

August 18, 2023

Dear Parents:

**Re: Enrollment Packets for 2023/2024 school year**

It is re-enrollment time again! Attached are the forms we need filled out and returned to the office by Friday, **September 1, 2023**, when your account will be charged the re-enrollment fee of **\$50.00** per family. If we do not receive the packet by then, your child will be dis-enrolled.

Our Parent Manual can be found online at [WeeLoveDaycare.com](http://WeeLoveDaycare.com) under the "Parent" tab. If you need a hard copy, please let us know and we will provide you with one.

The Licensing rules for daycare operation can be found at [Michigan.gov/MIchildcare.com](http://Michigan.gov/MIchildcare.com)

Just and update on our staff. Ms. Gabby and Ms. Belle have been here for the summer and will be leaving us soon. We are thankful for them and all they contributed to make this a fun summer. We will be welcoming back Ms. Cassie and Ms. Jessica for the school year and are excited to see them back here at Wee Love. Exciting things are ahead!

Should you have any questions, please feel free to call us at 586.296.7102.

Sincerely,

*Heather & Connie*

# Wee Love Registration Form

Child Name:
Date of Birth:
Parent/Guardian Names:

Insurance Provider: \_\_\_\_\_

Policy #: \_\_\_\_\_

I understand and agree that Wee Love Day Care & Learning Center may call an ambulance in case of an accident or acute illness and will arrange for necessary emergency medical and/or surgical care in the event that I am not immediately available. Any qualified physician called by the Center in case of an emergency may treat and do whatever is necessary for the health and well being of my child. I agree to accept responsibility for the cost of any medical services. A conscientious effort will be made to notify me before such action is taken.

Parent/Guardian's Signature: \_\_\_\_\_

Date: \_\_\_\_\_

# 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.	

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

# Enrollment Contract

Date Submitted: \_\_\_\_\_

Date Enrolled: \_\_\_\_\_

**I wish to enroll my child in Wee Love Day Care & Learning Center.**

\_\_\_\_\_

Child's Name

\_\_\_\_\_

Date of Birth

Weekly Rate: \$ \_\_\_\_\_

Qualified Discount: \_\_\_\_\_

Please fill in the information for the times you wish to contract your child to attend:

Day	Hour of Drop-Off	Hour of Pick-Up
Monday		
Tuesday		
Wednesday		
Thursday		
Friday		

I understand that the new tuition will be \$ \_\_\_\_\_ per week. (15% discount after first child.)

I have received the Parents' Handbook and the Enrollment Contract.

Upon signing this Contract, the parent or legal guardian agrees to abide by all the provisions contained in the above-noted documents.

Parent/Guardian's Signature: \_\_\_\_\_

Date: \_\_\_\_\_

Director's Signature: \_\_\_\_\_

Date: \_\_\_\_\_

# Pick-Up Authorization Form

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(child's name)

Date: \_\_\_\_\_

Effective: \_\_\_\_\_

I give permission for my child to be picked up at Wee Love Day Care & Learning Center by:

	<b>Name</b>	<b>Phone #</b> <small>[Including Area Code]</small>
<b>Mom</b>		
<b>Dad</b>		
<b>Name</b>		
<b>Name</b>		
<b>Name</b>		

I **do not** give permission to:

	<b>Name</b>	<b>Phone #</b> <small>[Including Area Code]</small>
<b>Name</b>		
<b>Name</b>		

Parent/Guardian's Signature: \_\_\_\_\_

Date: \_\_\_\_\_

Director's Signature: \_\_\_\_\_

Date: \_\_\_\_\_

# Non-Prescription Topical Medication Authorization Form

I request that Wee Love Day Care & Learning Center use:

\_\_\_\_\_ **Sunscreen** \_\_\_\_\_ on my child.

