# Dexter Co-op Preschool Enrollment Checklist

The paper forms below must be printed, completed and returned to the co-op. Please use one of the following options to submit the completed forms & enrollment check:

1) P.O. Box mailing address -
   Dexter Co-op Preschool
   P.O. Box 392
   Dexter, MI 48130

2) Drop Box outside of the preschool (on the east/gym side of Peace Lutheran Church) -
   8260 Jackson Rd.
   Ann Arbor, MI 48103

- ☐ **Child Information Record**

- ☐ **Co-op Family Form**

- ☐ **Health Appraisal Form:** This form required a doctor's signature. This form is not required by the initial deadline but is needed before school starts.

- ☐ **Food Allergy Action Plan:** If applicable, this requires a doctor's signature. **If it is not applicable, please write your child's name and "None" at the top.** The co-op needs a form on file for each child. This form is not required by the initial deadline but is needed before school starts.

- ☐ **Medication Permission and Instructions:** If applicable, this form requires a doctor's signature. **If it is not applicable, please write your child's name and "None" at the top.** The co-op needs a form on file for each child. This form is not required by the initial deadline but is needed before school starts.

- ☐ **Background Check Consent and Disclosure:** This form allows the co-op to begin the fingerprinting process. Further information will be provided to you about scheduling your fingerprinting appointment. Fingerprinting is required for all parents or guardians that will be assisting in the classroom.

- ☐ **Notification of the Licensing Handbook:** The handbook is found on our website www.dextercoop.com under "Forms."

- ☐ **Waiver Request Form for Young 3's and 4's:** Only applicable for a 3's student turning 3 / 4's student turning 4 between September 1st and December 1st.

- ☐ **$150 Enrollment Check**: Please submit a check to secure enrollment, made out to Dexter Cooperative Preschool.

Please contact dextercooperativemembership@gmail.com with any questions related to the enrollment requirements.

# 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.) | |



**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.

# Dexter Cooperative Preschool
# Co-op Family Form

**Section 1: Acknowledgement of Responsibility**
The Dexter Co-op is run entirely by its members – the parents. We believe this is what makes our school the best early educational experience for your child – and what makes it special. An efficient and fun school requires the cooperation and involvement of all its members in many different capacities. In an effort to avoid confusion and surprises we have compiled the following list of responsibilities and ask that you read them carefully.

**PARENT ASSIST DAYS**: Parents assist in the classroom on a rotating basis as scheduled by your session representative. Generally, you can expect to assist approximately two to three times per month depending on the size of your child's class. Scheduling requests, babysitting arrangements, etc. will be considered when the schedules are being developed.

**PARTIES AND EVENTS:** All assist and non-assist parents must plan one class party per child enrolled. All assist and non-assist families are strongly encouraged to attend and help with at least one event throughout the school year per child enrolled.

**FIELD TRIPS**: Parents are expected to attend field trips and provide transportation for their child.

**JOBS:** Each family will be assigned a job to be done throughout the school year. Every attempt will be made to make job assignments based on the preferences specified on the application, but may not be possible in all cases.

**GENERAL MEETINGS**: Members must attend all general membership meetings as many important topics are covered. Specific dates will be given to you with your orientation materials. If a member cannot attend, it is the member's responsibility to obtain the information covered at these meetings.

**HANDBOOK**: Dexter Cooperative Nursery School handbook can be found online here. Members need to review the material in the handbook, which includes school policies, board member job descriptions, assisting parent responsibilities, etc.

**TUITION**: All students must pay a non-refundable $150 enrollment fee which reserves a space in the program. Tuition is due on the 1st of each month. Payments not received by the 7th of the month will be assessed a $10.00 late fee.

Student Name (First, Last): ___________________________________________

Caregiver Name(s) (First, Last): ________________________________________

I indicate I have read the above and agree to fulfill the responsibilities of membership in the Dexter Cooperative Preschool.

Caregiver Signature: ___________________________________________
Date: _______________

**Section 2: Photography Release**
Please circle **Grant** or **Do Not Grant** below.

I [ **Grant** / **Do Not Grant** ] permission to Dexter Cooperative Preschool to photograph my child(ren) for possible placement in newsletters, our website, or other social media to promote the Co-op. [Note: Children will never be named or tagged in any placement in paper copy or online posts.]

