

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 Island Kiddie Kampus , 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.	

BCAL-3731 (Rev. 7-18) Previous edition 6-17 may be used.



Island Kiddie Kampus Enrollment Application



I/We would like to enroll our child/ children for the following dates and times:
(Please indicate drop off and pick up times)

Days	1/2 Days	Full Days
Monday	_____	_____
Tuesday	_____	_____
Wednesday	_____	_____
Thursday	_____	_____
Friday	_____	_____

Father/Guardian Name: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Mother/Guardian Name: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Child's Full Name: _____ Gender: _____ DOB: _____

Child's Full Name: _____ Gender: _____ DOB: _____

Child's Full Name: _____ Gender: _____ DOB: _____

Parent/Guardian Signature

Date

Parent/Guardian Signature

Date

Island Kiddie Kampus is prohibited from discriminating based on gender, race, color, national origin, religion, age, or disability. Island Kiddie Kampus is an equal opportunity provider and employer. To file a complaint of discrimination, write: USDA, Director, Office of Civil Rights, 1400 Independence Avenue SW, Washington D.C. 20250-9410 or call: (800) 795-3272 or (202) 720-5964 (TTY)



Island Kiddie Kampus Child Information Sheets



Child's Name: _____

Age: _____ Gender: _____ DOB: _____

Address: _____

Phone: _____

Father/Guardian Name: _____ SSN: _____

Occupation: _____ Work Phone: _____

Work Address: _____

Mother/Guardian Name: _____ SSN: _____

Occupation: _____ Work Phone: _____

Work Address: _____

Sibling: _____ Age: _____

Sibling: _____ Age: _____

Sibling: _____ Age: _____

Are the Parent's living together? Y / N

Divorced? Y / N Separated? Y / N Deceased? Y / N

Are other persons or relations living with the family?

How does your child relate to authority?

How does your child relate to his or her siblings?

How does your child relate to his or her peers?

Please describe your child's home and neighborhood play situations.

Does your child have any fears or anxieties?

Does your child get into conflicts? If so, how do they handle them?

How does your child adjust to new situations?

Does your child require special medications?

Does your child have any eating restrictions or allergies?

Does your child have any speech or hearing difficulties?

Are there any particular areas where your child may need help?

Does your child display particular problems, fears, or nervous habits?

How would you rate your child's social growth?

Does your child have any special interests?

When was your child toilet trained?

What time does your child go to bed?

What bedtime routines does your child follow?

Does your child exhibit any sleeping problems?

How many hours per day does your child interact with electronics?

What are his or her favorite shows?

What are your goals in bringing up your child/ children?

How do you handle discipline?

What do you hope your child will gain from this school experience?

Do you have any previous childcare experience? Where and When?

Who referred you to Island Kiddie Kampus?

Parent/Guardian Signature

Date

Parent/Guardian Signature

Date

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	Reading: _____			
<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	3
DTaP/DTP/DT/Td	1	4	Influenza (IIV/LAIV)	1	4
	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	OTHER Vaccines Specify Date & Type	Type of Vaccine(s)	Date of Vaccine(s)
	2	4		1	
Polio (IPV/OPV)	1	3		2	
Pneumococcal Conjugate (PCV7/PCV13)	1	3	3		
	2	4	<i>Indicate and attach physician diagnosis or laboratory evidence of immunity as applicable</i>		
Rotavirus (RV1/RV5)	1	3	*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.		
	2				
Measles, Mumps, Rubella (MMR)	1	2	Parent/Guardian refused immunizations: <input type="checkbox"/>		
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

_____ 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.

MEDICATION PERMISSION AND INSTRUCTIONS

CHILD CARE HOMES AND CENTERS

Department of Licensing and Regulatory Affairs

Child Care Licensing Bureau

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 _____ **Island Kiddie Kampus** _____ 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.

LARA is an equal opportunity employer/program.

