



CLAWSON PRESCHOOL

(248) 655-3838
313 REDRUTH AVENUE
CLAWSON, MI 48017

WWW.CLAWSONSCHOOLS.ORG

**2026-27 CLAWSON PRESCHOOL
3-YEAR OLD REGISTRATION PACKET**

TO REGISTER:

- 1. COMPLETE ALL REGISTRATION FORMS**
- 2. COMPLETE EMERGENCY CARD**
- 3. BRING IN BIRTH CERTIFICATE**
- 4. BRING IN THE REGISTRATION FEE**

**ALL OF THE ABOVE ITEMS
ARE NECESSARY TO REGISTER**

**WE CAN NOW INVOICE YOU THROUGH PAYPAL FOR ALL PAYMENTS.
WE ALSO ACCEPT CHECKS OR MONEY ORDERS PAYABLE TO CLAWSON
PUBLIC SCHOOLS. CASH PAYMENT IS NO LONGER ACCEPTED.**

**REGISTRATION BEGINS ON THURSDAY, MARCH 5TH 2026 AT THE
CLAWSON EARLY CHILDHOOD CENTER LOCATED AT 313 REDRUTH
AVE. BY APPOINTMENT ONLY.**

**TO REGISTER AFTER JUNE 5TH, 2026
CALL CLAIRE PROST AT 248-655-3836
OR HEATHER KOTZ AT 248-655-3834**

REGISTRATION IS ON A FIRST COME- FIRST SERVE BASIS

**THE FIRST DAY OF THE 2026-2027 SCHOOL YEAR WILL BE
TUESDAY, SEPTEMBER 8th, 2026 (Subject to change due to the district calendar)**

Dear Parents/Guardians:

Clawson Preschool is offering two 17-week semesters of preschool **for children who will be three years of age by September 1, 2026.** The program will begin on Tuesday, September 8th at the Clawson Early Childhood Center located at 313 Redruth Ave., Clawson, Mi 48017.

Children may attend on Monday/Wednesday or Tuesday/Thursday mornings from 9:30-11:30 or Monday/Wednesday or Tuesday/Thursday afternoon from 12:30-2:30. Parents will be required to donate the treat, drink, cups and napkins for their child's assigned snack days.

REGISTRATION

Please complete the enclosed registration forms. Registration for the 3-year old program will take place on Thursday, March 5th by appointment only. There will be a sign-up genius link posted on our website where you will sign up for a time to come up and register. This link will be posted on Monday, March 2nd at 9 AM. Please note that registration is on a first come – first serve basis. To register after June 5th, please call Claire Prost at 248-655-3836 or Heather Kotz at 248-655-3834.

PARENT MEETING

There will be a parent meeting in the beginning of September but the exact date and time have not yet been set. Parents/Guardians will be emailed this information.

IMMUNIZATIONS

When registering your child, the State of Michigan requires that you show proof of immunizations. Please complete the enclosed immunization sheet and bring with you to registration. To complete an immunization waiver form, please contact your child's pediatrician or the Oakland County Health Department.

HEALTH FORMS

The State of Michigan requires that any child entering school must have the enclosed health form completed. The enclosed health form must be completed by you **AND** your child's pediatrician. This form is due no later than October 1st, 2026. Health forms are only valid for one year.

Clawson Public Schools also have programs and assessments available for children who live in Clawson, birth to age 5 whose parents may have concerns about developmental delays in the areas of speech and language, gross or fine motor, cognitive, and/or social emotional development. Call Julie Carl at 248-655-4416.

Sincerely,

Claire Prost – Clawson Preschool Coordinator

**3-YEAR-OLD REGISTRATION FORM
2026-27 SCHOOL YEAR**

PLEASE PRINT:

NAME OF CHILD _____

M____ F____ BIRTH DATE: _____

PARENT/GUARDIAN NAMES _____

ADDRESS _____

CITY _____

ZIP _____

PHONE (home) _____

(work) _____

(cell) _____

1. Is your child's native tongue a language other than English? Yes ____ No ____

2. Is the primary language used in your home or environment a language other than English? Yes ____ No ____

If yes, what is the language? _____

FEES: \$720 FOR 2 DAY PROGRAM PER 17 WEEK SEMESTER PLUS A \$60 (\$100 FOR MORE THAN ONE CHILD) NON-REFUNDABLE ENROLLMENT FEE.

