PattiCake's Early Learning Center

Prior to registration for enrollment, please submit the following forms...

- CHILD INFORMATION RECORD
- HEALTH APPRAISAL (WITHIN 30 DAYS OF ENROLLMENT)
- SHOT RECORD
- IMMUNIZATION WAIVER FORM (IF APPLICABLE)
- SCHOOL AGE SIGN OFF FORM (IF APPLICABLE)
- ENROLLMENT AGREEMENT FORM
- FIELD TRIP POLICY/ AGREEMENT FORM
- MEDICINE/OINTMENTS ADMINISTER FORM
- INFORMATION PACKET FORM
- PHOTO RELEASE WAIVER FORM
- RECEIVED PARENT HANDBOOK ELECTRONICALLY _____

INITIALS DATE

- NON-REFUNDABLE **ANNUAL** REGISTRATION FEE $100.00 (PER CHILD)
- COPY OF PARENT/GUARDIAN IDENTIFICATION
- FOOD PROGRAM ELIBILITY FORMS
- TUITION CONTRACT
- CO PAYMENT AGREEMENT FORM
- CHILD PICK UP AUTHORIZATION FORM
- PARENT PARTICIPATION FORM

DHHS CLIENTS

• CDC PROVIDERS VERIFICATION FORM (TO BE FILLED OUT BY CENTER)

NOTE: PATTICAKES EARLY LEARNING CENTER **MUST RECEIVE A AUTHORIZATION LETTER**, BEFORE CHILD CAN START, HOWEVER THE PARENT/ GUARDIAN CAN CHOOSE TO PAY OUT OF POCKET TUITION

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 _____, 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 Revie wed	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 6-17may be used.

Medical Information

Child's name	Birth date

Child's Medical Care Provider

Primary physician's name	Primary physician's practice name		Phone
Physician's practice address	**City**	**State**	**Zip**
Preferred hospital/clinic for emergency care	**City**		**State**
Dentist's name	**Dentist's practice name**		**Phone**
Dentist's practice address	**City**	**State**	**Zip**

Child's Insurance Provider

Child's health insurance provider name	Policy number	Secondary health insurance provider name	Policy number

Child's Immunization History *(please attach a copy of your child's immunization records)*

Below is a list of immunizations that your child may have received. Immunizations in bold are required by our state. **[Check with your state requirements. You may do this at http://www.immunize.org/states/ Bold any immunization below that is a requirement.]**

Smallpox	Influenza	**Pneumococcal disease**	Anthrax
Tetanus	Lyme Disease	**Polio**	**Diphtheria**
Tuberculosis	**Measles**	Rabies	**Haemophilus Influenzae type b (Hib)**
Typhoid Fever	Meningococcal disease	Rotavirus	Hepatitis A
Varicella (Chickenpox)	**Mumps**	**Rubella**	**Hepatitis B**
Yellow Fever	**Pertussis (Whooping Cough)**	Shingles (Herpes Zoster)	Human Papillomavirus (HPV)

Additional Medical Policies

	Initial
1. Prior to enrollment, I must provide the center with updated medical and immunization information for my child. This information is to be kept current and updated in accordance with state childcare regulations.	
2. I agree to provide information to the childcare center about my child's conditions, illnesses, allergies or other needs.	
3. If my child becomes ill with a reportable contagious disease, I understand that he/she will not be able to return until I bring in a physician's note stating that he/she is no longer contagious.	
4. If my child becomes ill during his/her time at the childcare center, the staff will contact me to pick up my child. I will arrange for pick up as soon as possible and no later than 2 hours after being contacted. If I cannot be reached, the staff will contact those listed in the *Child Emergency Contact and Release*.	

Emergency Medical Authorization & Consent

	Initial
In case of a medical emergency, the staff will attempt to contact me, those listed in the *Child Emergency Contact and Release*, and lastly my physician.	
In case of a medical emergency, I agree that my child may receive first aid and/or CPR.	
In case of a medical emergency, I permit the transportation of my child to a local hospital or other urgent care facility, if necessary, by paramedics or other emergency personnel.	
In case of a medical emergency, I will be responsible for the emergency medical expenses.	
In case of an accidental ingestion of a poisonous substance, I consent to my child being treated as directed by the Poison Control Center.	