(topical medication name)

\_\_\_\_\_

(child's name)

- \_\_\_\_\_ as needed
- \_\_\_\_\_ for diaper rashes
- \_\_\_\_\_ at each diaper change
- \_\_\_\_\_ when going out in the sun
- \_\_\_\_\_ other \_\_\_\_\_

(please specify)

Parent/Guardian's Signature: \_\_\_\_\_

Date: \_\_\_\_\_

# General Field Trip Permission Form

I hereby give my permission to Wee Love Day Care & Learning Center for my child to participate in general field trips. In the case of an emergency, I hereby give permission for my child to be transported by vehicle when the destination is outside of walking distance.

The purpose of the General Field Trip Permission Form is to allow a child to be taken out of the classroom for general field trips within the scope of the building, the property, walk in the neighborhood, or in emergency transportation. A daycare buggy will be used when walking with the infants/young toddlers. I understand if the children take a walk in the neighborhood, they will remain on the sidewalks and the cross streets only at designated crosswalks.

If a specific destination field trip is planned, a “We’re Going on a Field Trip” form will be used. The field trip will be posted in the classroom with all pertinent information including the destination, the costs, departure and arrival times, and any additional information needed.

Parent/Guardian’s Signature: \_\_\_\_\_

Date: \_\_\_\_\_

# Photo Release Form

I hereby give my permission to Wee Love Day Care & Learning Center for the use of pictures and/or video recordings of my child, \_\_\_\_\_

(child's name)

to be used to decorate the Center, for use in arts & crafts projects, and/or for publication purposes.

Parent/Guardian's Signature: \_\_\_\_\_

Date: \_\_\_\_\_



# Infant and Toddler Food Agreement

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(child's name)

I will provide food for my infant or toddler. It will be prepared according to the following methods:

1. The formula or other liquids placed in an assembled bottle unit (i.e., bottle, nipple, and cover). This is to be prepared at home.
2. The bottle(s) are to be sterilized or disposable.
3. Each bottle is labeled with the child's name and date.
4. Any perishable foods (ex: milk, formula) must be transported between the home and the Center at required temperature.
5. Sufficient lunch and snack foods (ex: canned baby food) must be provided to meet the minimum needs of each child.

## Lunch Agreement

I understand that it is my responsibility to provide my child,

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(child's name)

with a daily nutritional service ready lunch including beverage, while he/she is in attendance at the Center. Service ready means that hot and cold foods must be stored in an appropriate container to keep the food at the proper temperature. We will not provide the means to refrigerate or heat up lunches. Acceptable containers include brown paper bag lunches that can be stored at room temperature, lunch boxes, thermoses, and/or insulated containers. All containers must be clearly marked with the child's name.

I understand that two (2) snacks will be served each day. A weekly snack schedule will be posted on the snack cart.

Parent/Guardian's Signature: \_\_\_\_\_

Date: \_\_\_\_\_

# Wee Love Parent Manual

August 18, 2023

Dear Parents:

## **Re: Parent Manual**

An updated Parent Manual can be found on our website ([weelovedaycare.com](http://weelovedaycare.com)), under "Parents" tab. Please take a few minutes to review our policies and procedures. If you would like a "hard copy", you may request one from the daycare office.

A licensing rule requires us to maintain written documentation that all parents have received the information contained in our Manual. Please sign below and return the form to us, acknowledging you have received it.

Thank you for your cooperation.

Sincerely,

*Heather & Connie*

Director

I acknowledge that I have received a "Parents' Manual".

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Name (please print)

Signature: \_\_\_\_\_

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Name of child in Center (please print)

Date: \_\_\_\_\_

**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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## WRITTEN INFORMATION PACKET DOCUMENTATION

Michigan Department of Licensing and Regulatory Affairs  
Child Care Licensing Bureau

Child(ren)'s Name(s) (Last, First)	Facility's Name and License Number
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A written information packet has been provided at the time of enrollment. The packet included all the following information (*R 400.8146 (1-2)*):

- Criteria for admission and withdrawal.
- Schedule of operation, denoting hours, days, and holidays during which the center is open, and services are provided.
- Fee policy.
- Discipline policy.
- Food service program.
- Program philosophy.
- Typical daily routine.
- Parent notification plan for accidents, injuries, incidents, and illnesses.
- Transportation policy, if applicable.
- Medication policy.
- Exclusion policy for child illnesses.
- Notice of the availability of the center's licensing notebook. **(CENTER MUST CHECK ONE)**
  - The center keeps a licensing notebook containing a summary sheet, all licensing inspections and special investigation reports, 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).
- Other \_\_\_\_\_

I certify that I received all of the above items.

