



WELCOME TO SUMMER CAMP

There are just a few things to take care of to make sure your child is safe while here with us. Please ask all the questions you have and bring all the paperwork before or on the first day of summer camp.

Our Parent Handbook can be found on our website, or you can ask for a paper copy.

We are glad you're becoming part of the family.

Food Allergy? Medical Condition? Please Contact Bethany Before your First Day of Camp.

New Families:

**Please return all
the paperwork in
this packet:**

- 1. Orange Child Information Record (Emergency Card)**
 - 2. Green Health Form & Immunization Record (both signed by a Dr.)**
 - 3. Contract and Weekly Tuition Addendum**
 - 4. Handbook & Photography agreement/ Licensing Notebook Acknowledgement**
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**WWW.FAMILY FIRST
LEARNING CENTER.COM**

734-398-1432

Child Information Record

Every line of this form must be completed. If something does not apply, please mark the line N/A

Name: _____ Birthdate: _____ Age: _____

Child's Parents Are (circle one): married living together divorced separated

Who does the child live with? _____

Address: _____

Please number all contacts in the order you would like them called in an emergency.

Parent #1 _____

Gender: Male or Female or _____
Has Legal Custody? Yes or No

Which days? _____ **call order**

Employer: _____

Work Hours: _____

Work Phone: _____

Cell Phone: _____

Prefer text? Y or N

Email Address: _____

Parent #2 _____

Gender: Male or Female or _____
Has Legal Custody? Yes or No

Which days? _____ **call order**

Employer: _____

Work Hours: _____

Work Phone: _____

Cell Phone: _____

Prefer text? Y or N

Email Address: _____

Step Parent #1 _____

Can pick up child? Yes or No **call order**

Employer: _____

Work Hours: _____

Work Phone: _____

Cell Phone: _____

Prefer text? Y or N

Health Insurance Information:

Primary Insured's Name: _____ Carrier: _____

Policy Number: _____ Carrier's Phone: _____

Hospital Preferred for Emergency Treatment: _____

Step Parent #2 _____

Can pick up child? Yes or No **call order**

Employer: _____

Work Hours: _____

Work Phone: _____

Cell Phone: _____

Prefer text? Y or N

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)	Birth History: 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 Examiner's Initials: _____
<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	
			_____ / /	
			Parent/Guardian Signature _____ 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				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		Influenza (IIV/LAIV)	1	3
				2	4
DTaP/DTP/DT/Td	1	4	Meningococcal (MCV4 / MPSV4)	1	2
	2	5			
	3	6	Human Papillomavirus (HPV9/HPV4/HPV2)	1	3
Tdap	1			2	
<i>Haemophilus Influenzae</i> 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	
	2	4	3		
Pneumococcal Conjugate (PCV7/PCV13)	1	3	<i>Indicate and attach physician diagnosis or laboratory evidence of immunity as applicable</i>		
	2	4	*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.		
Rotavirus (RV1/RV5)	1	3			
	2		Parent/Guardian refused immunizations: <input type="checkbox"/>		
Measles, Mumps, Rubella (MMR)	1	2			
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					
_____			_____		____/____/____
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

_____/_____/_____
Date

Examiner's Name (Print or Type)

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.



Family First Learning Center

3855 S Sheldon Road, Canton, MI 48188

Parent Handbook Agreement

Photography Agreement

1. I/We have received a copy of the Parent Handbook describing the program policies of Family First Learning Center, LLC (available online and in print).
2. I/We have read and agree to comply with the policies contained in the handbook which govern the terms of the child care contract, and have been given an opportunity to ask questions about the content of the handbook.
3. I/We understand that the handbook represents the current policies and procedures of Family First Learning Center, LLC and that it replaces and supersedes any prior policies, procedures, or handbooks.
4. I/We agree to conform to these policies and procedures and understand that these policies and benefits may be amended, modified, terminated or replaced by Family First Learning Center, LLC.
5. I/We understand that and agree that our child may be photographed by staff members and that these photos may be used for any legal purpose including but not limited to: art projects, yearbooks, and graduation materials.
6. I/We agree that photographs both print and digital may be used for advertising purposes including but not limited to: print ads, facebook posts, other social media posts, on our website, and in newsletters (both print and online).

OR We prefer to opt out of our child's image used on social media or advertisements.

Initial here for opt out only: _____

7. I/We understand that parents are permitted to take photos of their children and friends at birthday celebrations and class events. Family First is not responsible for these photographs and does not control their distribution.

Child's Name: _____

Parent/Guardian

Date

Director

Date

PARENT NOTIFICATION OF THE LICENSING NOTEBOOK

Child Care Organizations Act, 1973 Public Act 116

Michigan Department of Licensing and Regulatory Affairs

All child care centers must maintain a licensing notebook which includes all licensing inspection reports, special investigation reports and all related corrective action plans (CAP). The notebook must include all reports issued and CAPs developed on and after May 27, 2010 until the license is closed.