	Initial
I give my permission to this center to apply □ sunscreen and □ insect repellant to my child. *Please check which products you will permit.*	
I understand that I must supply my own sunscreen and/or insect repellant with a valid expiration date, and it will be labeled with my child's name.	
I □ have □ do not have special instructions for the application process. _____	

Parent initial _____ Staff initial _____ Date _____

Rate Agreement and Contract

Child's name	Birth date

Hours of Operation

Regular operating hours are (6:30am -6pm). **Current hours are 7am- 5:30pm** except closings for various holidays until further notice, and inclement weather as described in the Family Handbook. Please consult the current calendar for holidays. There is no reduction in tuition as a result of center closures.

The procedure to notify families should severely weather or other conditions prevent the program from opening on time or at all will be announced on **(WDIV Detroit, *Channel 7***). If it becomes necessary to close early, we will contact you or someone listed in the *Emergency Contact and Release*, and it will be your responsibility to arrange for your child's early pick up.

Scheduled Attendance

The days and hours that I wish to contract for childcare are as follows:

Day of week	Start time	AM/PM	End time	AM/PM	Comments
Monday					
Tuesday					
Wednesday					
Thursday					
Friday					

I would prefer to make tuition payments on a □ weekly □ bi-weekly □ monthly basis.

Fee Policy (to be completed by staff; reviewed and initialed by the parent/guardian/sponsor after completion)

	Initial
- Starting on _____ a fee of $_____ is due □ weekly. □ bi-weekly. □ monthly.	
- Tuition is due and payable by □ Every Monday no later Friday at 5:00p.m.. □ the 1st and 15th of the month or next business day. □ first business day of the month.	
- Tuition is not subject to discounts for holidays, emergency closures (i.e., weather or pandemic), or absence other than hospitalization, or absence at the request of a doctor (a written doctor's note is required to receive credit).	
- I agree to pay the full tuition in advance of services rendered.	
- I agree to pay the full tuition fee even if my child is absent for one or more days.	
- A late fee of **$25** is due if tuition is not received on time.	
- A non-refundable registration fee of **$50** is due yearly.	
- A late pick-up fee of **$1 per minute per child** (not to exceed **$30** per child) is due if my child is not picked up before closing.	
- Accounts two weeks in arrears may result in immediate termination of service.	
- My child may have the opportunity to participate in a special program or field trip that may have an additional fee due before the day of the event. A specific permission slip may be required.	
- All returned checks or ACH transactions (automatic debits) will be charged a fee of **$35**. Two or more returned checks or ACH transactions will result in my account being placed on "money order only" status.	
- A **two(2)-week written notice** is required for any child being withdrawn from the program. Failure to provide notice in writing will result in forfeiture of deposit.	
- A receipt for income tax purposes □ will □ will not be provided. Also available on BrightWheel.	

Other Agreements

PrivateEmploymentAcknowledgement and Release

	Initial
Any arrangement/employment between me and staff of this center (i.e., babysitting), outside of the programs and services offered by this center, is an individual endeavor and private matter not connected to or sanctioned by this center. This center shall remain harmless from any such arrangement.	

Media Release

	Initial
Occasionally, photos will be taken of the children at the center for use within the center or on our website and/or newsletters. Please indicate that you authorize the use and reproduction of photographs of your child in conjunction with the program.	

Parent initial _____ Staff initial _____ Date _____

Other Agreements *(continued)*

Child's name	Birth date

Walking Excursions

	Initial
I give my permission for my child to participate in supervised walking excursions near and around the center.	