\_\_\_\_\_  
Parent/Guardian Signature

\_\_\_\_\_  
Date

**Note:** A single CCL-4340 form may be used for all children in the same family.

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August 18, 2023

Dear Parents:

### Re: Push Notification App

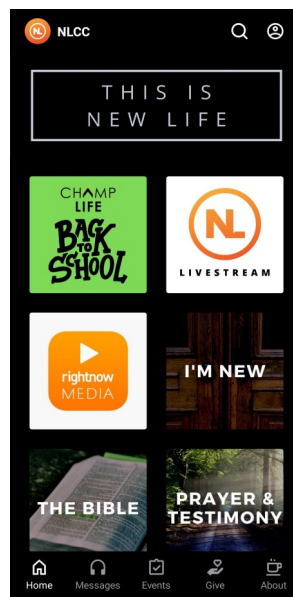
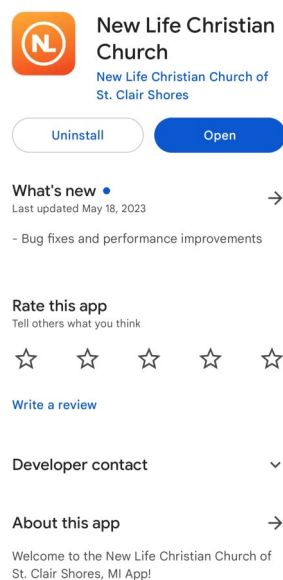
We would like to make sure everyone is using our New Life Christian Church app so you can receive information as efficiently and quickly as possible. The notifications are used anytime we need to close a classroom due to sickness or close the Center due to inclement weather or power outages. We will also post notifications on our Wee Love Family Group page on Facebook.

If you have not yet downloaded the New Life Christian Church app, we would strongly encourage you to do so. Once this app is downloaded, go into settings, then notifications and make sure to click on Wee Love notifications.

If you have any questions regarding this, please feel free to stop in the office.

Blessings,

*Heather & Connie*





## Tuition Cost Form

Hours: Monday - Friday, 7am - 5pm

Effective April 1, 2023

Prices subject to change.

### Policies:

- Tuition is due no later than Monday of the current week. Tuition is paid in advance of services.
- A late pick-up fee of \$1 *per minute* will be assessed after 5pm, with a minimum \$5 charge per child.
- A \$40 fee will be charged for any declined payment.

Updated: April 1, 2023

<b>Infant / Toddler (Birth - 30 months)</b>
<b>Full Time</b>
\$265

<b>Preschool (31 months - Pre-K)</b>
<b>Full Time</b>
\$240

<b>Pre-Kindergarten</b>
<b>Full Time</b>
\$230

<b>School Age / Summer Camp</b>
<b>Full Time</b>
\$225

Figure 1. Recommended Immunization Schedule for Children and Adolescents Aged 18 Years or Younger—United States, 2018.

(FOR THOSE WHO FALL BEHIND OR START LATE, SEE THE CATCH-UP SCHEDULE [FIGURE 2]).

These recommendations must be read with the footnotes that follow. For those who fall behind or start late, provide catch-up vaccination at the earliest opportunity as indicated by the green bars in Figure 1. To determine minimum intervals between doses, see the catch-up schedule (Figure 2). School entry and adolescent vaccine age groups are shaded in gray.

