - _____ - _____

Expiration Date _____ / _____

Billing Contact if different from primary member

Name _____ Phone _____

Electronic Funds Transfer Agreement (please initial each line)

By initialing each paragraph and signing this EFT Agreement I/we are allowing the YMCA of Greater Michiana ("YMCA") to electronically withdraw or otherwise electronically access and obtain funds to pay recurring membership charges using the payment method(s) and source(s) selected above. I/we understand and agree that the YMCA will electronically withdraw or otherwise electronically access and obtain funds for recurring charges on the 10th day of each month, or shortly thereafter, and immediately for one-time charges for programs fees.

_____ I/we represent and warrant that the billing information provided above is accurate. I/we understand and agree that I/we shall hold harmless and indemnify the YMCA for any liability imposed upon or expense incurred by the YMCA for breach of this representation and warranty.

_____ I/we are responsible to provide written cancellation or change requests for my/our membership charges prior to the first day of the month it is to take effect. The YMCA will not automatically terminate membership or refund membership charges because of non-use of the YMCA facilities or services.

_____ I/we are responsible for payment of all amounts incurred for membership charges or program fees while my our membership is active or if my/our cancellation request is provided after the 1st of the month.

_____ The YMCA has the right to adjust my/our membership charges after providing 60-day written notice.

_____ The YMCA will attempt to collect declined membership charges from a credit/debit card up to 3 times. A \$15 late fee will be applied and your membership will be suspended if not paid by the end of the month for which the charges are incurred.

_____ Non-sufficient funds available from electronically accessed checking/savings accounts will have a \$15 NSF fee added and returned checks will have a \$20 NSF fee. In either case, your membership will be suspended if not paid by the end of the month for which the charges are incurred

_____ If my/our membership is inactive for more than 30 days, I/we may be subject to pay a join fee when reactivating.

I agree to the above terms and authorize the YMCA of Greater Michiana to use the account listed for my membership, program fees, and donations.

Signature _____ Date _____

Signature _____ Date _____