TO BE COMPLETED BY THE CAREGIVER GIVING MEDICATION:

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



Health Insurance Information

Primary Insurance

Name of Insurance: _____

Name of Policyholder: _____

Policy Number: _____

Group Number: _____

SSN: _____

Employer's Name: _____

Secondary Insurance

Name of Insurance: _____

Name of Policyholder: _____

Policy Number: _____

Group Number: _____

SSN: _____

Employer's Name: _____

PLEASE PRESENT YOU INSURANCE CARD FOR VERIFICATION

Medication

Medication can only be given under the following circumstances:

- A medication form must be filled out by the parent. A copy of this form is attached to this handbook.
- Prescription medication must be in the original container with the doctor's name, child's name, instructions, name and strength of the medicine. The medicine will be given according to those instructions. The medicine must be in an unopened container. Thus, you need to tell the pharmacist your child is in day care and you need the dose split.
- Staff members cannot give the first dose due to possible allergic reactions.
- Children cannot bring any medication into the school. All medication must be brought into the school by an adult. This is for the safety of all the children at the center.

When your child should stay home

For the protection of all the children, parents should exercise every caution and keep their child at home if they show the following or unusual symptoms:

- Temperature (99°F or higher) — your child must be fever free without medication for 24 hours upon returning to school. therefore, if your child is sent home from school with a temperature, he or she may not return to school the next day. They must be fever free for 24 hours.
- Diarrhea or vomiting
- Rash
- Nasal, eyes or ears discharge

If the child has been exposed to a contagious disease, please inform the staff. However, if your child shows any signs of a contagious disease, the child must be kept home and the center notified immediately.

Measles, rubella, German Measles, mumps, hepatitis, scarlet fever, strep throat, conjunctivitis, scabies, pertussis (whooping cough), encephalitis and meningitis are among the contagious diseases which must be reported to the Health Department. Therefore, we are required to ask the reason for your child's absence. Physician's permission may be required before the child can return to school.

Parent Signature

Date

Island Kiddie Kampus Child Care Contract

I/We _____ agree to enroll our child/children
_____ at Island Kiddie Kampus Child
Development Center, Inc., which is licensed by the State of Michigan. I/We agree that our registration fee
of \$105.00 for one child or \$121.00 for a family is non-refundable.

I/We have received and read the attached policies developed by Island Kiddie Kampus and
agree to comply with all the rules, policies, and responsibilities stated therein. Island Kiddie Kampus 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.

Child care services will begin at _____ and end at _____ on the following circled days:

Monday Tuesday Wednesday Thursday Friday

I/We agree to pay Island Kiddie Kampus \$_____ per month. I/We agree to pay the
full fixed monthly rate regardless of absences. I/We understand that Island Kiddie Kampus reserves the
right to adjust the fixed monthly child care rate with 30 days written notice. We also understand that an
annual 10% tuition increase will occur in September.

I/We further agree that the child care fees are to be paid in full on the
_____ of the month in which services are rendered. I/We also agree to pay any
applicable late payment penalties and late pick-up fees established in the Parent Handbook.

I/We acknowledge that Island Kiddie Kampus will release (child's name)
_____ to only those persons authorized on the Child Information Record (BCAL 3731). I/
We further acknowledge agreement with Island Kiddie Kampus standard procedures used to release
children in special circumstances.

Finally, I/We agree that either party may terminate this agreement with two (2) weeks
written notice. If we do not provide two (2) weeks written notice of withdrawal, we agree to pay Island
Kiddie Kampus an amount equal to two (2) weeks of childcare fees. I/We also acknowledge that Island
Kiddie Kampus may terminate this agreement without notice if (child's name)
_____ 's continued participation in the program creates a direct threat to the safety
of (child's name) _____, other children and/or Island Kiddie Kampus Staff.

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

Parent/Guardian Signature

Date signed

Parent/Guardian Signature

Date signed

Island Kiddie Kampus Signature

Date signed

Island Kiddie Kampus Attendance Policy and Vacation Days

Attendance Policy

Our program is a licensed center and we are required to have staff available for the number of children enrolled. Program costs are based on your child's **EXPECTED** attendance, therefore there are **NO** credits or refunds. If extra are needed, you **MUST** give advance notice to the **OFFICE**.