Handbook Acknowledgement

	Initial
I understand and agree that it is my responsibility to read and familiarize myself with policies and procedures outlined in the Family Handbook and agree to abide by them.	
I understand that it is my responsibility to go directly to management with any questions I may have regarding the policies and procedures and information contained in this Enrollment Agreement.	
Information contained in the Family Handbook may be subject to change.	

Contract Approval

I certify that I have read, understand, and accept all of the terms and conditions described in this *Enrollment Agreement*.

Primary Parent/Guardian/Sponsor Signature	Date	Center Staff Signature	Date

MDHHS-3305, HEALTH APPRAISAL

Michigan Department of Health and HumanS ervices (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, ZipCode)	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)	

Reasonfor 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

EssentialFindingsDeviatingfromNormal	Exam Date

SECTION 4 – IMMUNIZATIONS

Statementssuchas"UP-TO-DATE" or "COMPLETE" will not be accepted. Admission to school may be deniedbasedonthisinformation. *

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.		
Haemophilus Influenzae 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.

Return this completed form to: PattiCake's Early Learning Center 22420 Fenkell Ave, Detroit, MI 48223 313-378-4313

Participant Enrollment Form

Instructions:

1. List full name of participant enrolled in care
2. Circle the typical days each participant is in care
3. List times each participant is in care
4. Circle the meals and snacks each participant typically receives while in care
5. Select the ethnicity of each participant using the following codes: H = Hispanic or Latino, N = Not Hispanic or Latino*
6. Select one or more racial designations of each participant using the following codes: A/I = American Indian or Alaskan Native, A = Asian, B = Black or African American, H/PI = Native Hawaiian or Pacific Islander, W = White*
7. Sign and date the form and return to your care center

Participant's First and Last Name	Typical Days in Care (circle all that apply)	List Times in Care	Meals/Snacks Received (circle all that apply)	Ethnicity	Race
	Mon Tues Wed Thu Fri Sat Sun		Breakfast AM Snack Lunch PM Snack Supper Evening Snack		
	Mon Tues Wed Thu Fri Sat Sun		Breakfast AM Snack Lunch PM Snack Supper Evening Snack		
	Mon Tues Wed Thu Fri Sat Sun		Breakfast AM Snack Lunch PM Snack Supper Evening Snack		
	Mon Tues Wed Thu Fri Sat Sun		Breakfast AM Snack Lunch PM Snack Supper Evening Snack		

*This information is voluntary. This will assist us in assuring the Child and Adult Care Food Program is administered in a nondiscriminatory manner.

_____ Adult/Parent/Guardian's Address

_____ Adult/Parent/Guardian's Phone Number

_____ Signature of Adult/Parent/Guardian

_____ Date Signed

Non-Discrimination Statement

In accordance with Federal civil rights law and U.S. Department of Agriculture (USDA) civil rights regulations and policies, the USDA, its Agencies, offices, and employees, and institutions participating in or administering USDA programs are prohibited from discriminating based on race, color, national origin, sex, disability, age, or reprisal or retaliation for prior civil rights activity in any program or activity conducted or funded by USDA. Persons with disabilities who require alternative means of communication for program information (e.g. Braille, large print, audiotape, American Sign Language, etc.), should contact the Agency (State or local) where they applied for benefits. Individuals who are deaf, hard of hearing or have speech disabilities may contact USDA through the Federal Relay Service at 800-877-8339. Additionally, program information may be made available in languages other than English.

To file a program complaint of discrimination, complete the USDA Program Discrimination Complaint Form, (AD-3027) (http://www.ascr.usda.gov/complaint_filing_cust.html) online, and at any USDA office, or write a letter addressed to USDA and provide in the letter all of the information requested in the form. To request a copy of the complaint form, call 866-632-9992. Submit your completed form or letter to USDA by: (1) mail: U.S. Department of Agriculture, Office of the Assistant Secretary for Civil Rights, 1400 Independence Avenue, SW, Washington, D.C. 20250-9410; (2) fax: 202-690-7442; or (3) email: program.intake@usda.gov. This institution is an equal opportunity provider.

