STUDENT NAME:____

PRESCHOOL REQUIRED FORMS CHECKLIST

(All items below must be turned in to the Elementary Office by the first day of school.)

DISTRICT REQUIREMENTS

☐ District Acknowledgement Form for the following policies:

- Acceptable Use, Social Media & Communication Policy
- Concussion Fact Sheet
- Muskegon Catholic Communication Agreement
- Spectator Code of Conduct

OFFICE REQUIREMENTS

☐ Birth Certificate (copy)
☐ Immunization Record (from doctor's office)
☐ Consent for Disclosures of Immunizations
☐ Background Check for Volunteers - VIRTUS Information
☐ Asthma Management Plan (if applicable)

STATE REQUIREMENTS

☐ BCAL 3305 - Health Appraisal (to be completed and signed by both parent and doctor)
☐ BCAL-3731 Child Information Record
☐ Health Records Confirmation
☐ BCAL 5053 Licensing Notebook Signature Page
☐ BCAL-4340 Written Information Documentation
☐ Preschool Handbook Signature Page
☐ BCAL 1243 - Medication Permission and Instructions Form (if applicable)

TEACHER REQUIREMENTS

☐ Pre-K Information Sheet
☐ How I Get Home Transportation Form

MUSKEGON CATHOLIC CENTRAL ELEMENTARY SCHOOL

Consent for Disclosure of Immunization Information to Local and State Health Departments

Immunizations are an important part of keeping our children healthy. Schools and State and Local health departments must monitor immunization levels to ensure that all communities are protected from potentially life-threatening diseases and, if necessary, respond promptly to an emerging public health threat. It is important that disease threats be minimized through the monitoring of students being immunized.

Sharing immunization and personally identifiable information including the student's name, Date of Birth, gender, and address with local and state health departments will help to keep your child safe from vaccine preventable diseases. The Family Educational Rights and Privacy Act (FERPA), 20 U.S.C. § 1232g, requires written parental consent before personally identifiable information from your child's education records is disclosed to the health department. If your child is 18 or over, he or she is an "eligible student" and must provide consent for disclosures of information from his or her education records.

You may withdraw your consent to share this information in writing at any time.

☐ *I authorize Muskegon Catholic Central Elementary School to release my child's immunization record to the Michigan Department of Health and Human Services and Local Health Department. I understand this information will be used to improve the quality and timeliness of immunization services and to help schools comply with Michigan Law. This includes any immunization information and limited personally identifiable information from the school.*

☐ *I do not authorize Muskegon Catholic Central Elementary School to release my child's immunization record to the Michigan Department of Health and Human Services and Local Health Department.*

Student's Name: ______________________________ Date of Birth: __/__/__

Signature of Parent/Guardian
or Eligible Student: ______________________________ Date:__/__/__

Printed Parent/Guardian Name: ______________________________

PLEASE RETURN THIS COMPLETED FORM TO THE MCCE SCHOOL OFFICE BEFORE THE FIRST DAY OF ATTENDANCE.

Rev.3/12/19

How to register for a Virtus PGC Training Session

All MCC/Diocesan employees and volunteers are required to complete Virtus PGC Training.

Begin registering online by going to: www.virtusonline.org

- On the left side of the page, click on FIRST-TIME REGISTRANT
- Click on "Begin the registration process"
- Click in the box stating "Select your organization"
- Scroll down to "Grand Rapids, MI (Diocese) and click on it
- Set your Virtus account by creating your user name and password
- Fill in your personal information. Those fields marked with a Red * must be filled in. If you do not have an email address, click on the No Email button.
- Click the Continue button
- Scroll down the drop-down menu to choose the parish or school/s you are associated with. Ours is "Greater Muskegon Catholic Schools".
- Click the continue button
- Check the box or boxes of role/s, and type in your title or position/s, and continue. If a volunteer, please be specific, such as "classroom helper" or "chaperone" or "library helper" or "reader".
- Check yes or no on the three questions, and continue
- Answer if you have already attended a Virtus Session?

1. Click no, if you have not attended.
2. Click yes, if you have attended.

- If you clicked yes, click on the session you attended from the drop-down menu, and click on Complete registration. (You should contact the diocese at 616 475-1246 or email ccastano@grdiocese.org to request approval for the session you've already attended)
- If you clicked no, click on the Virtus training you would like to attend. Volunteers may choose Online training in English or Spanish, or choose from any upcoming live training. Educators and Employees will need to pick from the available live Protecting God's Children for Adults sessions.
- Confirm the session you chose is correct
- If you chose the online training, you will then log into your Virtus account with the username and password that you just set up. Click on the training tab and begin the online training process.
- Those who choose the live training, you will receive an email confirming the session you've signed up for.