**Section 3: Class Distribution List**
Please circle **Grant** or **Do Not Grant** below.

I [ **Grant** / **Do Not Grant** ] permission to Dexter Cooperative Preschool to release my address and phone number listed on the class list to members of Dexter Cooperative Preschool. [Note: Name and email address will be used for communication purposes automatically.]

**Section 4: Sibling Care**
Please indicate whether your family is interested in being contacted regarding the sibling care program. Indicating interest here is not a commitment. This program will be held at Peace Lutheran Church, but is not officially affiliated with the church or the co-op. The co-op will simply connect families who would like to help each other with care for younger siblings during preschool assist times.

Please circle the appropriate option:

**Interested in Sibling Care** / **Not Interested in Sibling Care**

# Health Appraisal Form Instructions

When completing the health appraisal form for the Dexter Co-op Preschool, please be sure that each of the following sections are absolutely complete with appropriate signatures, dates, addresses, phone numbers, etc. Any section in the form that is not explained below is optional.

1. Personal – Every space needs to be completed. If not applicable place “N/A” in the space.
2. Section I – Health History- Complete and be sure to sign and date as parent or guardian.
3. Section III– Immunizations
    a. All dates have to be completed with month, day and year. Be sure this area is signed by a doctor or nurse. They should supply and verify this information. Parent’s signature will not be accepted here
    b. If you plan to use a Vaccination Waiver, you will need to make an appointment with your child’s pediatrician and the county, and have it approved and submitted prior to the first day of school. Please note that it can be difficult to get an appointment as we get closer to the start of school, so don’t delay.
4. Physician’s Signature – Must be completed by a doctor and all information (date, degree, or license, name, address and phone number) must be completed.

**Thank you for helping the co-op keep our records accurate and complete!**

# 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

**Birth History:**

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

If yes, please describe:

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<br>Date: / / | Visual Acuity | | | |
| | | | Muscle Imbalance | | | |
| | | | Other: | | | |
| ☐ | ☐ | HEARING<br>Date: / / | Audiometer | | | |
| | | | Other: | | | |
| ☐ | ☐ | URINALYSIS<br>Date: / / | Sugar | | | |
| | | | Albumin | | | |
| | | | Microscopic | | | |
| ☐ | ☐ | BLOOD LEAD LEVEL<br>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<br>Date: / / | Type:<br>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.

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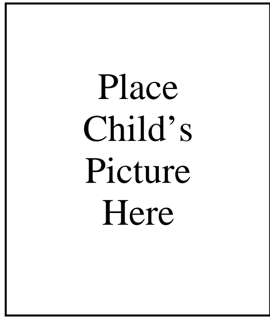
Developed in Cooperation with the Department of Health and Human Services, Education, Michigan American Association of Pediatrics, Early Childhood Investment Corporation, Child Care Licensing, Head Start, Michigan State Medical Society, Michigan Association of Osteopathic Physicians and Surgeons.

# Food Allergy Action Plan




**Student's Name:**___________________________**D.O.B:**__________**Teacher:**____________________

**ALLERGY TO**:______________________________________________________________

Asthmatic Yes* ☐ No ☐ *Higher risk for severe reaction

## ◆ STEP 1: TREATMENT ◆

| **Symptoms:** | | **Give Checked Medication****:<br>**(To be determined by physician authorizing treatment) |
|---|---|---|
| ▪ If a food allergen has been ingested, but *no symptoms*: | | ☐ Epinephrine ☐ Antihistamine |
| ▪ Mouth | Itching, tingling, or swelling of lips, tongue, mouth | ☐ Epinephrine ☐ Antihistamine |
| ▪ Skin | Hives, itchy rash, swelling of the face or extremities | ☐ Epinephrine ☐ Antihistamine |
| ▪ Gut | Nausea, abdominal cramps, vomiting, diarrhea | ☐ Epinephrine ☐ Antihistamine |
| ▪ Throat† | Tightening of throat, hoarseness, hacking cough | ☐ Epinephrine ☐ Antihistamine |
| ▪ Lung† | Shortness of breath, repetitive coughing, wheezing | ☐ Epinephrine ☐ Antihistamine |
| ▪ Heart† | Weak or thready pulse, low blood pressure, fainting, pale, blueness | ☐ Epinephrine ☐ Antihistamine |
| ▪ Other† | ________________________________ | ☐ Epinephrine ☐ Antihistamine |
| ▪ If reaction is progressing (several of the above areas affected), give: | | ☐ Epinephrine ☐ Antihistamine |

†Potentially life-threatening. The severity of symptoms can quickly change.

