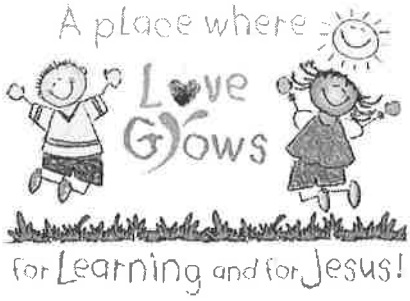


St. Matthew Lutheran

Early Learning Center

Dear Parent/Guardian:

Welcome to the St. Matthew Lutheran Early learning Program. We thank you for your interest and look forward to having you and your child(ren) in our program. Enclosed you will find the Parent Handbook and a packet of forms that must be completed before your child can attend. If you have any questions, please contact the school office at 734-425-0261 or the ELC Room at 734-425-0395

RETAIN:

Parent Handbook – Please read carefully

RETURN IMMEDIATELY OR BEFORE THE FIRST DAY OF THE PROGRAM:

1.	**PARENT CONTRACT**	Please Read and Sign
2.	**Student Application**	Please Fill Out and Return
3.	**FINANCIAL AGREEMENT**	Please Read and Sign
4.	**CHILDCARE INFORMATION CARD**	Fill out **COMPLETELY**, including zip codes,
5.	**HEALTH APPRAISAL FORM**	Please provide a completed health appraisal,

In addition to the above forms please provide us with a copy of your child's up to date Immunization Record and a copy of birth certificate.

Tuition payments can be mailed, delivered or phoned in to:

St. Matthew Lutheran School
5885 N. Venoy Rd.
Westland MI. 48185

Please make checks payable to ***St. Matthew Lutheran School***

St. Matthew Lutheran Early Learning Center
Student Application for 2017-2018 August 23-June 7

Family Information

Name of child_____(M)☐ (F)☐
(First) (Middle) (Last)
Date of Birth_____ Where?_____

Present Address_____ City_____Zip_____

Telephone_____Marital status of parents_____

Father's name_____Place of work_____Phone_____

Mother's name_____Place of work_____Phone_____

List name and ages of siblings_____

What language is spoken at home?_____

What name should your child be called at school?_____

Will your child attend Kindergarten in Sept. 2017?_____Where?_____

Religion

Date of child's baptism_____Where?_____

Church membership: Father_____Mother_____

Physical Background And Development

Emergency name & Phone number of friend or relative in town_____

Physician's name and phone number_____
Does your child have any serious illnesses, epilepsy, surgeries, accidents or hospital experience?

Explain_____

Does your child have allergies?_____ Please list: Foods_____others_____

Can your child dress independently? _____ Toilet problems?_____

Discipline and Habits

How does your child react to directions/requests?_____

_____

Does your child have any fears of which we should be aware?_____

Family and Play Information

Does child play alone? Usually ☐ Sometimes ☐ Never ☐

What type of play would you describe as being your child's favorite?_____

Other Information

Where did you hear about St. Matthew Early childhood program?_____

St. Matthew Lutheran ELC program is an extension of St. Matthew Lutheran School. We will follow the same school calendar with the exception of closing for "cold" days.

Please select your Child's schedule below

MORNING PRESCHOOL **8:00-11:00 a.m.**
Snacks Provided

Schedule	Amount of School Days	Annually 1 Time Payment	Monthly Fee August-May 10 equal Payments	Registration Fee
T & Thr	75	$1200	$120	$50
M, W, FRI	105	$1680	$168	$75
M-FRI	180	$2880	$288	$100

FULL DAY PRESCHOOL
Snacks provided by school- Lunch provided by parent

Number of Days Per Week	Weekly Rate	Registration Fee
2 Days	$72.00	$50
3 Days	$108.00	$75
4 Days	$144.00	$100
5 Days	$180.00	$125.00

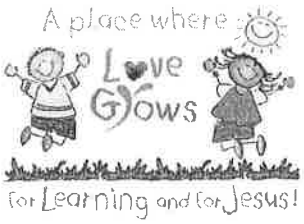
Please return this application with the non-refundable application fee. The application fee is due only with a confirmed space for your child. Checks should be made payable to:

St. Matthew Lutheran School
5885 N venoy Rd.
Westland MI. 48185
734-425-0395

For Office Use Only

Date received_____ Application fee paid$_____

Waitlisted_____ Yes or No_____



St. Matthew Lutheran Early Learning Center Parent Contract

Our Parent Handbook has outlined our mutual responsibilities, concerns, expectations and obligation. We have carefully explained the policies to insure the care and safety of your child(ren) and every child enrolled in our center. You can expect us to adhere to all State and Local licensing rules regarding safety, health, program operations and adult supervision. We encourage and welcome your comments and suggestions and extend our sincere thanks for your cooperation in adhering to our center's policies.

Please check all that apply:

Health and Safety

☐ The Staff has my permission to apply sunscreen on my child. I will provide the sunscreen in the original container, clearly labeled with my child's name.