Muskegon Catholic Central Elementary School
School-Based Asthma Management Plan
(To be completed by the Student's Parent/Guardian)

Child's Personal Information

Child's Name: ______________________________

Grade: __________ Date of Birth: ______________

Emergency Information

Parent/Guardian Name(s):

______________________________ Phone # ______________

______________________________ Phone # ______________

Primary Emergency Contact:

______________________________ Phone # ______________

Secondary Emergency Contact:

______________________________ Phone # ______________

Doctor's Name: ______________________________

Office Phone: ______________

To Be Completed By The Child's Physician

What To Do In An Acute Asthma Episode

1. ______________________________
2. ______________________________
3. ______________________________

When to Call 911/Ambulance (list the additional symptoms the student may present)

1. ______________________________
2. ______________________________
3. ______________________________

Daily Management Asthma Plan – Completed by the Child's Physician on Reverse Side

Daily Management Asthma Plan

Child's Name: ____

Asthma Triggers:

______________________________ ______________________________

______________________________ ______________________________

Allergies:

______________________________ ______________________________

Medications To Be Dispensed At School:

Name of Medicine	Dosage	When To Use

Possible Side Effect To Be Report To The Child's Physician:

______________________________ ______________________________

______________________________ ______________________________

Does Student Have Exercise-Induced Asthma? Yes ________ No ________

This Student Uses An Inhaler Before Engaging In Physical Exercise And If Wheezing During Physical Activity: Yes ________ No ________

Activity Restrictions: (if applicable:

______________________________ ______________________________

Please Check ALL That Apply:

_______ I have instructed this child in the proper way to use his/her inhaled medications. It is my professional opinion that this child should be allowed to carry and use that medication by him/herself.

_______ It is my professional opinion that this student should NOT carry his/her inhaled medications or Eigen by him or herself.

_______ Please contact my office for instructions in the use of this nebulizer, metered-dose inhaler, and/or EpiPen

_______ I have instructed this child in the proper use of a peak flow meter. His/her personal best peak flow is: ____________

Doctor's 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) MI	TODAY'S DATE (mm/dd/yy) / /
PARENT/GUARDIAN (Last, First, Middle)			HOME TELEPHONE NUMBER ( )
ADDRESS (Number & Street)	(City)	(ZIP Code) MI	WORK TELEPHONE NUMBER ( )

SECTION I - HEALTH HISTORY

Yes	No	Resolved	# Is your child having any of the problems listed below?
☐	☐	☐	1 Allergies or Reactions (for example, food, medication or other)
☐	☐	☐	2 Hay Fever, Asthma, or Wheezing
☐	☐	☐	3 Eczema or Frequent Skin Rashes
☐	☐	☐	4 Convulsions/Seizures
☐	☐	☐	5 Heart Trouble
☐	☐	☐	6 Diabetes
☐	☐	☐	7 Frequent Colds, Sore Throats, Earaches (4 or more per year)
☐	☐	☐	8 Trouble with Passing Urine or Bowel Movements
☐	☐	☐	9 Shortness of Breath
☐	☐	☐	10 Speech Problems
☐	☐	☐	11 Menstrual Problems
☐	☐	☐	12 Dental Problems: Date of Last Exam / /
☐	☐	☐	Other (please describe): ________

☐ ☐ Does your child take any medication(s) regularly?

Reason for Medication ⇨

________ / /
Parent/Guardian Signature Date

Birth History:

Are there any current or past diagnosis(es) ☐ Yes ☐ No

If yes, please describe:

If yes, list medications:

Was the health history reviewed by a health professional?
☐ Yes ☐ No *Examiner's Initials:* ________

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
☐	☐	VISION Date: / /	Visual Acuity			
			Muscle Imbalance			
			Other:			
☐	☐	HEARING Date: / /	Audiometer			
			Other:			
☐	☐	URINALYSIS Date: / /	Sugar			
			Albumin			
			Microscopic			
☐	☐	BLOOD LEAD LEVEL Date: / /	Level ______ ug/dl ⇨			