ADDITIONAL FEE OF \$25 PER SEMESTER FOR FAMILIES WHO LIVE OUT OF CLAWSON.

CLASS TIMES:

____ 9:30-11:30 AM – MONDAY/WEDNESDAY

____ 9:30-11:30 AM – TUESDAY/THURSDAY

____ 12:30-2:30 PM – MONDAY/WEDNESDAY

____ 12:30-2:30 PM – TUESDAY/THURSDAY

Tuition is due September 22nd, 2026. You can pay in full per semester, monthly from September through May or you can also make 4 quarterly payments, Sept., Nov., Feb. and April. Please make checks or money orders payable to Clawson Public Schools. We no longer accept cash payments. You may also pay tuition via PayPal. If you choose PayPal please be sure to provide the email you use for your account. Please note that all lines must be filled in on the emergency card.

REGISTRATION FE ENCLOSED: \$ _____

RECEIPT #: _____

OR

INVOICE ME VIA PAYPAL, MY EMAIL IS: _____

CHILD INFORMATION RECORD

State of Michigan

Department of Lifelong Education, Advancement, and Potential – 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 strikethrough, or "N/A" are not acceptable responses.

For Provider Use Only:	Date of Admission:	Date of Discharge:
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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	2nd Phone (if applicable)	
Home Address (if not child's address)	City	State	Zip Code
Email Address (optional)	Employer Name	Work Phone	
Parent/Legal Guardian's Name (optional)	Primary Phone	2nd Phone (if applicable)	
Home Address (if not child's address)	City	State	Zip Code
Email Address (optional)	Employer Name	Work Phone	

Name of Child's Physician or Health Clinic	Physician's or Health Clinic's Phone Number
Preferred Hospital for Emergency Treatment (optional)	Allergies, Disabilities and/or Special Instructions? Attach additional sheets if necessary.

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 st Individual:	Phone:	2 nd Phone:
2 nd Individual:	Phone:	2 nd Phone:
3 rd Individual:	Phone:	2 nd Phone:

Release of Child Only: List all individuals, other than the parents or legal guardians, to whom the child may be released to (if more individuals, attach additional sheets).

1 st Individual:	Phone:
2 nd Individual:	Phone:
3 rd Individual:	Phone:

Parent/Legal Guardian Initials: I, _____ (initial here), give permission to _____ (child care provider), licensed by the Department of Lifelong Education, Advancement, and Potential, 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:
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Date Record Reviewed	Parent / Guardian Initials	Date Record Reviewed	Parent / Guardian Initials	Date Record Reviewed	Parent / Guardian Initials
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Individuals with disabilities may contact the MiLEAP ADA Coordinator to request an alternative format to these materials. Please visit www.Michigan.gov/ADA for a list of state ADA Coordinators.	MiLEAP is an equal opportunity employer/program.
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CLAWSON PUBLIC SCHOOLS
STUDENT DATA FORM (please print)

Student# _____ Year of Grad. _____
Entry Date _____ Schools of Choice _____
Resident District _____

School to attend: _____

Entering Grade: _____

Student's **Legal** Name: _____ Gender: ☐ Male ☐ Female
(As shown on birth certificate) Last First Middle Name

Birth date: _____ Birth Place: _____ Country of Birth: _____
Month / Day / Year City or Township

Address: _____
Number Street Apt. # City Zip Code

Primary Phone Number _____

Ethnicity/Race Information (collected for statistical purposes only)

Part A. Is this student Hispanic/Latino? (Choose only one)

- ☐ No, not Hispanic/Latino
☐ Yes, Hispanic/Latino (A person of Cuban, Mexican, Puerto Rican, Cuban, South or Central American, or other Spanish culture or origin regardless of race)

The above question is about ethnicity, not race. No matter what you selected above, please continue to answer the following by marking one or more boxes to indicate what you consider your student's race to be.