No days are to be exchanged for another. If you bring your child in without permission from the office, **YOU WILL BE CHARGED THE DAILY RATE, PLUS AN ADDITIONAL CHARGE OF \$50.00 PER CHILD.**

Vacation Days

A vacation credit will be given according to your child's attendance schedule. Vacation credits are only given when your child is registered for a year (consecutive 12 month period). Vacation credits will not exceed what is stated below.

A two-week notice is required to receive the credit. Vacation credits will not be given without the two-week notice.

Vacation credits cannot be used while your child is in attendance.

Parents, please do not deduct vacation days from your tuition payment. The vacation credits will be processed to your account the following month by Island Kiddie Kampus.

The following are the vacations days given with a year-round attendance (consecutive 12 month attendance). Credits do not extend to accommodate your actual vacation.

<u>Attendance Schedule</u>		<u>Vacation Credits</u>
2 days a week	=	4 days vacation credit
3 days a week	=	6 days vacation credit
4 days a week	=	8 days vacation credit
5 days a week	=	10 days vacation credit

By signing below, I (parent printed name) _____
have reviewed and understand the information regarding Attendance and Vacation Days.

Parent Signature

Date

Staff Signature

Date



Island Kiddie Kampus Brightwheel

Our program has partnered with brightwheel, the leading early education app, for parent communication, tuition billing, and more. It is highly reviewed, secure, and commended for its ease-of-use. We're excited for you to see what it's all about!

Soon, you'll receive an email or text invitation from brightwheel to connect to your child's profile. Simply click the link in the brightwheel message to finish creating your account. If you already have a brightwheel account, it will automatically link to our program when you click the invite link.

Every user with a brightwheel account has a check-in code assigned to them upon the account's creation. These codes can be modified by the user and should not be shared.

The code is located either at the bottom of the screen when opening the app (Android) or within the personal profile section (Apple).

Sign-in/ out procedure

1. Open the brightwheel app and tap "Check in/out"
2. Give the app permission to use your camera (if not done already)
3. Scan the QR code (these are located at the front entrance and by each of the classroom doors)
4. Tap the "Check in/out" by your child/children's names.
5. Tap "Done" then enter your 4-digit code on your phone.

Your child/children must be signed in and out every day of attendance as mandated by the State of Michigan. If you fail to check the child/children in or out, a \$5.00 fee will be charged to your account for each instance the child has not been signed in or out.

Food Agreement

Infant Food Agreement

I/We choose to provide all food and beverages for my infant (ages birth to 12 months). It will be appropriate for their individual nutritional requirements, developmental stages and special dietary needs, including cultural preferences in accordance with this food agreement and the Center's food policy.

- Formula shall be furnished daily to the Center in clean, sanitary, ready-to-feed single-serve assembled bottles.
- Formula shall be iron-fortified for a child less than 6 months of age, unless instructed otherwise by a licensed health care provider.
- Iron-fortified cereal, if not already provided by 6 months of age, shall be provided when the iron-fortified formula is discontinued, unless instructed otherwise by a licensed health care provider.
- Formula and food shall be covered and labeled as to the contents, date, date of opening (when applicable) and the name of the child it is to be used for.
- The Center will support and accommodate breastfeeding.
- Expressed breast milk shall arrive at the Center in clean, sanitary, ready to feed, single-serving, assembled bottles labeled with the child's full name and bearing the date of collection.

Parent's Signature: _____ Date: _____

Toddler Food Agreement

I/We choose to provide all food and beverages for child (ages 12 months to 29 months). It will be appropriate for their individual nutritional requirements, developmental stages and special dietary needs, including cultural preferences, in accordance with this food agreement and the Center's food policy.

I/We will provide whole homogenized vitamin-D fortified cow's milk, unless written authorizations provided by the child's licensed health care provider.

I/ We realize that I may request that they join the food program as long as I/We sign off on the breakfast and snacks provided. I/We realize that the Center will not introduce a food to a child for the first time.