MICHIGAN Department of Education

Return this completed form to: PattiCake's Early Learning Center 22420 Fenkell Ave, Detroit, MI 48223 313-378-4313

Household Income Eligibility Statement – Child Care Institutions

Part 1 – Households Receiving Food Assistance Program (FAP), Family Independence Program (FIP), or Food Distribution Program on Indian Reservations (FDPIR)

If any member of your household receives FAP, FIP, or FDPIR, provide the name and case number for the person who receives the benefits.

Name:_____ **Case Number:** _____

Part 2 – Household Information

						How Often? (x)						How Often? (x)						How Often? (x)					
First and Last Names of All Household Members, Related and Unrelated	Enrolled for Child Care (x)	Age	Birth Date	Foster Child (x)	Amount of Earnings from Work (before deductions)	Annually	Monthly	2xMonth	BiWeekly	Weekly	Amount of Welfare, Child Support, or Alimony	Annually	Monthly	2xMonth	BiWeekly	Weekly	Amount of All Other Income (Indicate source and amount)	Annually	Monthly	2xMonth	BiWeekly	Weekly	Mark if No Income (x)

Part 3 – All Households: Signature and Last Four (4) Digits of Adult Social Security Number (Adult household member MUST sign and date)

I certify that all information on this form is true and that all income is reported. I understand that the center or day care home will receive federal funds based on the information I give. I understand that CACFP officials may verify the information. I understand that if I purposely give false information, the participant receiving meals may lose the meal benefits, and I may be prosecuted.

Signature:_____ Print Name:_____ Date:_____

Last four digits of Social Security Number: XXX-XX-____ I do not have a Social Security Number

For Institution Use Only:

For Institution Use Only		
Total Household Members:	Total Income: $ ___ Annually ___ Monthly ___ 2x Month ___ Bi-Weekly ___ Weekly	APPROVED CATEGORY Categorical Eligibility (A/Free): Foster FIP FAP FDPIR Other Household Children: A (Free) B (Reduced) C (Paid)
Institution Official Signature: _____ Approval Date: _____		

This form is valid for 12 months from the date of institution signature. Approval date and institution signature are required.

Privacy Act Statement
The Richard B. Russell National School Lunch Act requires the information on this application. You do not have to give the information, but if you do not, we cannot approve the participant for free or reduced-price meals. You must include the last four digits of the Social Security Number of the adult household member who signs the application. The Social Security Number is not required when you apply on behalf of a foster child or you list a Food Assistance Program (FAP), Family Independence Program (FIP), or Food Distribution Program on Indian Reservations (FDPIR) case number for the participant or other FDPIR identifier or when you indicate that the adult household member signing the application does not have a Social Security Number. We will use your information to determine if the participant is eligible for free or reduced-price meals, and for administration and enforcement of the Program.

USDA Nondiscrimination Statement
In accordance with federal civil rights law and U.S. Department of Agriculture (USDA) civil rights regulations and policies, this institution is prohibited from discriminating on the basis of race, color, national origin, sex (including gender identity and sexual orientation), disability, age, or reprisal or retaliation for prior civil rights activity.

Program information may be made available in languages other than English. Persons with disabilities who require alternative means of communication to obtain program information (e.g., Braille, large print, audiotape, American Sign Language), should contact the responsible state or local agency that administers the program or USDA's TARGET Center at (202) 720-2600 (voice and TTY) or contact USDA through the Federal Relay Service at (800) 877-8339.

To file a program discrimination complaint, a Complainant should complete a Form AD-3027, USDA Program Discrimination Complaint Form which can be obtained online at: USDA Program Discrimination Complaint Form, from any USDA office, by calling (866) 632-9992, or by writing a letter addressed to USDA. The letter must contain the complainant's name, address, telephone number, and a written description of the alleged discriminatory action in sufficient detail to inform the Assistant Secretary for Civil Rights (ASCR) about the nature and date of an alleged civil rights violation. The completed AD-3027 form or letter must be submitted to USDA by: 1. **mail:** U.S. Department of Agriculture, Office of the Assistant Secretary for Civil Rights, 1400 Independence Avenue, SW, Washington, D.C. 20250-9410; or 2. **fax:** (833) 256-1665 or (202) 690-7442; or **email:** program.intake@usda.gov

This institution is an equal opportunity provider.

