WELCOME!

Dear Parents,

We want to welcome you to the Ms. C & T's Learning Place family. We are so glad to have you as a part of the MCTLP family. It means so much to us to have your support and we are pleased to have you on this journey with us. It is our mission to provide quality childcare for children and families in the Saginaw area. Our learning program exists to provide infants, toddlers, preschoolers, and school-age children with a warm and loving environment where they feel empowered, safe and loved. Our classrooms provide an engaging environment for children while supporting their cognitive, physical, social and emotional developmental needs. We promote acceptance, respect, and individuality. Ms. C & T's Learning Place is committed to nurturing and challenging each child to progress as individuals. The Ms. C & T's Learning Place staff wants to take this opportunity to personally welcome you to our family.

Enrollment Application | Registration

Mother/Legal Guardian

Name	
Street Address	
City, State	
Zip Code	
Phone Number	
Email	
Employer	
Phone Number	

Father/Legal Guardian

Name	
Street Address	
City, State	
Zip Code	
Phone Number	
Email	
Employer	
Phone Number	

Children Enrolling

Child's Full Name	Date of Birth	Genesee Site	Michigan Site
1.			
2.			
3.			
4.			
5.			
6.			
7.			
8.			
9.			
10.			

Enrolment Plan *(Initial the program you would like to enroll in and the number of children to be enrolled.)*

_____**Full time (25-45 hours a week)**

Birth- 2½ yrs: $227.25	2½ yrs.- 5 yrs: $171.00	5yrs- up: $166.50

_____**Part-time (16-25 hours a week)**

Birth- 2½ yrs: $126.25	2½ yrs.- 5 yrs: $95.00	5yrs- up: $92.50

DHS Information

Case Worker Name:	
DHS Case Number:	
Social Security Number:	
State ID/ Driver License Number:	

The following has been agreed upon between the two parties beginning on: _____/_____/_____ The child(ren) first day will be: _____/_____/_____

Child Care Agreement

This agreement is made by and between Ms. C & T's Learning Place, licensed child care provider and _____(print full name) I,_____understand that the use of childcare service from Ms. C & T's Learning Place must be approved by DHS. Any hours not approved by my caseworker and/ or DHS, I will be responsible for paying. I understand that any fees not covered by DHS, I will be responsible to pay (co-pay may be required) . I understand that DHS approved dates and times must match the times and dates that I use child care services from Ms. C & T's Learning Place. If I am found misusing DHS child care service, my child care may be terminated. If not using DHS, I agree to the weekly fees for my child(ren) listed above. I understand that failure to pay any fees I may owe to Ms. C & T's Learning Place may end in termination of service.

I,_____have received, understand and agree with Ms. C And T's Learning Place parent handbook located on their website at www.mctlp.com.

Applicable Law

This contract shall be governed by the laws of the state of Michigan in Saginaw county and any applicable Federal Law.

Parent/Legal Guardian(s) Signature:_____Date:_____/_____/_____

Provider's Signature:_____Date:_____/_____/_____

Enrollment Application | School-Age Statement of Health and Immunizations

Parent/legal guardian must initial all of the following that apply to the child(ren) enrolled

Health Status:

_____My child(ren) does/ do not have any health conditions, which could pose a risk to other children and/ or adults.

_____My child(ren) does/ do not have any limitations or special needs that will limit daily activities.w

_____My child(ren) has/ have health conditions, which could pose a risk to other children and/ or adults.

_____My child(ren) has/ have limitations of special needs or needs treatment while in care that will limit daily activities.

(Please describe limitations down below.)

Child(ren) Name

1.	2.
3.	4.
5.	6.
7.	8.
9.	10.

Describe Here:

_____

_____

_____

_____

____

Parent/legal guardian must initial all of the following that apply to the child(ren) enrolled

Immunization Status:

_____My child(ren) has/have not completed or is/are not in progress of receiving immunization as recommended by the Michigan Department of Health and Human Services. If not, please specify the reason:

_____**Religious** _____**Medical** _____**Other**

_____My child(ren) has/have completed or is/are in progress of receiving immunizations as recommended by the Michigan Department of Health

Child(ren) Name

1.	2.
3.	4.
5.	6.