☐ The Staff has my permission to allow my child to use hand sanitizer.

Snack and Meal Agreement

☐ I understand that the center will offer an AM and/or PM snack for all children. The parent is responsible for supplying a reusable water bottle marked with their child's name to be kept at school. If the child is part of our full day program the parent is responsible for supplying a healthy lunch for their child.

Photo permission

☐ I give permission for my child to be photographed in the classroom. The photos may be used in pamphlets, brochures, newspapers, publications and displays to promote the program.

☐ I ***do not give*** permission for my child to be photographed in the classroom.

Handbook Acknowledgment

☐ I hereby acknowledge that I have received one copy of the St. Matthew Lutheran Early Learning Center Parent Handbook

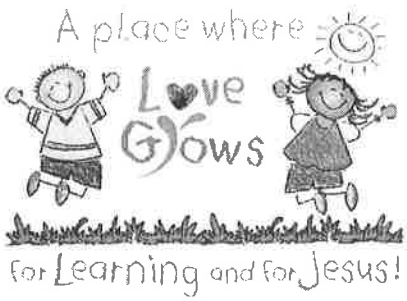
Licensing Notebook

☐ 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). 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.

Parent's Name _____ Date _____

Child's Name _____ Birth Date _____

School _____ Program _____



St. Matthew Lutheran
Early Learning Center
Financial Agreement

The St. Matthew Lutheran Early Learning program is an educational program for children who are between the ages of 3 and 5 years of age. The program operates on a year round basis. Our contract is valid from the date of enrollment until June 7, 2018. The summer contract will begin June 11, 2018.

Please read carefully and check each box:

- ☐ I have received the Parent Handbook and agree to follow the policies therein.
- ☐ I understand the minimum requirement for attendance is two (2) days per week.
- ☐ I understand that my child(ren) are enrolled for the same hours and the same days of each week for the entire contract unless otherwise discussed and a schedule change form has been approved.
- ☐ Tuition is due the 5th of each month if paying monthly or the first contracted day of the week- if paying weekly unless otherwise notified.
- ☐ I understand that a $25.00 late payment fee will be imposed on any account not paid in full by the due date.
- ☐ I will give a two (2) week notice, in writing, if I need to dis-enroll my child from the program.
- ☐ I am responsible for all tuition costs, any fees such as additional childcare, change of schedule fees, late payment fees, late pick up/early drop off fees and any other fees that may appear on my bill.
- ☐ I understand that credit will not be given for absences due to illness or class cancellations.
- ☐ I understand that I must give a 5 day advance notice for any additional time.
- ☐ I am responsible for any "Returned Check" charges resulting from "Insufficient Funds" or "Closed Accounts".

_____
Child's Name

_____ _____
Parent/Guardian Signature Date

_____ _____
Parent/Guardian Signature Date

Please keep a copy of this signed document for your records.

CHILD INFORMATION RECORD

State of Michigan Department of Human Services - Bureau of Children and Adult 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
Father/Legal Guardian's Name	Home Phone ( )	Mother/Legal Guardian's Name		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 (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 Special Instructions (Attach additional sheets, if necessary.)				

BCAL-3731 (Rev. 7-12) Previous editions 9-09, 3-08, 10-07, & 1-06 may be used until 12/31/13.

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.	( )

I give permission to _____ , licensed by the Department of Human Services
(Provider's Name)

to secure emergency medical and/or emergency surgical treatment for the above named minor child while in care.

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

Department of Human Services (DHS) will not discriminate against any individual or group because of race, religion, age, national origin, color, height, weight, marital status, sex, sexual orientation, gender identity or expression, political beliefs or disability. If you need help with reading, writing, hearing, etc., under the Americans with Disabilities Act, you are invited to make your needs known to a DHS office in your area.

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

BCAL-3731 (Rev. 7-12) Previous editions 9-09,3-08, 10-07, & 1-06 may be used until 12/31/13