- This 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.

I have read the above statement issued by _____ .
Name of Child Care Center

Child(ren)'s Name(s) _____

Parent Name _____

Parent Signature _____ Date _____

LARA is an equal opportunity employer/program.



Family First Learning Center

3855 S Sheldon Road, Canton, MI 48188

Preschool Contract- Please Print Neatly, see director for assistance

Child's Name: _____

I/We _____ agree to enroll my/our

child _____ in the Family First Learning Center child care program licensed by the state of Michigan as Family First Learning Center II, LLC. We agree that our registration fee of \$25 dollars is nonrefundable.

I/We have received and read the policies developed by Family First Learning Center, LLC and agree to comply with all of the rules, policies and responsibilities stated therein. Family First Learning Center, LLC has reserved the right to modify the rules and policies at its sole discretion with 30 days written notice. Such notice requirements shall not be applicable in the event of emergencies or licensing mandates.

Preschool or child care services will normally begin at _____ and end at _____
On the following days of the week: _____.

I/We agree to pay the provider _____ per week, beginning on _____. This fee does not include meals or snacks. Snacks may be purchased at the rate of \$1 per snack. Meals are not available for purchase. If a meal is forgotten one will be provided at the rate of \$5 per meal. This fee is due by the end of the week. We agree to pay the full and fixed tuition rate regardless of absences. We understand that Family First Learning Center, LLC reserves the right to adjust the fixed preschool and child care tuition with 30 days written notice.

I/We further agree that tuition and fees are to be paid in full on Monday the week that services are rendered. I/We also agree to pay any applicable late payment penalties and late pick up fees established in the parent policy manual. We further agree to pay Provider's reasonable costs of collection on our account, including attorney fees.

I/We acknowledge that Family First Learning Center, LLC will release my child/children to only those persons authorized on the child emergency card. I/We further acknowledge agreement with provider's standard procedures used at the release of children in special circumstances.

Finally, I/we agree that either party may terminate this agreement with 2 weeks written notice. We agree that tuition payment is nonrefundable and will time our withdrawal to

best suit our family circumstances and financial needs. If notice is not given, two week's tuition is due as reasonable compensation, not a penalty.

We also acknowledge that Family First Learning Center, LLC may terminate this agreement without notice if my child's /children's continued participation in the program creates a direct threat to the safety of my child or other children, or Family First Learning Center staff. Or ii) tuition and fees are not paid when due, or iii) Parent engages in inappropriate conduct as defined in the parent handbook, or iv) we are unable to meet the needs of the student within our program with reasonable modifications.

If any provision of this contract, the attached program policies, rules and responsibilities are held invalid or unenforceable, it should be ineffective only to the extent of the invalidity, without effecting or impairing the validity or enforceability of the remainder of the provision or the remaining provisions or intent of this contract. No waiver by the Provider of any right or remedy on one occasion shall be a waiver of that right or remedy on a future occasion.

This contract constitutes the entire agreement among the parties to it and supersedes any prior understandings or agreements. Each party acknowledges and states that no representation, inducement, or condition not set forth in this contract has been made or relied upon by either party.

We have been informed that Family First Learning Center, LLC is a Christian School and we agree that our child will be taught about Jesus in school.

This contract shall be governed by the laws of the state of Michigan.

Parent/Guardian

Date

Parent/Guardian

Date

Director

Date

Family First Learning Center

Summer Contract Addendum

Weekly payment due dates. Tuition is due weekly but payments may be biweekly if more convenient for the family.

Payment Policies:

- Payments are due in full by the first day of class.
- If payment has not been paid the first day of class, attendance will be denied until payment is made.
- In case of a waiting list, the seat will be given up to the next student on the list.

Student Name: _____

2020-2021 Summer Due Dates and Amounts

Weekly Payment Amount: _____ Prorated Amount Week of 6/29 _____

✓	Payment Due Date	Dates Paying For		✓	Payment Due Date	Dates Paying For
	6/1/20	6/1-6/5			7/20/20	7/20-7/24
	6/8/20	6/8-6/12			7/27/20	7/27-7/31
	6/15/20	6/15-6/19			8/3/20	8/3-8/7
	6/22/20	6/22-6/26			8/10/20	8/10-8/14
	6/29/20	6/29-7/2			8/17/20	8/17-8/21
	7/6/20	7/6-7/10			8/24/20	8/24-8/28
	7/13/20	7/13-7/17				

Parent/Guardian

Date

Highlight the weeks registered for (or strikethrough other weeks)