## DOSAGE

**Epinephrine:** inject intramuscularly (circle one) EpiPen® EpiPen® Jr. Twinject® 0.3 mg Twinject® 0.15 mg
(see reverse side for instructions)

**Antihistamine:** give____________________________________________________________
medication/dose/route

**Other:** give_______________________________________________________________
medication/dose/route

**IMPORTANT: Asthma inhalers and/or antihistamines cannot be depended on to replace epinephrine in anaphylaxis.**

## ◆ STEP 2: EMERGENCY CALLS ◆

1. Call 911 (or Rescue Squad: __________). State that an allergic reaction has been treated, and additional epinephrine may be needed.

2. Dr. ______________________________ Phone Number: ________________________________

3. Parent______________________________ Phone Number(s) ______________________________

4. Emergency contacts:
Name/Relationship Phone Number(s)

a. ___________________________________ 1.)____________________ 2.) __________________

b. ___________________________________ 1.)____________________ 2.) __________________

**EVEN IF PARENT/GUARDIAN CANNOT BE REACHED, DO NOT HESITATE TO MEDICATE OR TAKE CHILD TO MEDICAL FACILITY!**

Parent/Guardian's Signature_______________________________________ Date____________________

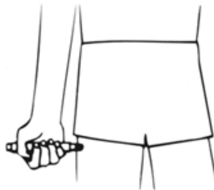
Doctor's Signature_______________________________________________ Date____________________
(Required)

| TRAINED STAFF MEMBERS | |
|---|---|
| 1. ______________________________ | Room ________ |
| 2. ______________________________ | Room ________ |
| 3. ______________________________ | Room ________ |

**EpiPen® and EpiPen® Jr. Directions**

- **Pull off gray activation cap.**

- **Hold black tip near outer thigh (always apply to thigh).**



- **Swing and jab firmly into outer thigh until Auto-Injector mechanism functions. Hold in place and count to 10. Remove the EpiPen® unit and massage the injection area for 10 seconds.**

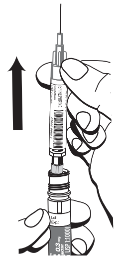
**Twinject® 0.3 mg and Twinject® 0.15 mg Directions**

- **Remove caps labeled "1" and "2."**

- **Place rounded tip against outer thigh, press down hard until needle penetrates. Hold for 10 seconds, then remove.**

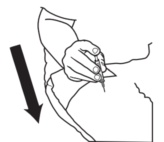
**SECOND DOSE ADMINISTRATION:**
**If symptoms don't improve after 10 minutes, administer second dose:**

- **Unscrew rounded tip. Pull syringe from barrel by holding blue collar at needle base.**



- **Slide yellow collar off plunger.**

- **Put needle into thigh through skin, push plunger down all the way, and remove.**



**Once EpiPen® or Twinject® is used, call the Rescue Squad. Take the used unit with you to the Emergency Room. Plan to stay for observation at the Emergency Room for at least 4 hours.**

**For children with multiple food allergies, consider providing separate Action Plans for different foods.**

***Medication checklist adapted from the Authorization of Emergency Treatment form developed by the Mount Sinai School of Medicine. Used with permission.*

June/2007

# 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 |
|---|---|---|---|---|
| | | | | |
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| 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 |
|---|---|---|---|---|
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# Dexter Co-op Preschool Background Check Consent and Disclosure Instructions

In addition to completing the following form, please read and fill out the following information.

Please list the primary assist parent (person who will most often assist in the classroom, also the person who wishes to primarily receive co-op emails from session reps):

_______________________________________

Additional parents/guardians who will be assisting for your family:

_______________________________________

_______________________________________

_______________________________________

_______________________________________

**Please note that each additional assist will need to fill out a Background Check Consent and Disclosure form.*
** Each person getting fingerprinted is responsible for covering the cost of the fingerprinting.*

Notes on how to fill out the form:

1. If someone has lived out of state at any time in the previous five years, they need to include all addresses in and out of state as well as the month/date/year that they lived in each residence.
2. Please double check that the form is filled out completely and correctly, as all of this information will need to be entered into the system.