St Matthew 2017-2018 School Calendar

August -7 Days

S	M	T	W	Th	F	S
		1	2	3	4	5
6	7	8	9	10	11	12
13	14	15	16	17	18	19
20	21	22	23	24	25	26
27	28	29	30	31		

September-19 days

S	M	T	W	Th	F	S
					1	2
3	4	5	6	7	8	9
10	11	12	13	14	15	16
17	18	19	20	21	22	23
24	25	26	27	28	29	30

October-22 Days

S	M	T	W	Th	F	S
1	2	3	4	5	6	7
8	9	10	11	12	~~13~~	14
15	16	17	18	19	20	21
22	23	24	25	26	27	28
29	30	31				

November-18 Days

S	M	T	W	Th	F	S
			1	2	3	4
5	6	7	8	~~9~~	10	11
12	13	14	15	16	17	18
19	20	21	22	23	24	25
26	27	28	29	30		

December-16 Days

S	M	T	W	Th	F	S
					1	2
3	4	5	6	7	8	9
10	11	12	13	14	15	16
17	18	19	20	21	~~22~~	23
24	25	26	27	28	29	30
31						

January-17 Days

S	M	T	W	Th	F	S
	1	2	3	4	5	6
7	8	9	10	11	12	13
14	15	16	17	18	19	20
21	22	23	24	25	26	27
28	29	30	31			

February-18 Days

S	M	T	W	Th	F	S
				1	2	3
4	5	6	7	8	9	10
11	12	13	14	15	16	17
18	19	20	21	22	23	24
25	26	27	28			

March-20 Days

S	M	T	W	Th	F	S
				1	2	3
4	5	6	7	8	9	10
11	12	13	14	15	16	17
18	19	20	21	22	23	24
25	26	27	28	29	30	31

April-16 Days

S	M	T	W	Th	F	S
1	2	3	4	5	6	7
8	9	10	11	12	13	14
15	16	17	18	19	20	21
22	23	24	25	26	27	28
29	30					

May-21 Days

S	M	T	W	Th	F	S
		1	2	3	4	5
6	7	8	9	10	11	12
13	14	15	16	17	~~18~~	19
20	21	22	23	~~24~~	25	26
27	28	29	30	31		

June-6 Days

S	M	T	W	Th	F	S
					1	2
3	4	5	6	~~7~~	~~8~~	9
10	11	12	13	14	15	16
17	18	19	20	21	22	23
24	25	26	27	28	29	30

July

S	M	T	W	Th	F	S
1	2	3	4	5	6	7
8	9	10	11	12	13	14
15	16	17	18	19	20	21
22	23	24	25	26	27	28
29	30	31				

Notes:

- August 23: 1st Day of School-Half Day
- Sept 1,4: Labor Day Holiday- No School
- Oct 13: Teacher Conf- Half Day
- Nov 3: End of 1st Quarter
- Nov 9: P/T Conferences- ½ Day
- Nov 10: Day after P/T Conf- No School
- Nov 22-24:Thanksgiving Break-No School
- Dec 22: Holiday Celebration – 1/2 Day
- Dec 23-Jan 5: Christmas Break
- January 12: End of 2nd Quarter
- January 15: MLK Day-No School
- Feb 16-19:Mid Winter Break-No School
- March 5-9: Lutheran Schools Week
- March 23: End of 3rd Quarter
- March 29-April 6-Easter Break- No School
- May 18: Grandparents Day-1/2 Day
- May 20: : Confirmation Sunday
- May 24: Field Day-1/2 Day
- May 25-28:Memorial Holiday-No School
- June 6: Graduations - 1/2 Day
- June 7: Last Day of School- 1/2 Day (Party)

2017-2018

Michigan Department of Community Health

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: ____/____/____

Address: _____ (Number & Street) _____ (City) MI _____ (ZIP Code) Today's Date: ____/____/____

Parent/ Guardian: _____ (Last) _____ (First) _____ (Middle) Telephone: (____) _____ (Home)

Address: _____ (Number & Street) _____ (City) MI _____ (ZIP Code) Telephone: (____) _____ (Work)

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 Programs: Date of Last Exam: ____ / ____ / ____
☐	☐	☐		Other (please describe): _____

Birth History:

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

If yes, please describe

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

Reason for medication:

If yes, list medications:

_____ (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

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: _____ µg/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: _____ Negative: ☐			

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	DATE ADMINISTERED MM/DD/YYYY	
Hepatitis B (Hep B)	1	3
	2	
DTa / DTP / DT Td / Tdap (circle type)	1	5
	2	6
	3	7
	4	8
Haemophilus Influenza type b (HIB)	1	3
	2	4
Polio – IPV / OPV (circle type)	1	3
	2	4
Pneumococcal Conjugate (PCV7)	1	3
	2	4
Rotavirus (Rota)	1	3
	2	
Measles, Mumps, Reubella (MMR)	1	2
Varicella (Chickenpox)	1	2

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

VACCINES	DATE ADMINISTERED MM/DD/YYYY	
Hepatitis A (Hep A)	1	2
Influenza TIV/LAIV	1	3
	2	4
Meningococcal MCV4 / MPSV4	1	2
Human Papillomavirus (HPV)	1	3
	2	4
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 child's school or local health department.

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 _____'s teeth. As a result of this examination, my recommendation for treatment is: _____

child's name

_____ ____/____/____

Dentist's Signature Date

PHYSICIAN'S SIGNATURE

_____ ____/____/____ _____ _____

Examiner's Signature Date Examiner's Name (print or type) Degree or License

_____ _____ MI _____ (____) _____

Number & Street City ZIP Code Telephone:

Information required for:

Early On®	Hearing and Vision Status; Diagnosis; Health Status
Child Care Licensing	Physical Exam, Restrictions, Immunizations
Head Start/Early Head Start	Determination that child is up-to-date on a schedule of age-appropriate preventive and primary health care, including medical, dental, and mental health. The schedule must incorporate the schedule of well-child care 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 Departments of Human Services, Education, Community Health; 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