USDA Civil Rights Complaint Link:
https://www.usda.gov/sites/default/files/documents/USDA-OASCR%20P-Complaint-Form-0508-0002-508-11-28-17Fax2Mail.pdf

Photo Release Form

Dear Parents,

Your child will be participating in variois activities, events, and fun learning experiences while attending our center. We often take photos to post in the classroom, use for crafts or to share them on our Facebook page.

Social media is a great way to keep you updated on important events and center information while allowing you to see the fun experiences your child is enjoying. Be sure and follow us on our social media platforms.

Please indicate below if you give us permission to use your child's photos.

___I GIVE permission to take and use my child's photos for reasons
listed above.

___I DO NOT give permission to take and use my child's photos for reasons listed above.

Student's Full Name _____

Parent's Signature _____

Date _____

Child Pick-Up Authorization

Name ofChild/Children:_____

The following people listed below are authorized to pick up the above named child(ren) at any time from PattiCake's Early Learning Center.

I authorize _PattiCake's Early Learning Center, to release my child(ren) into the care of the following people whenever they come to pick-up at the center.

Authorized Pick-Up Person

	Name	*Relationship to Child	Address	Phone
1.				
2.				
3.				
4.				

I understand that:

- ☐ The "Authorized Pick-Up Person" must be at least 18 years old and may be asked to provide a photo ID to the staff. (abbreviate ex. GM (grandmother)
- ☐ This authorization shall remain in force until edited or rescinded in writing by the signers of this authorization.

Authorized by:

Parent/Guardian Signature:_____

Date:_____

Field Trip Policy & Agreement

Purpose

To outline the procedures and expectations for participation in program-sponsored field trips, ensuring safety, organization, and fairness for all participants.

Scope

This policy applies to all families, children, staff, and approved attendees of [Center Name] field trips.

1. Registration & Payment

- All field trip tickets must be purchased by the stated deadline - NO exceptions.
- Payment for field trips is NON-REFUNDABLE, regardless of attendance or cancellation.
- Tickets will only be issued upon full payment.

2. Attendance Eligibility

- Only parents/guardians (adults) and siblings of enrolled children may attend.
- No additional extended family members, friends, or guests are permitted unless pre-approved by administration.

3. Transportation

- Families may choose to ride the bus with the group or travel separately.
- Those NOT riding or following the bus must purchase their own tickets directly at the venue's ticket window and will be responsible for all transportation and parking arrangements.

4. Safety & Supervision

- Parents/guardians are responsible for supervising their child(ren) during the entire field trip.
- All participants must follow staff instructions and venue rules to ensure safety and a positive experience for everyone.

5. Final Confirmation

- No late payments, registrations, or ticket purchases will be accepted.
- The program is not responsible for lost tickets or missed events due to late arrival.

Field Trip Policy Acknowledgement & Signature

I have read and understand the Field Trip Policy provided by [Center Name]. I agree to follow all guidelines stated in the policy, including payment deadlines, eligibility rules, transportation guidelines, and supervision requirements.

I understand that all field trip payments are non-refundable and that tickets must be purchased by the stated deadline with no exceptions.

Parent/Guardian Name: _____

Signature: _____

Date: _____

PattiCake's Early Learning Center

Food From Home Agreement

Child's Name: _____

Parent/Guardian Name: _____

PattiCake's Early Learning Center is not enrolled in CACFP. Parents are required to provide a daily packed lunch for their child.

By signing this agreement, I understand:

- I must provide a nutritious lunch each day.
- Candy, soda, and fast food are not allowed.
- The center provides morning and afternoon snacks.
- PattiCake's ELC is a peanut-sensitive center, and peanut products may only be brought with prior Director approval.
- All food containers must be labeled with my child's name.