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS

Part 1 – Consent
Part 2 – Disclosure
Part 3 – Reporting Requirements
Part 4 – Individual Rights
Part 5 – Application Information

# MICHIGAN CHILD CARE BACKGROUND CHECK CONSENT AND DISCLOSURE

The Child Care Background Check Program is specifically for the comprehensive background check of licensed child care providers in the state of Michigan. The system will be used by:

- Licensed Family Child Care Homes
- Licensed Group Child Care Homes
- Licensed Child Care Centers
- Michigan Department of Education (License Exempt Facilities)

The following individuals connected to a licensed child care provider must have a comprehensive background check, including FBI fingerprints:

- Applicants/licensees.
- Licensee designees.
- Program directors.
- Child care staff members.
- Unsupervised volunteers.
- Adult household members in child care homes.

Refusal to submit to this comprehensive background check will result in being found ineligible to hold one of the above roles in a licensed child care facility within the State of Michigan. Falsifying, omitting, or failing to provide complete information in connecting with a comprehensive background check will also result in the individual being found ineligible.

**Child Care Provider (this section is to be completed by the Child Care Provider)**

**Licensee Name:** **Dexter Cooperative Nursery, Inc.**

**Facility Name(s):** **Dexter Cooperative Nursery, Inc.**

**Facility License Number(s):** **DC810377610**

**Name of Individual to be Background Checked:** ______________________________

a. Must not knowingly employ or allow an individual to have unsupervised access to children in care if that individual has been convicted of a disqualifying crime or is listed on a disqualifying registry.
b. Must ensure that the individual has been fingerprinted and found eligible prior to allowing the individual to work in the child care facility, move into the home, and/or have unsupervised access to children.
c. May terminate the background check and/or decide not to hire the individual at any stage of the process.
d. Must ensure that any background check information provided will only be used for the purpose of determining an individual's ability to be connected with a child care program.
e. **Must retain a copy of the signed Consent and Disclosure form on file** at the child care facility.
f. Must ensure that all individuals entered into the system for their facility meet the requirements for the comprehensive background check as outlined above.
g. Must make the final decision regarding whether the individual is connected with the child care facility.



LARA is an equal opportunity employer/program.

## Part 1 – Consent to Conduct Background and Criminal Record Checks

As a condition of being considered for licensing, employment, or connection with a child care facility:

a. I hereby consent to and authorize the Department of Licensing and Regulatory Affairs to conduct a comprehensive background check that includes 1) a review of the licensing database of individuals with previous disciplinary action under PA 116 as Amended, or an adult foster care facility; 2) a search of the individual through the national and state sex offender registries; 3) a search of the individual through all state criminal registries or repositories for any states of residence in the past five years; 4) a request that the Department of State Police perform a criminal history check on the individual; 5) a search of the child abuse and neglect registry for Michigan and any states of residence in the past five years.
b. I understand that refusing to complete the comprehensive background check or knowingly providing false information in connection with a background check will result in me being found ineligible.
c. I understand that the child care provider will make the final decision regarding whether I am connected with the child care facility. I also understand that the child care facility may terminate the background check or decide not to allow me to be connected with the child care facility at any stage in the process.
d. I understand that if the provider withdraws me from the Child Care Background Check (CCBC) System, the department will stop processing my comprehensive background check; requiring a new background check upon being re-entered into the CCBC System.
e. I agree to provide all the information necessary to conduct a complete comprehensive background check including but not limited to all additional names I have used.

