

# Building Blocks - Morning Preschool Enrollment

Parent • Guardian • Student Information – please complete this form thoroughly

**\* Required Field**

CHILD'S FIRST NAME:\* \_\_\_\_\_ BIRTH DATE:\* \_\_\_\_\_

CHILD'S LAST NAME:\* \_\_\_\_\_ M \_\_\_\_\_ F PHONE #: \_\_\_\_\_

ADDRESS:\* \_\_\_\_\_ CITY\* \_\_\_\_\_ ZIP\* \_\_\_\_\_

| PARENT / GUARDIAN 1       | PARENT / GUARDIAN 2       |
|---------------------------|---------------------------|
| FIRST NAME:* _____        | FIRST NAME: _____         |
| LAST NAME:* _____         | LAST NAME: _____          |
| STREET ADDRESS : _____    | STREET ADDRESS : _____    |
| CITY / STATE / ZIP: _____ | CITY / STATE / ZIP: _____ |
| HOME #: _____             | HOME #: _____             |
| EMPLOYER:* _____          | EMPLOYER : _____          |
| WORK #:* _____            | WORK #: _____             |
| CELL PHONE #:* _____      | CELL PHONE #: _____       |
| EMAIL ADDRESS:* _____     | EMAIL ADDRESS: _____      |

EMERGENCY NAME:\* \_\_\_\_\_ PHONE#: \_\_\_\_\_ CELL PHONE#: \_\_\_\_\_

|   |                      |
|---|----------------------|
| Starting Date: _____                                      | School Year Calendar |
| ____ Ready K – Monday, Wednesday, Friday - 8:30am-12:00pm |                      |
| ____ Sunshine Club – Tuesday, Thursday - 8:30am-12:00pm   |                      |
| Monthly Tuition \$ _____                                  |                      |

**Health / Nutrition Information** – I assure the Berkley School District that my child is in good health and I will assume responsibility for his / her health while attending in Berkley School District's Child Care Program. I will provide my child with: \_\_\_\_ Nutritious snack  
In case emergency service is required and parents cannot be reached, my child may be taken to the emergency room at Wm. Beaumont Hospital / Royal Oak • Providence Hospital / Oak Park.

Your electronic signature below indicates your acknowledgment and agreement to all above statements and assurances.

Parent / Guardian Signature:\* \_\_\_\_\_ Date:\* \_\_\_\_\_

**BERKLEY SCHOOL DISTRICT FEDERAL TAX ID# 38-6003087**

|                                    |                                   |   |
|------------------------------------|-----------------------------------|---|
| <b>Office Use Only:</b>            | Extra Payment:\$ _____            |   |
| Non-refundable Fee \$ <u>60</u>    | Enrollment Month Tuition:\$ _____ | Total Received:\$ _____   |
| ____ Cash <input type="checkbox"/> | ____ Check #: _____               | ____ Visa <input type="checkbox"/> ____ MasterCard <input type="checkbox"/> ____ Discover |
| Card #: _____                      | Ex. Date: _____                   | V Code: _____   |
| Name on Card _____                 | Received by: _____                | 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.

|  |       |  |  |                   |  |
|--|-------|--|--|-------------------|--|
| <b>For Provider Use Only:</b>  |       | 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<br>(     )                         | Parent/Legal Guardian's Name (Optional)                |                   | Primary Phone<br>(     )                         |
| Home Address (if not child's address)  |       | 2 <sup>nd</sup> Phone (if applicable)<br>(     ) | Home Address (if not child's address)                  |                   | 2 <sup>nd</sup> Phone (if applicable)<br>(     ) |
| City   | State | Zip Code   | City   | State             | Zip Code   |
| Email Address (optional)   |       |  | Email Address (optional)                               |                   |  |
| Employer Name  |       | Work Phone<br>(     )                            | Employer Name  |                   | Work Phone<br>(     )                            |
| Name of Child's Physician or Health Clinic   |       |  | Physician's or Health Clinic's Phone Number<br>(     ) |                   |  |
| Hospital Preferred for Emergency Treatment (optional)  |       |  |  |                   |  |
| Allergies, Special Needs and/or Special Instructions? Yes <input type="checkbox"/> No <input type="checkbox"/> If yes, explain:<br>(Attach additional sheets, if necessary.) |       |  |  |                   |  |

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

See Reverse Side

|  |  |         |  |            |  |
|--|--|---------|--|------------|--|
| <b>Emergency Contact &amp; Release of Child:</b> 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.   |  | (     ) |  | (     )    |  |
| <b>Release of Child Only:</b> 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. (     ) |  |

|   |
|---|
| <b>Parent/Legal Guardian Initials:</b>  |
| _____ I give permission to <u>Berkley Building Blocks</u> licensed by the Department of Licensing and Regulatory Affairs to secure emergency medical treatment for the above named minor child while in care. |

|   |             |
|---|-------------|
| <b>I certify that I accurately completed this form and if anything changes, I will notify the provider by updating this form.</b> |             |
| 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<br>COMPLETION: Required<br>PENALTY: Rule Violation Citation. |                                   |

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\* Required Field

## Berkley School District Building Blocks Policy and Procedures Statement

\_\_\_\_\_ I have read the Parent Handbook for the Berkley School District Building Blocks programs. I fully understand the stated policies and procedures and agree to follow the policies and procedures stated in the Parent Handbook.

\_\_\_\_\_ I give my permission for the school personnel to discuss information relevant to the program planning for my child.

\_\_\_\_\_ I agree to pay my tuition by the 1<sup>st</sup> of every month on a monthly basis. I understand a late fee will be charged for payments received after the 5<sup>th</sup> of the month. My tuition will be based on the fees of the Building Blocks program I am enrolled, I understand tuition may increase yearly.

Typing your name below as a parent/legal guardian represents both your electronic signature and indicates that you have reviewed these documents and are certifying on behalf of yourself that you understand the rules and procedures of the Berkley School District as referenced above.

\*

\_\_\_\_\_  
Parent/Guardian Signature

\*

\_\_\_\_\_  
Date



## WRITTEN INFORMATION PACKET DOCUMENTATION

Michigan Department of Licensing and Regulatory Affairs  
Child Care Licensing Bureau

|   |  |
|---|--|
| <b>Child(ren)'s Name(s) (Last, First)</b> | <b>Facility's Name and License Number</b><br>Avery (Building Blocks) - DC630019539 |
|---|--|

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. **(CENTER MUST CHECK ONE)**
  - ☐ The center keeps a licensing notebook containing a summary sheet, all licensing inspections and special investigation reports, and related corrective action plans for the last 5 years. The licensing notebook is available to parents/guardians during regular business hours. Reports from at least the past three years are available at [www.michigan.gov/michildcare](http://www.michigan.gov/michildcare).
  - ☒ The center does not keep a licensing notebook, but internet is available onsite. Reports from at least the last three years are available at [www.michigan.gov/michildcare](http://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.



# BERKLEY SCHOOLS

ENGAGE INSPIRE ACHIEVE  
WWW.BERKLEYSCHOOLS.ORG

## Parent Orientation Checklist

These are topics that we discuss during a Building Blocks tour. Please check the topics you may have questions on or would like more information on. We will be happy to answer them for you.

\_\_\_\_\_ Tour of the facility

\_\_\_\_\_ Introduction to teaching staff

\_\_\_\_\_ Parent visits the classroom

\_\_\_\_\_ Overview of the handbook

\_\_\_\_\_ Overview of the community board and handouts/resources for families

\_\_\_\_\_ Opportunity for you to visit again if needed

\_\_\_\_\_ Expectations of family and needs of child discussed with teacher

\* If an interpreter is needed please let us know

Parent Signature \_\_\_\_\_ Date \_\_\_\_\_

Printed Parent Name \_\_\_\_\_





## Building Blocks Parent Questionnaire

This questionnaire is intended to help teachers become better acquainted with your child and to assist staff in planning activities. All information is confidential.

- What name do you usually call your child? \_\_\_\_\_
- Does your child have any physical disabilities, including allergies, of which the Building Blocks should be aware? If so, please explain \_\_\_\_\_
- What terminology does your child use to ask to go to the bathroom? \_\_\_\_\_
- What type of food does your child like? \_\_\_\_\_
- What type of food does your child dislike? \_\_\_\_\_
- Does your child require a nap?    ☐ Yes    ☐ No, Do you prefer they take a nap?    ☐ Yes    ☐ No
- Does your child have tantrums?    ☐ Yes    ☐ No, Does he/she suck their thumb?    ☐ Yes    ☐ No
- Does your child have unusual fears? If so, explain \_\_\_\_\_
- Does your child use the following at home?    ☐ Crayons    ☐ Pencils    ☐ Chalk    ☐ Markers    ☐ Scissors
- Are there any areas in which you anticipate difficulty for your child? (crafts, sharing, following direction) If so, please explain \_\_\_\_\_  
\_\_\_\_\_
- Has your child been involved in child care before this experience?    ☐ Yes    ☐ No If so, check all that apply  
☐ Babysitter    ☐ Family Home Daycare    ☐ Child Care Center, What was name of Facility and Program? \_\_\_\_\_  
\_\_\_\_\_
  - Was the experience enjoyable?    ☐ Yes    ☐ No If so, please explain \_\_\_\_\_  
\_\_\_\_\_
- List names and ages of other children in your family \_\_\_\_\_
- If you are divorced do you have? (Optional)    ☐ Joint Custody    ☐ Regular Visitation    ☐ Irregular Visitation
- What factor influenced placement of your child in the Berkley Building Blocks Program? \_\_\_\_\_  
\_\_\_\_\_





# BERKLEY SCHOOLS

ENGAGE INSPIRE ACHIEVE

WWW.BERKLEYSCHOOLS.ORG

Dear Berkley Building Blocks Families,

We value the participation of our parents at many levels. Our handbook states: "Parents are a child's primary teacher. Parents are invited to participate and are always welcome to visit at any time." Our most recent parent survey showed that many parents are not aware of ways they can participate in their child's experience at the Berkley Building Blocks. We hope this survey opens the door for more opportunities for our Building Blocks families.

**1. Teaming up with families can enrich your child's classroom environment. It does not always mean time away from work! Place an X next to ways you might be able to help.**

\_\_\_\_\_ One sided paper from my work.

\_\_\_\_\_ I'm a crafter! I have left over "stuff".

Other. Please describe \_\_\_\_\_

**2. You are always welcome to visit the Building Blocks! You can stop in anytime, but with just a little planning, there are many other ways to participate. Place an X next to ways you might consider participating.**

\_\_\_\_\_ Help plan special evening events. \_\_\_\_\_ Help plan classroom holiday celebrations.

\_\_\_\_\_ Set up a time to read to the children before or after work.

\_\_\_\_\_ Set up a time to participate in an art project.

\_\_\_\_\_ Do you have another suggestion? Describe \_\_\_\_\_

**3. Do you have a special talent to share with young children?**

\_\_\_\_\_ I play an instrument!

\_\_\_\_\_ I am good at woodworking!

\_\_\_\_\_ I can juggle!

\_\_\_\_\_ I love to do digital photography!

\_\_\_\_\_ I have a connection to a service or business that could do a presentation for children.

Other. Please describe \_\_\_\_\_

Please Print Your Name \_\_\_\_\_

Please Print Your Child's Name \_\_\_\_\_





## COMMUNICATIONS CONSENT FORM

Child's Name: \* \_\_\_\_\_ Current Teacher: \_\_\_\_\_

Our district communication provides us with many opportunities to showcase students and their work. Each month, our Board of Education honors students for special accomplishments, the weekly district newsletter displays student artwork, photos, and success stories; our Building Blocks newsletters, Shutterfly, Facebook and Twitter accounts publish photos of classroom activities and our website gives us the chance to highlight our curriculum and student learning and student achievements. If you have questions, please call the Communications Office at 248.837.8095.

Please select yes or no.

\_\_\_\_\_ **YES**, the Berkley School District and the Building Blocks program has my permission to use my child's work, photo, video, voice, and/or name in district communications or other media.

\_\_\_\_\_ **NO**, the Berkley School District and the Building Blocks program does not have my permission to use my child's work, photo, video, voice, and/or name in district communications or other media. I understand that if I select No, my student cannot be recognized for any accomplishments in district and school communications and/or local media.

Typing your name below as a parent/legal guardian represents both your electronic signature and indicates that you have reviewed these documents and are certifying on behalf of yourself that you understand the rules and procedures of the Berkley School District as referenced above.

Signature: \* \_\_\_\_\_ Date: \* \_\_\_\_\_







## SCHOOL COMMUNICATION

In order to best communicate with you in a school closure or other emergency situation, the Berkley School District will send a School Communication to all families. School Messenger is an emergency notification system that has the ability to call, text, and email families with important information or emergency messages from the school.

In the event of an emergency or closure impacting Berkley Building Blocks, we will notify you immediately via School Messenger. School Messenger phone calls and/or texts will be sent to the phone number(s) you request so please be sure it is a direct line to you not a main line switch board at your place of work. Please make sure this telephone number is one that you have access to during school hours, update new phone numbers in the Building Blocks Office.

Please also be sure to include a valid email address. Several District and Building Blocks communications are sent via email only and will not reach you without a valid email address.

Student Name: \_\_\_\_\_ Room#/Teacher \_\_\_\_\_ Date \_\_\_\_\_  
(Please Print)

**Phone Number:** Please print your primary telephone number (to be called, not texted) below. Again, this should be a *direct* line to you – not a main switch board or operator at your place of work:

**1<sup>st</sup> Phone Number:** \_\_\_\_\_ **2<sup>nd</sup> Phone Number** \_\_\_\_\_

**Text Message:** If you wish to receive emergency text messages (snow days and other emergencies), please enter a telephone number in the space provided. In order to receive text messages, every parent must opt-in. In order to opt in, text the word YES (in message field) to the phone number 67587 (in the To field). Please note that the district is not responsible for any fees you may incur through your cell phone provider\*:

**1<sup>st</sup> Text Message Number:** \_\_\_\_\_ **2<sup>nd</sup> Text Message Number** \_\_\_\_\_

\*Please note that not all providers will allow texting from the district. Most of the major carriers (Verizon, AT&T, etc.) will allow texting from School Messenger, but some may not. Check with your provider if you have concerns about texting.

**E-Mail Address:** Several District and Building Blocks communications are sent via email only and will not reach you without a valid email address.

**E-mail address:** \_\_\_\_\_ **2<sup>nd</sup> E-mail address:** \_\_\_\_\_

If at any point your information changes (new phone number, new email address, etc.), you are responsible for contacting the office to update the information in our database.





**Berkley Building Blocks  
Common Medications Consent  
(Sunscreen/Diaper Cream)**

(Please Print)

Student Name \_\_\_\_\_ Room # \_\_\_\_\_

Sunscreen, lotions, chapstick and diaper cream are **not** available at Berkley Building Blocks. These must be sent in by a parent/guardian with this signed consent form in order for us to administer this nonprescription medication to your child. Please list the brand name and expiration date of each item you'll be sending with your student. If you do not wish to provide one of these items, no initials are required. Sunscreen is **required** during the spring/summer instruction.

| Category     | Brand Name | Expiration Date | Parent Initials |
|--------------|------------|-----------------|-----------------|
| Sunscreen    |            |                 |                 |
| Lotion       |            |                 |                 |
| Chapstick    |            |                 |                 |
| Diaper Cream |            |                 |                 |

**Parent/Guardian**

I hereby give my permission to Berkley Building Blocks school personnel designated by the school principal to give the above mentioned medications/creams to my child.

I further agree to hold the Berkley School District and all employees harmless in any and all claims arising from the administration of this medication in school.

I agree to notify the school **in writing** at the termination of this request or when any change in the above is necessary.

Signature of Parent/Legal Guardian \_\_\_\_\_

Printed Name \_\_\_\_\_



# 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)<br>/ / |
| ADDRESS (Number & Street)             | (City) | (ZIP Code)<br>MI / /            |
| PARENT/GUARDIAN (Last, First, Middle) |        | HOME TELEPHONE NUMBER<br>( )    |
| ADDRESS (Number & Street)             | (City) | (ZIP Code)<br>MI / /            |
|                                       |        | WORK TELEPHONE NUMBER<br>( )    |

## SECTION I - HEALTH HISTORY

| Yes                              | No                       | Resolved                 | #   | Is your child having any of the problems listed below?          | Birth History:   |
|----------------------------------|--------------------------|--------------------------|---|---|--|
| <input type="checkbox"/>         | <input type="checkbox"/> | <input type="checkbox"/> | 1   | Allergies or Reactions (for example, food, medication or other) |  |
| <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                   | Are there any current or past diagnosis(es) <input type="checkbox"/> Yes <input type="checkbox"/> No |
| <input type="checkbox"/>         | <input type="checkbox"/> | <input type="checkbox"/> | 9   | Shortness of Breath   | If yes, please describe:   |
| <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? |   | If yes, list medications:  |
| Reason for Medication            |                          |                          |   |   |  |
| _____ / /                        |                          |                          |   |   | Was the health history reviewed by a health professional?  |
| <b>Parent/Guardian Signature</b> |                          |                          |   | Date  | <input type="checkbox"/> Yes <input type="checkbox"/> No <b>Examiner's Initials:</b> _____           |