Part B. What is the student's race? (Check all that apply)

- ☐ American Indian/Alaska Native ☐ Asian ☐ Black/African American ☐ Native Hawaiian/Other Pacific Islander ☐ White

MEDICAL CONDITIONS/PROBLEMS: check all that apply

If checked a medical plan must be on file in your child's school office

- | | | |
|--|---|--|
| ☐ ADD/ADHD | ☐ Headaches | ☐ Seizure disorder # _____ |
| ☐ Asthma # _____ | ☐ Heart Condition | ☐ Other Allergy: _____ |
| ☐ Bee Sting Allergy # _____ | ☐ Nose bleeds | ☐ Other Medical Conditions: _____ |
| ☐ Diabetes# _____ | ☐ Peanut Allergy # _____ | |

☐ *Takes medication regularly? Please indicate medication and how often taken _____

*If taken during school hours, please contact school and obtain an Authorization for Medication form to be completed by the student's physician and parent or guardian.

LAST SCHOOL ATTENDED:

School Name _____ Grade _____
Address _____ Date Entered _____ Date Left _____
City _____ State & Zip _____ Phone Number _____

SERVICES YOUR CHILD RECEIVED AT PRIOR SCHOOL:

Does your child have a 504 plan? Yes _____ No _____ (Please provide a copy of the 504 plan)

Does your child have an IEP (Individual Education Plan) Yes _____ No _____ (Please provide a copy of the IEP and MET)

Eligibility (if known) _____

Information about Parents / Guardians:

	<u>Female Parent/Guardian in Household</u>	<u>Male Parent/Guardian in Household</u>	<u>PARENT Living Elsewhere</u>
Name:			
Relationship to child:			
Cell Phone:			
Work Phone:			
Email:			
On Full-time Active Military Duty?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Parent Living Elsewhere Address: _____ (Should this person receive mailings?) ☐ Yes ☐ No Are custody papers on file with Clawson Public Schools ☐ Yes ☐ No Clawson Public Schools cannot enforce custody restrictions without a court order on file.			

Emergency Contact Information:

When parent/guardian is unavailable, please list four adults to whom the child can be released from school due to illness and/or provide transportation. Adults may be asked to present identification. List in order of preference. PLEASE PRINT LEGIBLY

NAME _____ RELATIONSHIP TO CHILD _____ PHONE: (____) _____

NAME _____ RELATIONSHIP TO CHILD _____ PHONE: (____) _____

NAME _____ RELATIONSHIP TO CHILD _____ PHONE: (____) _____

NAME _____ RELATIONSHIP TO CHILD _____ PHONE: (____) _____

Other children that reside in the home:

Child's Name	Birth Date	Relationship	Grade

Please note any problems or concerns, which would assist the school in working with your child:

I affirm that as the parent/legal guardian, all information provided above is true and accurate, and that my child and I reside at the listed address. I understand any false information provided by me, may subject me to legal penalties for perjury.

Parent/Legal Guardian signature

Date

**CLAWSON PUBLIC SCHOOLS
HOME LANGUAGE SURVEY**

The Clawson Public Schools district is collecting information regarding the language background of each of its students. This information will be used by the district to determine the number of children who should be provided bilingual instruction according to Sections 380.1152-380.1157 of the School Code of 1995, Michigan's Bilingual Education Law.

Today's Date _____ School _____

Name of student _____
First Middle Last

Student birth date: _____ Grade _____ Country of birth _____

1. Is your child's native tongue a language other than English? ☐ Yes ☐ No

(The child's native tongue/language is the language most often spoken by the student.)