**Privacy Act Statement:**

**Authority:** Acquisition, preservation, and exchange of fingerprints and associated information by the Federal Bureau of Investigation (FBI) is generally authorized under 28 U.S.C. 534. Depending on the nature of your application, supplemental authorities include Federal statutes, State statues pursuant to Pub. L. 92-544, Presidential Executive Orders, and federal regulations. Providing your fingerprints and associated information is voluntary; however, failure to do so may affect completion or approval of your application.
**Principal Purpose:** Certain determinations, such as employment, licensing, and security clearances, may be predicated on fingerprint-based background checks. Your fingerprints and associated information/biometrics may be provided to the employing, investigating, or otherwise responsible agency, and/or the FBI for the purpose of comparing your fingerprints to other fingerprints in the FBI's Next Generation Identification (NGI) system or its successor systems (including civil, criminal, and latent fingerprint repositories) or other available records of the employing, investigating, or otherwise responsible agency. The FBI may retain your fingerprints and associated information/biometrics in NGI after the completion of this application and, while retained, your fingerprints may continue to be compared against other fingerprints submitted to or retained by NGI.
**Routine Uses:** During the processing of this application and for as long thereafter as your fingerprints and associated information /biometrics are retained in NGI, your information may be disclosed pursuant to your consent, and may be disclosed without your consent as permitted by the Privacy Act of 1974 and all applicable Routine Uses as may be published at any time in the Federal Register, including the Routine Uses for the NGI system and the FBI's Blanket Routine Uses. Routine Uses include, but are not limited to, disclosures to: employing, governmental or authorized non-governmental agencies responsible for employment, contracting, licensing, security clearances, and other suitability determinations; local, state tribal, or federal law enforcement agencies; criminal justice agencies; and agencies responsible for national security or public safety.
**Procedure to Obtain a Change, Correction, or Update of Identification Records:** If, after reviewing his/her identification record, the subject thereof believes that it is incorrect or incomplete in any respect and wishes changes, corrections, or updating of the alleged deficiency; he/she should make application directly to the agency which contributed the questioned information. The subject of a record may also direct his/her challenge as to the accuracy or completeness of any entry on his/her record to the FBI, Criminal Justice Information Services (CJIS) Division, ATTN: SCU, Mod. D2, 1000 Custer Hollow Road, Clarksburg, WV 26306. The FBI will then forward the challenge to the agency which submitted the data requesting that agency to verify or correct the challenged entry. Upon the receipt of an official communication directly from the agency which contributed the original information, the FBI CJIS Division will make any changes necessary in accordance with the information supplied by that agency. (28 CFR § 16.34).
To challenge or correct an In State record the subject may contact the Michigan State Police directly at (517) 241-0606 or by email at MSP-CRD-APPLHELP@michigan.gov. He/she should provide their name, method of contact, and reason behind the challenge/correction request.
**Consent:** I understand that my personal information and biometric data being submitted by Live Scan, will be used to search against identification records from both the Michigan State Police (MSP) and the FBI for the purpose listed above. I hereby authorize the release of my personal information for such purposes and release of any records found to the authorized requesting agency listed above.

| Signature: | Date: |
|---|---|
| | |



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## Part 2 – Disclosure Statements (applicant disclosure)

Convictions for certain crimes and/or being listed on certain registries will make an individual ineligible to be employed at or connected to a child care facility. For more details on the convictions or registries, go to www.michigan.gov/ccbc.

Listed below are all offenses that I have been convicted of and/or a substantiated finding of child abuse and/or neglect. (Attach additional sheets if necessary).

| Offense | Date of Conviction/Finding | City | State |
|---|---|---|---|
| | | | |
| | | | |
| | | | |
| | | | |

I certify that the above statements are correct and complete to the best of my knowledge and that failure to provide accurate information will result in a determination of ineligible.

Signature of Individual to be Background Checked ______________________ Date ______________________

## Part 3 – Final Employment and/or Connection with a Child Care Facility & Reporting Requirements

After a determination of eligible:

a. I understand that if I am a child care licensee, licensee designee, or program director, I shall report to the department within 3 business days after I have been arraigned for or convicted of 1 or more of the crimes listed in MCL 722.115r.

b. I understand that if I am a child care staff member, I shall report to the child care facility within 3 business days after I have been arraigned for or convicted of 1 or more of the crimes listed in MCL 722.115r.

c. A child care licensee, licensee designee, or program director shall report to the department within 3 business days after receiving a report from a child care staff member under subsection (b) or knows or reasonably knows that a member of the household has been arraigned for or convicted of 1 or more of the crimes listed in MCL 722.115r.

d. If I fail to report an arraignment or conviction of a crime listed in MCL 722.115r and the crime involved in the violation is a misdemeanor that is a listed offense or is a felony, I am guilty of a felony punishable by imprisonment for not more than 2 years or a fine of not more than $2,000.00, or both.

e. If I fail to report an arraignment or conviction of a crime listed in MCL 722.115r and the crime involved in the violation is a misdemeanor that is not a listed offense, I am guilty of a misdemeanor punishable by imprisonment for not more than 1 year or a fine of not more than $1,000.00, or both.

I certify that the above statements are correct and complete to the best of my knowledge.