Vaccine	Birth	1 mo	2 mos	4 mos	6 mos	9 mos	12 mos	15 mos	18 mos	19-23 mos	2-3 yrs	4-6 yrs	7-10 yrs	11-12 yrs	13-15 yrs	16 yrs	17-18 yrs
Hepatitis B <sup>1</sup> (HepB)	1 <sup>st</sup> dose	← 2 <sup>nd</sup> dose →					← 3 <sup>rd</sup> dose →										
Rotavirus <sup>2</sup> (RV) RV1 (2-dose series); RV5 (3-dose series)		1 <sup>st</sup> dose		2 <sup>nd</sup> dose	See footnote 2												
Diphtheria, tetanus, & acellular pertussis <sup>3</sup> (DTaP; <7 yrs)		1 <sup>st</sup> dose		2 <sup>nd</sup> dose	3 <sup>rd</sup> dose			← 4 <sup>th</sup> dose →				5 <sup>th</sup> dose					
<i>Haemophilus influenzae</i> type b <sup>4</sup> (Hib)		1 <sup>st</sup> dose		2 <sup>nd</sup> dose	See footnote 4		← 3 <sup>rd</sup> or 4 <sup>th</sup> dose, See footnote 4 →										
Pneumococcal conjugate <sup>5</sup> (PCV13)		1 <sup>st</sup> dose		2 <sup>nd</sup> dose	3 <sup>rd</sup> dose		← 4 <sup>th</sup> dose →										
Inactivated poliovirus <sup>6</sup> (IPV; <18 yrs)		1 <sup>st</sup> dose		2 <sup>nd</sup> dose	← 3 <sup>rd</sup> dose →							4 <sup>th</sup> dose					
Influenza <sup>7</sup> (IV)							Annual vaccination (IV) 1 or 2 doses						Annual vaccination (IV) 1 dose only				
Measles, mumps, rubella <sup>8</sup> (MMR)						See footnote 8	← 1 <sup>st</sup> dose →					2 <sup>nd</sup> dose					
Varicella <sup>9</sup> (VAR)							← 1 <sup>st</sup> dose →					2 <sup>nd</sup> dose					
Hepatitis A <sup>10</sup> (HepA)							← 2-dose series, See footnote 10 →										
Meningococcal <sup>11</sup> (MenACWY-D ≥9 mos; MenACWY-CRM ≥2 mos)						See footnote 11								1 <sup>st</sup> dose		2 <sup>nd</sup> dose	
Tetanus, diphtheria, & acellular pertussis <sup>13</sup> (Tdap; ≥7 yrs)														Tdap			
Human papillomavirus <sup>14</sup> (HPV)														See footnote 14			
Meningococcal B <sup>12</sup>														See footnote 12			
Pneumococcal polysaccharide <sup>5</sup> (PPSV23)														See footnote 5			

Range of recommended ages for all children
  Range of recommended ages for non-high-risk groups that may receive vaccine, subject to individual clinical decision making
  Range of recommended ages for catch-up immunization
  Range of recommended ages for certain high-risk groups
  No recommendation

**NOTE: The above recommendations must be read along with the footnotes of this schedule.**

# 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) / /
PARENT/GUARDIAN (Last, First, Middle)			HOME TELEPHONE NUMBER ( )
ADDRESS (Number & Street)	(City)	(ZIP Code)	WORK TELEPHONE NUMBER ( )

## 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 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				<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			2	3
DTaP/DTP/DT/Td	1	4	Influenza (IIV/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 (HPV9/HPV4/HPV2)	1	3
	2	4		2	
Polio (IPV/OPV)	1	3	OTHER Vaccines Specify Date & Type	Type of Vaccine(s)	Date of Vaccine(s)
Pneumococcal Conjugate (PCV7/PCV13)	1	3		1	
	2	4		2	
Rotavirus (RV1/RV5)	1	3	3		
Measles, Mumps, Rubella (MMR)	1	2	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 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: _____					
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: \_\_\_\_\_

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.

\*\*\*\*\*

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.