No	Yes	Was child tested for:	Test results:	Normal	Referred	Under Care
☐	☐	HEIGHT & WEIGHT	Height			
			Weight			
☐	☐	Other: ________	Other			
☐	☐	HEMOGLOBIN / HEMATOCRIT	⇨			
☐	☐	BLOOD PRESSURE	Reading: ________			
☐	☐	TUBERCULIN Date: / /	Type: ________ Neg.: ☐ Pos.: ☐ ______ mm			

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	
Hepatitis B (HepB)	1	3
	2	
DTaP/DTP/DT/Td	1	4
	2	5
	3	6
Tdap	1	
Haemophilus Influenzae type b (HIB)	1	3
	2	4
Polio (IPV/OPV)	1	3
	2	4
Pneumococcal Conjugate (PCV7/PCV13)	1	3
	2	4
Rotavirus (RV1/RV5)	1	3
	2	
Measles,Mumps, Rubella (MMR)	1	2
Varicella (Chickenpox)	1	2

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

VACCINES (Circle Type)	DATE ADMINISTERED MM/DD/YYYY	
Hepatitis A (HepA)	1	2
Influenza (IIV/LAIV)	1	3
	2	4
Meningococcal (MCV4 / MPSV4)	1	2
Human Papillomavirus (HPV9/HPV4/HPV2)	1	3
	2	
OTHER 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.

Parent/Guardian refused immunizations: ☐

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	
☐	☐	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:
☐	☐	Should the child's activity be restricted because of any physical defect or illness? If yes, check and explain degree of restriction(s): ☐ Classroom ☐ Playground ☐ Gymnasium ☐ Swimming Pool ☐ Competitive Sports ☐ Other

Other Recommendations

SECTION V - DENTAL EXAMINATION AND RECOMMENDATIONS (OPTIONAL)

I have examined ____________ (child's name) 's teeth. As a result of this examination, my recommendation for treatment is: ____________

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.

CHILD INFORMATION RECORD CARD

The attached card is required by the State of Michigan.
It needs to be filled out correctly, as it would be used in an emergency situation.
There can be no "blank" spaces, "lines" through the boxes or "NA".
YOU MUST FILL IN EVERY BOX, if information is not known put **UNKNOWN** OR **NONE**.

Section	***Field Information***	***Instructions***
A	Name of Child/ Date of Birth/ Address	Please complete full name and address, no abbreviation
B	1st Parent Information	If information is not known, put UNKNOWN in each box
C	2nd Parent Information (Optional)	Complete as Section B if applicable
D	Name of Child's Physician	Very Important Information
E	Hospital Preferred	Your choice
F	Allergies, Special Needs and Special Instructions	This is very important to know in case of emergency needs
G	Emergency Contact & Release of Child	These are who will be contacted in case of emergency, parents should be listed first
H	Release of Child Only	These are individuals who are allowed to pick up and take your child from school
I	Emergency Release	Type your initials in the first box and enter "Muskegon Catholic Central" in the second box
J	Signature	IMPORTANT to sign and date

CHILD INFORMATION RECORD

State of Michigan - Department of Licensing and Regulatory Affairs - Child Care Licensing Bureau

Instructions: Unless otherwise indicated, all requested information must be provided. If the information is not known or does not apply, "unknown" or "none" is the required response. A blank field, a line through a field or "N/A" are not acceptable responses.

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		Primary Phone ( )	Parent/Legal Guardian's Name (Optional)		Primary Phone ( )
Home Address (if not child's address)		2nd Phone (if applicable) ( )	Home Address (if not child's address)		2nd Phone (if applicable) ( )
City	State	Zip Code	City	State	Zip Code
Email Address (optional)			Email Address (optional)		
Employer Name		Work Phone ( )	Employer Name		Work Phone ( )

Name of Child's Physician or Health Clinic	Physician's or Health Clinic's Phone Number ( )
Hospital Preferred for Emergency Treatment (optional)	
Allergies, Special Needs and/or Special Instructions? Yes ☐ No ☐ If yes, explain: (Attach additional sheets, if necessary.)	

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

See Reverse Side

Emergency Contact & Release of Child: List all individuals, including parents/legal guardians, in order of preference, to be contacted in an emergency. If possible, include at least one person other than the parents/legal guardians to be contacted in an emergency and to whom the child can be released. The second phone number column can be left blank. (If more individuals, attach additional sheets.)

1.	( )	( )
2.	( )	( )
3.	( )	( )

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

1.	( )	2.	( )
3.	( )	4.	( )

Parent/Legal Guardian Initials:

________I give permission to ______________________________, licensed by the Department of Licensing and Regulatory Affairs to secure emergency medical treatment for the above named minor child while in care.