## 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                | Visual Acuity     |        |          |            | <input type="checkbox"/>   | <input type="checkbox"/> | HEIGHT & WEIGHT         | Height   |        |          |            |
|                          |                          | Date: / /             | Muscle Imbalance  |        |          |            |  |                          | Weight                  |  |        |          |            |
|                          |                          |                       | Other:            |        |          |            | <input type="checkbox"/>   | <input type="checkbox"/> | Other: _____            | Other  |        |          |            |
| <input type="checkbox"/> | <input type="checkbox"/> | HEARING               | Audiometer        |        |          |            | <input type="checkbox"/>   | <input type="checkbox"/> | HEMOGLOBIN / HEMATOCRIT |  |        |          |            |
|                          |                          | Date: / /             | Other:            |        |          |            | <input type="checkbox"/>   | <input type="checkbox"/> | BLOOD PRESSURE          | Reading: _____   |        |          |            |
| <input type="checkbox"/> | <input type="checkbox"/> | URINALYSIS            | Sugar             |        |          |            | <input type="checkbox"/>   | <input type="checkbox"/> | TUBERCULIN              | Type: _____  |        |          |            |
|                          |                          | Date: / /             | Albumin           |        |          |            |  |                          | Date: / /               | Neg.: <input type="checkbox"/> Pos.: <input type="checkbox"/> _____ mm |        |          |            |
| <input type="checkbox"/> | <input type="checkbox"/> | BLOOD LEAD LEVEL      | Level _____ ug/dl |        |          |            | <b>NOTE:</b> 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: / /                            |

| <b>SECTION III - IMMUNIZATIONS</b><br><small>Statements such as "UP-TO-DATE" or "COMPLETE" will not be accepted. Admission to school may be denied on the basis of this information.*</small> |  |                       |                      |
|---|--|-----------------------|----------------------|
| VACCINES (Circle Type)  | DATE ADMINISTERED<br><small>MM/DD/YYYY</small> |                       |                      |
| 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? <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  |  |                       |                      |
| _____<br><b>Health Professional's Signature</b>   |  | _____<br><b>Title</b> | _____<br><b>Date</b> |

|                          |                          | <b>SECTION IV - RECOMMENDATIONS</b><br><small>(Required for Child Care and Head Start/Early Head Start)</small>   |
|--------------------------|--------------------------|---|
| 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    |                          |   |
| _____                    |                          |   |
| _____                    |                          |   |

| <b>SECTION V - DENTAL EXAMINATION AND RECOMMENDATIONS (OPTIONAL)</b>  |
|---|
| I have examined _____ child's name _____'s teeth. As a result of this examination, my recommendation for treatment is: _____<br>_____ |
| _____<br><b>Dentist's Signature</b>   |
| _____<br><b>Date</b>  |

| <b>PHYSICIAN'S SIGNATURE</b>         |                      |   |                                   |
|--------------------------------------|----------------------|---|-----------------------------------|
| _____<br><b>Examiner's Signature</b> | _____<br><b>Date</b> | _____<br><b>Examiner's Name (Print or Type)</b> | _____<br><b>Degree or License</b> |
| _____<br><b>Number &amp; Street</b>  | _____<br><b>City</b> | MI _____<br><b>ZIP Code</b>                     | (_____) _____<br><b>Telephone</b> |

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.

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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.



## Berkley Building Blocks Parent Handbook Agreement

\_\_\_\_\_ I have read the Parent Handbook for the Berkley School District Building Blocks programs. I fully understand the stated policies and procedures and agree to follow the policies and procedures stated in the Parent Handbook.

\*

\_\_\_\_\_

Print student Name

\*

\_\_\_\_\_

Print Parent/Guardian Name

\*

\_\_\_\_\_

Parent/Guardian Signature

\*

\_\_\_\_\_

Date



**BERKLEY BUILDNG BLOCKS / KIDS' ZONE**  
**PAYMENT AUTHORIZATION FORM**

For your convenience, the Berkley Building Blocks uses the Procure App as our primary payment option to process your monthly childcare payments. Monthly payments are due by the 5th of each month. When you set up your Procure account you will select "make a payment" and "set up payment". You can select auto-pay, in which case the payment will be deducted on the due date of each invoice. If you do not initiate auto-pay, card information can be saved, but you will be responsible for initiating payment and any related late fees if payment is not made by the due date. If you choose to opt out of the Procure card payment altogether, you must select your method of payment below.

Checks and cash should be placed in the drop box at the address below.

Berkley School District  
ATTN: Accounts Receivable  
14700 W. Lincoln Blvd. Oak  
Park, MI 48237

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Name of Child(ren): \_\_\_\_\_

School(s): \_\_\_\_\_

Class(es) to be included: \_\_\_\_\_

Home Address: \_\_\_\_\_

Choose a method of payment                      (Recommended) I will pay using Procure Auto-Pay

I will initiate each monthly payment on Procure

I will pay by Check

I will pay by Cash

Total Monthly Amount \$\_\_\_\_\_

Print Name: \_\_\_\_\_

Signature\_\_\_\_\_

A new authorization form must be completed each school year.

If you have any questions, please contact Kristin Folsom at 248-837-8439 or [Kristin.Folsom@berkleyschools.org](mailto:Kristin.Folsom@berkleyschools.org)