If yes, what is that language? _____

2. Is the **primary** language used in your child's home or environment a language other than English?

(The primary language is the dominant language used at home regardless of the language spoken by the student.)

☐ Yes ☐ No

If yes, what is that language? _____

3. Did your child attend school in another country? ☐ Yes ☐ No

If yes: How many years? _____ Which country? _____

4. Has your child been enrolled in a school in the United States? ☐ Yes ☐ No

If yes, when did your child first enroll in that school? Month _____ Year _____

5. What language (or languages) does your child read? _____

6. What language (or languages) does your child write? _____

7. Has your child ever been in a bilingual or English as a Second Language program? _____

8. If so, what was the last grade in which he/she was enrolled in that program? _____

I understand that my child, _____, will receive English language proficiency testing if he/she speaks a language other than English. I will be notified if my child qualifies for English as a Second Language program services. I understand that at that time I have the right to refuse English as a Second Language program services for my child. However, I can request services at a later date.

Parent or Guardian signature

Date

CLAWSON PRESCHOOL
PARENTAL RELEASE FORM

Dear Parent/Guardian:

Occasionally, for educational purposes, pictures or videotaped recordings will be made in classrooms and/or of students in other schools programs. Some of the pictures or recordings may be used in presentations or used on local cable or broadcast stations or in local newspapers. Your child's name may be mentioned with either a picture or in the videotaped recordings.

PLEASE CIRCLE DO OR DO NOT IN THE FOLLOWING STATEMENTS:

I DO/DO NOT give permission for _____
(Student's Name)
to be included in any videotaped recordings.

I DO/DO NOT give permission for _____
(Student's Name)
to be photographed for the news media or special programs and/or
presentations.

I DO/DO NOT give permission for _____
(Student's Name)
photographs and/or videotaped recordings to be put on school related websites.

I understand my child's name may be used in conjunction with any pictures(s)
used.

Parent/Guardian Signature

Date

MEDICATION PERMISSION AND INSTRUCTIONS
CHILD CARE HOMES AND CENTERS

State of Michigan

Department of Lifelong Education, Advancement, and Potential – Child Care Licensing

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 OR GUARDIAN

I give my permission for _____ to give or apply the medication,
(Child Care Facility/Licensee)

_____ 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 Giving 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	
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Continue onto page 2 to detail the specific information of how, when, and by whom the medication was administered.

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

Individuals with disabilities may contact the MiLEAP ADA Coordinator to request an alternative format to these materials. Please visit www.Michigan.gov/ADA for a list of state ADA Coordinators.	MiLEAP is an equal opportunity employer/program.
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To be Completed by the Child Care Staff Member/Licensee Giving Medication:

[illegible]

PARENTS' VACCINES REQUIRED FOR CHILD CARE AND PRESCHOOL IN MICHIGAN



Whenever infants and children are brought into group settings, there is a chance for diseases to spread. Children must follow state vaccine laws in order to attend child care and preschool. These laws are the minimum standard for preventing disease outbreaks in group settings. The best way to protect your child from other serious diseases is to follow the recommended vaccination schedule at www.cdc.gov/vaccines. Talk to your health care provider to make sure your child is fully protected.

	2-3 months	4-5 months	6-15 months	16-18 months	19 months—4 years	5 years
Diphtheria, Tetanus, Pertussis (DTaP)	1 dose DTaP	2 doses DTaP	3 doses DTaP		4 doses DTaP	
Pneumococcal Conjugate (PCV13)	1 dose	2 doses	3 doses or Age-appropriate complete series	4 doses or Age-appropriate complete series	None	
<i>H. influenzae</i> type b (Hib)	1 dose	2 doses		1 dose at or after 15 months or Age-appropriate complete series	None	
Polio	1 dose	2 doses			3 doses	
Measles, Mumps, Rubella (MMR) *	None		1 dose at or after 12 months			
Hepatitis B *	1 dose	2 doses			3 doses	
Varicella (Chickenpox) *	None		1 dose at or after 12 months or Current lab immunity or History of varicella disease			

These rules apply to children who are the above ages upon entry into child care or preschool. During disease outbreaks, incompletely vaccinated children may be excluded from child care and preschool. Parents and guardians choosing to decline vaccines must obtain a certified non-medical waiver from a local health department. Read more about waivers at www.michigan.gov/immunize.
 *If the child has not received these vaccines, documented immunity is required. All doses of vaccines must be valid (correct spacing and ages) for child care and preschool entry purposes.

When Do Children and Teens Need Vaccinations?

Age	HepB Hepatitis B	RSV- mAb	DTaP/Tdap Diphtheria, tetanus, pertussis (whooping cough)	Hib Haemophilus influenzae type b	IPV Polio	PCV Pneumo- coccal conjugate	RV Rotavirus	MMR Measles, mumps, rubella	Vari- cella Chickenpox	HepA Hepatitis A	COVID-19	Dengue	HPV Human papillomavirus	Men- ACWY Meningococcal	MenB Meningococcal	Influenza Flu
at Birth	✓	✓ ² (0-7 mos)														
2 months	✓		✓	✓	✓	✓	✓									
4 months	✓ ¹		✓	✓	✓	✓	✓									
6 months	✓		✓	✓ ¹	✓	✓	✓ ¹									✓
8 months	✓ (6-18 mos)				✓ (6-18 mos)											✓ (6 mos and older)
12 months		✓ ² (8-19 mos)														
15 months			✓ ³ (15-18 mos)	✓ (12-15 mos)		✓ (12-15 mos)		✓ (12-15 mos)	✓ (12-15 mos)	✓ (2 doses given 6 months apart routinely at age 12-23 months)	✓ ⁴ COVID-19 vaccine is recommended for everyone age 6 months and older					
18 months																
19-23 months																
4-6 years			✓		✓			✓	✓	HepA vaccine (2 doses) is also recommended for children and teens not previously vaccinated						
7-10 years																
11-12 years			✓ (Tdap)													
13-15 years																
16-18 years																

NOTES 1 Your child may not need this dose depending on the brand of vaccine that your healthcare provider uses.

2 Infants whose mother did not receive an RSV vaccination during pregnancy and who are younger than 8 months 0 days should receive RSV preventive antibody (RSV-mAb) before or during the RSV season (typically October through March). Certain high-risk children (8 through 19 months) will need RSV-mAb before their second RSV season.

3 This dose of DTaP may be given as early as age 12 months if it has been 6 months since the previous dose.

4 Children age 5 years or older generally need only one dose. The number of doses for children age 6 months through 4 years is determined by the vaccine brand.

5 Children ages 9 through 16 years who live in Puerto Rico, American Samoa, U.S. Virgin Islands, Federated States of Micronesia, Republic of Marshall Islands, and the Republic of Palau, and have lab-confirmed previous dengue infection are recommended to receive a 3-dose series of dengue vaccine.

6 HPV vaccine is routine at age 11 or 12 years but may be started at age 9.

7 Children with certain medical conditions will need a third dose.

8 This vaccine may be given to healthy teens. It is also recommended for adolescents with certain health conditions.

9 Your teen may need an additional dose depending on your healthcare provider's recommendation.

10 When MenACWY and MenB vaccines are both needed, a MenBACWY combination vaccine may be used.

One dose each fall or winter. Some children younger than age 9 years need 2 doses; ask your child's healthcare provider if your child needs more than 1 dose.

Influenza vaccine is recommended every year for everyone age 6 months and older

Dengue vaccine is recommended for certain children

✓⁵

✓^{6,7}

✓

✓^{8,9,10}



FOR PROFESSIONALS www.immunize.org / FOR THE PUBLIC www.vaccineinformation.org

www.immunize.org/catg.d/p4050.pdf

Item #P4050 (12/18/2023)



Scan for PDF

MDHHS-3305, HEALTH APPRAISAL
Michigan Department of Health and Human Services (MDHHS)
(Revised 7-24)

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 1. Section 4 may be certified by the transcription of information from the certificate of immunization. The remaining sections are to be completed by a doctor, nurse, dentist, dental therapist, and dental hygienist.