I certify that I accurately completed this form and if anything changes, I will notify the provider by updating this form.

Signature of Parent or Guardian　　　　　　　　　　Date Signed

Date Card Reviewed	Parent or Legal Guardian Initials	Date Card Reviewed	Parent or Legal Guardian Initials	Date Card Reviewed	Parent or Legal Guardian Initials	Date Card Reviewed	Parent or Legal Guardian Initials

LARA is an equal opportunity employer/program.

AUTHORITY: 1973 PA 116
COMPLETION: Required
PENALTY: Rule Violation Citation.

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

Muskegon Catholic Central
Preschool & Childcare Programs

1145 W. Laketon Ave.
Muskegon, MI 49441
231-755-2201

State of Michigan
Licensing Rules for Preschool & Child Care Centers
Rule R 400.5305 - Health Records

Rule 305. (1) Upon enrollment and annually thereafter, the center shall obtain and keep on file at the center a signed statement from the school-age child's parent all of the following:

(a) The child is in good health with activity restrictions noted.
(b) The child's immunizations are up-to-date.
(c) The immunization record or appropriate waiver is on file with the child's school.

1. My child ____________________ is in good health.
   Name

2. My child's immunizations are up-to-date.

3. My child's immunization record/or waiver is on file at Muskegon Catholic Central Elementary office.

____

Parent/Guardian 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 ______________________________.
Name of Child Care Center

Child(ren)'s Name(s) ______________________________

____

Parent Name ______________________________

Parent Signature ______________________________ Date ______________

LARA is an equal opportunity employer/program.

WRITTEN INFORMATION PACKET DOCUMENTATION
Michigan Department of Licensing and Regulatory Affairs
Child Care Licensing Bureau

Child(ren)'s Name(s) (Last, First)	Facility's Name and License Number

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

- Criteria for admission and withdrawal.
- Schedule of operation, denoting hours, days, and holidays during which the center is open, and services are provided.
- Fee policy.
- Discipline policy.
- Food service program.
- Program philosophy.
- Typical daily routine.
- Parent notification plan for accidents, injuries, incidents, and illnesses.
- Transportation policy, if applicable.
- Medication policy.
- Exclusion policy for child illnesses.
- Notice of the availability of the center's licensing notebook.
    - The licensing notebook contains all the licensing inspection and special investigation reports and related corrective action plans for the last 5 years.
    - The licensing notebook is available to parents during regular business hours.
    - Licensing inspection and special investigation reports, and corrective action plans from at least the past 3 years are available on the department's website at **www.michigan.gov/michildcare.**
- Other ______________________________

I certify that I received all of the above items.

______________________________ ______________
Parent/Guardian Signature **Date**

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

LARA is an equal opportunity employer/program.

Muskegon Catholic Central
Preschool & Childcare Programs

1145 W. Laketon Ave.
Muskegon, MI 49441
231-755-2201

Dear Parents,

Please take time and read this handbook carefully. If you have any questions please feel free to contact the Program Director.

I, the parent, have read and fully understand the Preschool &/or Childcare Handbook. With my signature, I, the parent, enter into an agreement with Muskegon Catholic Central-State of Michigan License #DC 610 302 316 and in accordance with the laws of, the State of Michigan under Rule 8146(2). I, the parent, have received a copy of the Handbook for my records.

____

Parent/Guardian Signature Date

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 ______________________________ 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

Pre-K Information Sheet

Child's name: ____

What do you want your child to be called at school? ______________________

Child's birthday: ____

Parent's names: ____

Child's siblings: ____

____

Family pets: ____

Email Address: ____

Child's allergies: ____

____

What are your child's likes/dislikes? ___________________________________

____

What are your child's previous childcare or organized play experiences? ____________

____

How do you comfort or help your child when they are upset or uncomfortable? ___

____

Does your child have any social, physical or emotional needs we should be aware of?

____

Is there any other information you would like to share with us in regards to your child?

____

Transportation

Please tell me how your child will usually be arriving and going home each day and the name of the person picking them up or if they will be going to childcare. Thank you!

Child's Name ______________________________

Parent's Name ______________________________

Contact phone number ______________________________

Monday	arrive: dismiss:
Tuesday	arrive: dismiss:
Wednesday	arrive: dismiss:
Thursday	arrive: dismiss:
Friday	arrive: dismiss: