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.)				

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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.

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PERMISSION TO SELF-APPLY
2024/2025

I, _____, the parent/guardian of

_____

give permission for my student to use the following parent provided, FDA approved, over-the-counter *topical* substances:

1. Antibiotic ointment

2. Itch cream

3. Lip Balm

4. Lotion

5. Sunscreen

6. Insect Repellant

7. School Provided Hand Sanitizer/Alcohol Wipes

I understand that my student will need to apply these topical substances and that my student knows not to share this with any other students.

Parent's signature:_____ Date:_____

HEALTH APPRAISAL

Michigan Department of Health and Human Services

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, dentist, dental therapist, and dental hygienist.
(**BE SURE TO BRING YOUR CHILD'S IMMUNIZATION RECORDS TO THE EXAMINATION**).

PERSONAL

Child's Name (Last, First, Middle)	Date of Birth (mm/dd/yy)
Address (Number, Street, City, Zip Code)	Today's Date (mm/dd/yy)
Parent/Guardian (Last, First, Middle)	Home/Cell Phone Number
Address (Number, Street, City, Zip Code)	Work Phone Number

SECTION I – 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, please describe
☐	☐	☐	11	Shortness of Breath	
☐	☐	☐	12	Speech Problems	
☐	☐	☐	13	Menstrual Problems	
☐	☐	☐	14	Dental Problems Date of Last Exam_____ **OR** Date of Last Assessment_____	
☐	☐	☐		Other (please describe)_____	

Reason for Medication		
Concussion History		
Parent/Guardian Signature	Date	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

Test and Measurements

Yes	No	Was child tested for	Tests and results		Normal	Referred	Under care
☐	☐	Vision Date _____	Visual Acuity		☐	☐	☐
					☐	☐	☐
			Muscle Imbalance		☐	☐	☐
☐	☐	Hearing Date _____	Other				☐
			☐ Audiometer	(R= Right, L=Left)	R/L	R/L	☐
			☐ OAE	(R= Right, L=Left)	R/L	R/L	☐
☐	☐	Urinalysis	Other	(R= Right, L=Left)	R/L	R/L	☐
			Sugar		☐	☐	☐
			Albumin		☐	☐	☐
☐	☐	Blood Lead Level Date _____	Microscopic Level_____ug/dl		☐	☐	☐

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

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 based on this information.*****

Vaccines (Circle Type)	Date Administered		Vaccines (Circle Type)	Date Administered mm/dd/yy	
Hepatitis B (HepB)	1	3	Hepatitis A (HepA)	1	3
	2	4		2	
DTaP/DTP/DT/Td	1	4	Influenza (IIV/LAIV)	1	3
	2	5		2	4
	3	6	Meningococcal MenACWY (MCV4)	1	3
				2	
Tdap	1		Meningococcal B (Bexsero, Trumenba)	1	3
				2	
Haemophilus Influenzae type b (HIB)	1	3	Human Papillomavirus (9vHPV, 4vHPV, 2vHPV)	1	3
				2	
	2	4	Additional Vaccines Specify Date & Type	Type of Vaccine(s)	Date of Vaccine(s)
Polio (IPV/OPV)	1	4		1	
	2	5		2	
	3			3	
Pneumococcal Conjugate (PCV7/PCV13)	1	3	Indicate and attach physician diagnosis or laboratory evidence of immunity as applicable.		
	2	4			
Rotavirus (RV1/RV5)	1	3	***Note:** According to Public Act 368 of 1978, any child enrolling in a Michigan school for the first time must be adequately immunized, vision tested and hearing tested. Exemptions to these requirements are granted for medical, religious, and other objections, provided that the waiver forms are properly prepared, signed and delivered to school administrators. Forms for these exemptions are available at your provider office for medical waiver forms and through your local health department for nonmedical waiver forms.		
	2				
Measles, Mumps, Rubella (MMR/MMRV)	1	3			
	2				
Varicella (Chickenpox), (Var, MMRV)	1	2			
History of Chickenpox Disease? ☐ Yes ☐ No If yes, date _____			Parent/Guardian refused recommended immunizations at visit: ☐		
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)

Yes	No	
☐	☐	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 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 <u>one</u>) ☐ Routine care ☐ Referral for dental treatment ☐ Referral for urgent dental care
Provider Signature	Date
Provider Type (Check **one)** ☐ Dentist ☐ Dental Therapist ☐ Dental Hygienist	

PHYSICIAN'S SIGNATURE

Examiner's Signature	Date	Examiner's Name (Print)		Degree or License
Number & Street	City	MI	Zip Code	Telephone Number

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.