(BE SURE TO BRING YOUR CHILD'S IMMUNIZATION RECORDS TO THE EXAMINATION).

SECTION 1 – 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/Cell Phone Number
Address (Number, Street, City, Zip Code)	Work Phone Number

SECTION 2 – HEALTH HISTORY

Yes	No	Resolved	Is your child having any of the problems listed below?	Birth History
☐	☐	☐	1. Allergies or Reactions (for example, food, medication or other)	
☐	☐	☐	2. Anaphylaxis	
☐	☐	☐	3. Does your child take any medication(s) regularly?	If yes, list medications
☐	☐	☐	4. Hay Fever, Asthma, or Wheezing	
☐	☐	☐	5. Eczema or Frequent Skin Rashes	
☐	☐	☐	6. Convulsions/Seizures	
☐	☐	☐	7. Heart Trouble	
☐	☐	☐	8. Diabetes	
☐	☐	☐	9. Frequent Colds, Sore Throats, Earaches (4 or more per year)	Are there any current or past diagnosis(es) ☐ Yes ☐ No
☐	☐	☐	10. Trouble with Passing Urine or Bowel Movements	If yes, describe

☐	☐	☐	11. Shortness of Breath	
☐	☐	☐	12. Speech Problems	
☐	☐	☐	13. Menstrual Problems	
☐	☐	☐	14. Dental Problems Date of Last Exam OR Date of Last Assessment	
☐	☐	☐	15. Other (describe)	

Reason for Medication

Concussion History

Parent/Guardian Signature

Date

Was the health history reviewed by a health professional?

Examiner's Initials

☐ Yes ☐ No

SECTION 3 - PHYSICAL EXAMINATION, INSPECTION, TESTS AND MEASUREMENTS

Required for Child Care and Head Start / Early Head Start

Test and Measurements

Yes	No	Was child test for	Tests and results	Normal	Referred	Under Care
☐	☐	Vision	Visual Acuity	☐	☐	☐
		Date	Muscle Imbalance	☐	☐	☐
			Other	☐	☐	☐
☐	☐	Hearing	☐ Audiometer (R= Right, L=Left)			
		Date	☐ OAE (R= Right, L=Left)			
			☐ Other (R= Right, L=Left)			
☐	☐	Urinalysis	Sugar	☐	☐	☐
			Albumin	☐	☐	☐
			Microscopic	☐	☐	☐
☐	☐	Blood Lead Level	Level ug/dl	☐	☐	☐
		Date				

Note: All children in Medicaid need to be tested at 1 and 2 years of age, or once between 3 and 6 years of age if not previously tested. All children, regardless of Medicaid status, should be tested at those same ages if they live in an area where lead risk is high.

☐	☐	Height & Weight	Height	☐	☐	☐
			Weight	☐	☐	☐
☐	☐	Other	Other	☐	☐	☐
☐	☐	Hemoglobin/Hematocrit	⇒	☐	☐	☐
☐	☐	Blood Pressure	Reading	☐	☐	☐

Complete pediatric tuberculosis risk assessment available at:

https://www.michigan.gov/documents/mdhhs/4_MI_Pediatric_TB_Risk_Assessment_661537_7.pdf OR feel free to use the attached QR code instead of the full link text.