Parent's Signature: _____ Date: _____

Lunch Food Agreement

I/We choose to provide all food and beverages for my child's lunch, if in attendance during that time. It will be appropriate for the individual, nutritional requirements, developmental stages and special dietary needs, including cultural preferences, in accordance with this food agreement and the Center's food policy. Meals will meet the minimum meal requirements of the child and adult food care program as administered by the State Department. A copy is available in the Office.

Parent's Signature: _____ Date: _____

Snack/Lunch

Nutritious snacks will be provided for the children by Island Kiddie Kampus in the morning and afternoon.

Lunch is to be provided by the Parents. Please remember to keep the portions child-sized and nutritious. Lunch must meet the State Nutritional Guidelines. We discuss good nutrition in our programs. Some foods may NOT be allowed in the classrooms because of food allergies. If applicable, a list with these food items will be posted outside of your child's classroom. All lunches must be READY-TO-EAT. We are unable to prepare Easy-Mac or other similar foods.

Bottles are warmed in a bottle warmer and food is warmed in a microwave. All items will be tested for a safe temperature before feeding. Bottles will never be propped or used in or on sleeping equipment. caregivers shall hold the infant's bottle unless they are able to hold their own bottle. After a bottle is warmed, the time between feeding and discarding unused portions is never more than one hour. Food will be served from a dish, not from the factory sealed container.

Parent's Signature: _____ Date: _____

Release Form

I hereby irrevocably grant Shirley Mohny and Island Kiddie Kampus Child Development Center, Inc. the right (but not the obligation), in all media, now and hereafter known, to use (in any manner she deems appropriate, and without limitation) in connection with Island Kiddie Kampus Child Development Center, Inc. by whatever means exhibited, advertised, my, my child's/children's and/or my Spouse's appearance, still photographs, recordings of our voices taken or made of us by Island Kiddie Kampus Child Development Center, Inc and use of our actual or fictitious names. We will not be paid or otherwise reimbursed for said use.

On my own behalf, and on the behalf of my heirs, next of kin, executors, administrators, successors and assigns, I hereby release Shirley Mohny, her agents, licensees, successors and assigns, from any and all claims, liabilities and damages arising out of the rights granted hereunder, or exercise thereof.

I authorize Shirley Mohny and Island Kiddie Kampus Child Development Center, Inc. to use our images, sounds in any medium extant or later invented. She may also choose not to use these images, sounds as needed.

Date: _____

Your Printed Name: _____

Spouse's Printed Name: _____

Your Child's/Children's Printed Name(s):

Your Signature: _____

Spouse's Signature: _____

Street Address: _____

City, State and Zip Code: _____

Phone Number: _____

email: _____

Sun Safety Permission Form

Please provide the following materials and give our staff permission to use the indicated measures to help your child stay safe in the Sun while in our care.

I _____
Parent/Guardian

agree to supply the following for my child: _____

1. Parents/Guardians should provide Broad-Spectrum (UVA and UVB), PABA free sunscreen, SPF 15 or greater, that is not an aerosol or spray (required).
2. Wide-brimmed (+/- 3" brim) hat that shades the face, ears and neck (preferred).
3. Child-sized sunglasses, polycarbonate or impact-resistant, labeled with 99% to 100% UV lens protection or prescription glasses with UV protective coating (preferred).
4. lip balm with SPF 15 or greater (preferred).
5. Light-colored, light-weight, tightly woven, long-sleeved shirts and long pants (preferred).

I give permission for my child to receive applications of sunscreen following the manufacturer's instructions.

I understand that sunscreen will be applied 15 to 30 minutes before going outside and every two (2) hours as recommended by the manufacturer.

Parent/Guardian (printed name)

Parent/Guardian (signature)

Date

Sun Safety permission form shall remain in effect unless Shirley Mohney, Owner, receives written changes.



Island Kiddie Kampus Handbook Acknowledgement

I have received a copy of the Island Kiddie Kampus Parent Handbook.

Child's name: _____

Child's name: _____

Parent's name: _____

Parent's Signature: _____

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 Island Kiddie Kampus .
Name of Child Care Center

Child(ren)'s Name(s) _____

Parent Name _____

Parent Signature _____ Date _____

LARA is an equal opportunity employer/program.