Parent/Guardian Signature: _____ Date: _____

Director Signature: _____ Date: _____

PattiCake's Early Learning Center

Parent Participation Form

Child's Name: _____

Parent/Guardian Name: _____

At PattiCake's, we believe families are partners in every child's success.

By signing this form, I agree to:

- Support my child's consistent attendance and timely arrival.
- Participate in at least two center events per year (family nights, field trips, holiday programs, etc.).
- Attend scheduled conferences with my child's teacher(s).
- Maintain open communication with staff regarding my child's progress, needs, and family updates.

Parent/Guardian Signature: _____ Date: _____

Director Signature: _____ Date: _____

PattiCake's Early Learning Center

Tuition Contract

Child's Name: _____

Parent/Guardian Name: _____

I understand and agree to the following tuition policies:

- Tuition is due weekly, by Friday for the upcoming week.
- A $35 late fee applies if tuition is not received by Monday morning.
- A $35 returned check fee applies. After two returned checks, future payments must be by money order or cash.
- Tuition is due regardless of absences, holidays, or closures (except for one vacation week per year).
- A late pick-up fee of $15 for the first 15 minutes, and $1 for each additional minute will be charged if my child is picked up after 6 PM.

I agree to abide by this financial agreement to maintain my child's enrollment at PattiCake's ELC.

Parent/Guardian Signature: _____ Date: _____

Director Signature: _____ Date: _____

PattiCake's EARLY LEARNING CENTER

We're excited to provide you with quick access to our **Parent Handbook!**

Scan the QR code below to view important policies, procedures, and resources at your convenience.

Note - If any discrepancy arises between this handbook and the Enrollment Agreement, the Enrollment Agreement supersedes.

Please request a new copy of this Handbook every August, when it will be updated.

I have completely read and understand the Operational Policies and Procedures of PattiCake's Early Learning Center. By signing this form, I agree to abide by all policies and procedures located In this Handbook. I also agree that I have been given a copy of the Operational Policies and Procedures Family Handbook, and a copy of this signature page has been placed in my child's

Child's Name: _____

Parent / Guardian Name: _____

Parent / Gaurdian Signature: _____

Date: _____

Office Staff Signature: _____

Date: _____

WRITTEN INFORMATION PACKET DOCUMENTATION

MichiganDepartmentof Licensing andRegulatoryAffairs
Child Care Licensing Bureau

Child(ren)'sName(s)(Last,First)	Facility's Name and License Number PattiCake's Early Learning Center DC820412337

Awritteninformationpackethasbeen provided at the time of enrollment. The packet included all the following information *(R 400.8146 (1-2)):*

- Criteriaforadmissionandwithdrawal.
- Scheduleofoperation,denoting hours, days, and holidays during which the center is open, and services are provided.
- Feepolicy.
- Discipline policy.
- Food service program.
- Program philosophy.
- Typicaldaily routine.
- Parentnotificationplanforaccidents, injuries, incidents, and illnesses.
- Transportationpolicy,ifapplicable.
- Medication policy.
- Exclusionpolicyforchildillnesses.
- Noticeoftheavailabilityofthecenter's licensing notebook. (CENTER MUST CHECK ONE)

  ☐ Thecenterkeepsalicensing notebook containing a summary sheet, all licensing inspections and special investigationreports,andrelated corrective action plans for the last 5 years. The licensing notebook is availabletoparents/guardians during regular business hours. Reports from at least the past three years are availableatwww.michigan.gov/michildcare.

  ☐ Thecenterdoesnotkeep a licensing notebook, but internet is available onsite. Reports from at least the lastthreeyearsareavailable at www.michigan.gov/michildcare.

- Other _____

IcertifythatIreceivedalloftheabove items.

_____ _____

Parent/Guardian Signature **Date**

Note: Asingle CCL-4340 form may beused for all children in the same family.

LARA is an equal opportunity employer/program.