Applicant's Signature ______________________ Date ______________________


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## Part 4 – Individual Rights

a. I understand that upon my written request, the department will provide a copy of any disqualifying record information found on any of the relevant registries or databases.

b. I understand that if I believe the results of any disqualifying information found on any relevant registry is inaccurate, it is my responsibility to contact the agency that maintains the registry to correct the registry information.

c. I understand that if I believe the results of the criminal history fingerprint record are inaccurate, or if the conviction contained in the criminal history record is one that may be expunged or set aside, I may file a redetermination request with the Department of Licensing and Regulatory Affairs.

__________________________________ ____________________________
Applicant's Signature Date

**THIS FORM MUST BE MAINTAINED IN THE APPLICANT'S FILE AND SHALL BE MADE AVAILABLE TO THE CHILD CARE LICENSING DEPARTMENT UPON REQUEST.**

**If you are concerned about maintaining personal information in the file, you may only black out the following information as all additional information is required by Michigan State Police:**

- **Social Security Number**
- **Address**
- **Driver's License Number**
- **Telephone Number**
- **Email Address**
- **Prior Residency Information.**



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**Part 5 – Applicant Information. This information is required to process a complete comprehensive background check. As the comprehensive background check includes name-based searches of registries, you must include all aliases.**

**Individual Information:** Social Security Number: ____________________ Date of Birth: _______________

**Facility and Role**

Facility Name ________________________________

Role
- ☐ Applicant/Licensee
- ☐ Program Director
- ☐ Licensee Designee
- ☐ Adult Household Member
- ☐ Child Care Staff Contractual/Self-Employed
- ☒ Volunteer/Individual with Unsupervised access to children

**Personal Information (Legal Name). All aliases must be listed. Omitting or providing false information below will result in a determination of ineligible.**

First ____________________ Middle ______________ Last _______________________ Suffix __________

Add All Maiden/Aliases ________________________________________________________________

Place of Birth (State or Country) _____________________ Country of Citizenship ___________________________

Height _________ Weight ________ Hair Color ___________________ Eye Color _________________ Gender ☐ Male ☐ Female Race _______________

**Address**

Country ____________________ Address _______________________________

City ____________________ State/Province _________________ Zip _________ County ______________

**Driver's License or State Identification/Phone/E-mail address**

Drivers/ID Number _________________________ State Issued _________________________________

Phone Number _________________________ Email _________________________________

**Residency**

*Did applicant continuously reside in Michigan within the last five years?* ☐ **Yes** ☐ **No**

If No, you must complete all previous addresses both in MI and out of state for the past 5 years

Previous address (use additional paper, if applicable)

Date of Residency To ______________ From __________________

Country _______________ Address __________________________________

City _______________ State/Province ______________________ Zip _______ County __________

Previous address

Date of Residency To ______________ From __________________

Country _______________ Address __________________________________

City _______________ State/Province ______________________ Zip _______ County __________



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**PARENT NOTIFICATION OF THE LICENSING HANDBOOK**

Child Care Organizations Act, 1973 Public Act 116

**Michigan Department of Human Services**

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 28, 2018 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 Children and Adult Licensing website at CCHIRP (michigan.gov).

I have read the above statement issued by ______________________________

Name of Child Care Center

Child(ren)'s Name(s) ______________________________

______________________________

Parent Name ______________________________

Parent Signature ______________________________ Date ______________

# Waiver Request Form for Young 3's and 4's

According to Michigan Law, provides that if a child does not meet the minimum age requirement to be eligible to attend school for that school year, turning 3 (for the 3-Year-Old class) or 4 (for the 4-Year-Old class) before September 1st, but will be 3 or 4 years of age not later than December 1st of that school year, the Dexter Cooperative Nursery School may enroll the child for that school year if the parent or legal guardian has notified the preschool in writing that he or she intends to enroll the child in the 3-Year-Old class/4-Year-Old class for that school year.

A preschool that receives this written notification may make a recommendation to the parent or legal guardian that the child is not ready to enroll in the 3-Year-Old class or 4-Year-Old class due to the child's age or other factors. However, regardless of this recommendation, the parent or legal guardian retains the sole discretion to determine whether or not to enroll the child in the 3-Year-Old class or 4 Year-Old class.

Student Name: ______________________________________

Date of Birth: ______________________

School Year Requested for Preschool Entry:_______________________

Evidence of School Readiness (provided by parent):

1)

2)

3)

Parent/Guardian's Printed Name: ______________________________________

Parent/Guardian's Signature: ______________________________________