Parent Name:_____

Parent Signature:_____Date:_____/_____/_____

Enrollment Application | Multiple Media & Photography Consent Form

Parents of a child/children at Ms. C & T's Learning Place, I agree to the following:

I,_____ understand that my child(ren) whose name(s) are listed below may be photographed and videoed at Ms. C & T's Learning Place, during normal child care hours, field trips, or activities. I understand that these photographs may be used in promoting child care services, either in print, on the Internet, or for social media and our website.

Child(ren) Name

1.	2.
3.	4.
5.	6.

Parent Name:	**Phone Number:**
Address:	**City:**
State:	**Zip Code:**

I give permission for my child(ren) to be photographed, or their images recorded for print or electronic use in promoting our child care services. I understand that it is my responsibility to update this form in the event that I no longer wish to authorize the above uses. I agree that this form will remain in effect during the term of my child's enrollment. I understand that there will be no payment for me or my child's participation.

Parent Name:_____

Parent Signature:_____Date:_____/_____/_____

Enrollment Application | Yearly Non-Prescription Medications Consent Form

I,_____, the parent of the child(ren) listed below give a yearly consent for the staff of MCTLP to use non-tropical medicine on my child(ren), for the year of _____.
Examples: Sunscreen, butt paste, Insect repellent, vaseline.

Child(ren) Name

1.	2.
3.	4.
5.	6.

Parent Name:_____

Parent Signature:_____Date:_____/_____/_____

Enrollment Application | Yearly Walk to the Parks Consent Forms

I, _____, the parent of the child(ren) listed below give a yearly consent for the staff of MCTLP to take my child(ren) on walks to the parks for the year of_____

Child(ren) Name

1.	2.
3.	4.
5.	6.

Parent Name:_____

Parent Signature:_____Date:_____/_____/_____

Enrollment Application | Allergy Alert

_____ My Child(ren) does not have any allergies.

_____ My child(ren) does have allergies.

Child(ren) Name:

1. _____
2. _____
3. _____

List any allergies: _____

_____

_

_____

_

_____

_

Parent Name:_____

Parent Signature:_____Date:_____/_____/_____

__It is the responsibility of the parent to update allergy information__

Enrollment Application | Infant Weekly Supply List

1. Items to bring:
    a. Prepared Bottles (Enough for the day)
    b. Breastmilk dated (If breastfeeding)
    c. Pacifiers (If Used)
    d. Diapers for the week (25-30 diapers)
    e. Wipes for the week
    f. At least two extra changes of clothes (EX: undershirts, shirt, pants, socks.)
    g. Extra formula (For emergencies use only)
    h. Baby food (If on a special diet)
2. Items that will be provided:
    a. Bibes
    b. Blankets
    c. Burper clothes
    d. Baby food
    e. Baby size bowls and spoons
3. Please Remember:
    a. Please label all items with your child(ren) first and last name.
    b. All bottles MUST be labeled with the child first and last name and dated.
    c. All creams that need to be applied require a medical authorization form.
    d. All prescriptions must be in the original containers with the patient's name, dosage, and prescribed time to be given. Also, require a medical authorization form.
    e. Any over-the-counter medications (Tylenol, Motrin, etc.) require a medical authorization form, along with a dose amount that fits the child's age and/ or weight.
    f. No outside toys are allowed.

ANY CHILD THAT IS ON DIAPERS, PULL UPS OR POTTY TRAINING, NEEDS TO BRING THE FOLLOWING ITEMS LISTED ABOVE.

Enrollment Application | Submitting Schedules Protocol

1. How to submit a schedule:
    a. Schedules are due every Thursday by 3pm (Even if no child care is needed).
    b. Go to www.mctlp.com/schedules to sumbint schedule.
    c. Scroll down and click “submit a schedule”
    d. Fill in ALL the information that is asked.
    e. Be sure to click the right dates and times that you need.
    f. Once you are done, click submit.
2. How to clock in and out on the Kiosk:
    1. Parents must sign their child(ren) in/ out every day they attend.
    2. Click start here.
    3. Type in your personal ID number (this number is the last four digits of your phone number with a zero at the end) click next.
    4. Type in your password (this number is the last four digits of your phone number) click next.
    5. Click on the child(ren) you wish to clock in.
    6. Click finish.

The following forms must be printed and signed by a doctor. Please return these docuements to us in person or scan them and email them in. BE SURE TO BRING YOUR CHILD'S IMMUNIZATION RECORDS TO THE EXAMINATION.)

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:

_____ / /

Parent/Guardian Signature Date

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 _____ '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.