Examinations and/or Inspections

Essential Findings Deviating from Normal

Exam Date

SECTION 4 – IMMUNIZATIONS

Statements such as "UP-TO-DATE" or "COMPLETE" will not be accepted. Admission to school may be denied based on this information.*

Vaccines (Select Type)	Date Administered (mm/dd/yy)		
Hepatitis B (HepB)	1.	2.	3.
	4.		
DTaP/DTP/DT/Td	1.	2.	3.
	4.	5.	6.
Tdap	1.		
<i>Haemophilus Influenzae</i> type b (HIB)	1.	2.	3.
	4.		
Polio (IPV/OPV)	1.	2.	3.
	4.	5.	
Pneumococcal Conjugate (PCV)	1.	2.	3.
	4.		
Rotavirus (RV1/RV5)	1.	2.	3.
Measles, Mumps, Rubella (MMR/MMRV)	1.	2.	3.
Varicella (Chickenpox), (Var, MMRV)	1.	2.	
Hepatitis A (HepA)	1.	2.	3.

Influenza (IIV/LAIV)	1 .	2 .	3 .
	4 .		
Meningococcal (MCV4, MenABCWY)	1 .	2 .	3 .
Meningococcal B (Bexsero, Trumenba, MenABCWY)	1 .	2 .	3 .
Human Papillomavirus (HPV)	1 .	2 .	3 .

Additional Vaccines Specify Date & Type

Type of Vaccine(s)	Date of Vaccine(s)
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.

History of Chickenpox Disease? If yes, date
☐ Yes ☐ No

☐ Parent/Guardian refused recommended immunizations at visit.

I certify that the immunization dates are true to the best of my knowledge

Health Professional Signature Title Date

SECTION 5 - RECOMMENDATIONS (Required for Child Care and Head Start/Early Head Start)

Is there any defect of vision, hearing, or other condition for which the school could help by seating or other actions?

☐ Yes ☐ No

If yes, explain

Should the child's activity be restricted because of any physical defect or illness?

☐ Yes ☐ No

Check all that apply

☐ Classroom ☐ Playground ☐ Gymnasium
☐ Swimming Pool ☐ Competitive Sports ☐ Other

If yes, explain degree of restriction(s)

Other Recommendations

SECTION 6 - DENTAL EXAM OR ASSESSMENT RECOMMENDATIONS

Child's Name	Type of Service ☐ Dental Exam	☐ Dental Assessment
Findings (Check all that apply) ☐ No findings ☐ Treated Decay ☐ Untreated Decay		
Recommendations (Check one) ☐ Routine Care ☐ Referral for dental treatment ☐ Referral for urgent dental care		
Provider Signature		Date
Check one ☐ Dentist ☐ Dental Therapist ☐ Dental Hygienist		

SECTION 7 - PHYSICIAN'S SIGNATURE

Examiner's Name (Print)	Degree or License	Telephone Number
Examiner's Signature	Date	
Address	City	State Zip Code MI

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 preventative and primary health care, including medical, dental, and mental health. The schedule must incorporate the well-childcare 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.

The Michigan Department of Health and Human Services (MDHHS) does not discriminate against any individual or group on the basis of race, national origin, color, sex, disability, religion, age, height, weight, familial status, partisan considerations, or genetic information. Sex-based discrimination includes, but is not limited to, discrimination based on sexual orientation, gender identity, gender expression, sex characteristics, and pregnancy.

WRITTEN INFORMATION PACKET DOCUMENTATION
Michigan Department of Lifelong Education, Advancement and Potential
Child Care Licensing Bureau

Child's (or Children's) Name (Last, First)	Facility Name

An information packet has been provided to me, either electronically or hard copy, at the time of enrollment. The packet included all the following information (**R 400.8113(1)**):

- 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 and that it contains the items described in R 400.8110(4).

(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.

☒ 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.

• Other _____

I certify that I received all the above items.

Parent/Guardian Signature

Date

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

MiLEAP is an equal opportunity employer/program.

Individuals with disabilities may contact the MiLEAP ADA Coordinator to request an alternative format to these materials. Please visit www.Michigan.gov/ADA for a list of state ADA Coordinators.

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

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☒ 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.

I have read the above statement issued by

Clawson Early Childhood Center

Name of Child Care Center

Child(ren)'s Name(s):	
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Parent Name _____

Parent Signature _____ Date _____

LARA is an equal opportunity employer/program.