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.

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Medication Prescriber/Parent Authorization Form for Self-Administration/Self-Possession

Self-administration means that the student can administer the medication in a manner directed by the physician without additional direction or supervision by school staff. Self-possession means that under the direction of the physician, the student may carry medication on his/her person to allow for immediate and self-determined administration. For medication other than inhalers, only that day's supply of medication is to be carried. The school district recommends that spare medication, properly labeled in its original container, be kept in the clinic/office in case the student runs out/forgets the medication. The building administrator may discontinue the student's self-administration privilege upon advanced notice to the parent/guardian. The student must carry a copy of this form at school.

Student Name:_____ Birthdate: _____ School Year: _____ Start date: _____ Stop date: _____

To be completed by physician/licensed prescriber:

	Medication Name	Dose	Time to be given	Form/Route*	Side Effects	Adverse Reactions
1						
2						

*Routes ~ oral (pill/capsule/chewable, liquid) ~ inhaled (inhaler, nebulizer) ~ topical skin application ~ topical (eye drop, ointment) ~ topical ear drop ~ injection ~ other (list)

List minimal frequency between doses (especially if p.r.n.): _____

If p.r.n., list symptoms/conditions under which medication is to be given: _____
The student is capable of ☐ self-administering ☐ self-possessing the above medication(s)

_____ _____ _____
Physician's signature Date Physician's Printed name

Physician's Phone #: _____ Fax #: _____ Address: _____

To be completed by parent/guardian:
I request and give permission for my child (named above) to: ☐ self-administer ☐ self-possess the above medication(s) according to school district policy and for the physician('s)/staff and school district staff to share information regarding my child's medication needs.

_____ _____
Parent/guardian signature Date **(OVER)**

Peck Elementary School
586.510.2600 Phone
586.510.2609 Fax

Student Name: _____

To be completed by student:

I agree to:

1. Never share my medication with another person
2. Carry the medication in its original properly labeled prescriptive/over-the-counter container
3. Take medication only at the prescribed time/frequency and dose
4. Carry a copy of this form with me and present it to school staff if asked

I am knowledgeable regarding the dose, desired effects, side effects, administration, etc. of the medication(s). I understand if I do not comply with this agreement that the medication will be confiscated and returned to my parents/guardian, and the privilege(s) of self-administration/self-possession denied.

_____ _____

Signature Date

Peck Elementary School

"OVER THE COUNTER"

MEDICINE DISPENSING FORM

We request that since children are in school for only six and one-half hours each day, if at all possible, that all medicine (over-the-counter or prescribed) be given prior to or after the school day. However, if it is necessary for your child to take medication during the school day, kindly supply the school with the medication and specific details of administration.

STUDENT _____ GRADE _____

Name of Medicine _____ (Please send in original container.)

Dosage _____ Frequency _____ Preferred time of day _____
(Directions for dispensing should be in agreement with recommended dosage.)

Under what conditions do you want us to dispense this medication:

Comments: _____

I request, as parent or legal guardian, that my child be administered his/her "Over-the Counter" medication at school. I understand it is my responsibility to notify the school of any change or discontinuation of the medication. I agree to provide the school with any written documents as may be required. I understand that the medication will be administered as per my written direction and must be in the original, properly labeled container.

_____ _____
Date Parent/Guardian

_____ _____
Telephone – work Street Address

_____ _____
Telephone – home City Zip Code

TOTAL P.01

Parent Handbook Acknowledgement Form

It is the parent's responsibility to read the Handbook completely before signing it. Signing this means you agree to abide by the information presented.

I have received, read, and agree to abide by the policies in the Summer Daze Parent Handbook.

_____

Date

X _____

Parent's Signature

X _____

Parent's Name (Printed)

X _____

Child's Name

Playground Permission Form

Our playground may or may not meet the expectations of the Public Playground Safety Handbook of November 2010. By signing this form it gives us your permission to let your child use the playground.

X _____

Child's or Children's Name

X _____

Parent's Signature

X _____

Date

Camp Permission Slip

CHILDS NAME _____ Date _____

Photographs/Video

_____I give my permission for photographs and/or video to be taken of my child for camp for **personal use** by the campers and staff. Staff will not post photos of campers on personal social media.

_____ I give my permission for photographs and/or video to be taken of my child for camp for **promotional use** by Center Line Parks and Recreation and Center Line Public Schools including but not limited to print and social media.

_____I do NOT give permission for my child to be photographed.

Media

_____I give my permission for my child to view movies rated PG.

_____I do NOT give my permission for my child to view movies rated PG.

Sunblock

I give permission to the Summer Daze staff to apply sunscreen that I have provided, or any sunscreen they have available, on my child while he/she is in attendance.

____YES ____NO

Insect Repellent

I give my permission to the Summer Daze staff to apply insect repellent that I have provided, or any insect repellent they have available, on my child while he/she is in attendance.

____YES ____NO

Parent's Signature: _____

Field Trip PERMISSION SLIP

CHILDS NAME: _____

These are all of the field trips planned for the Summer Daze Camp, some trips may change due to the weather. **If you do not want your child to attend one of the listed field trips—do not bring your child to camp on that day—there will be no staff at the camp location while we are out on field trips.**

- June 26th Spencer Park 10:30-4:00
- June 28th Universal Lanes 1:00-4:30
- July 3rd Spencer Park 10:30-4:00pm
- July 5th Belle Isle Nature Center 10:00-3:00
- July 10th Spencer Park 10:30-4:00
- July 12th Train Museum 9:00-4:00
- July 17th Spencer Park 10:30-4:00
- July 19th Detroit Zoo 9:30-3:00
- July 24th Spencer Park 10:30-4:00
- July 26th Diamond Jack's Boat Tour 9:00-3:00
- July 31st Spencer Park 10:30-4:00
- August 2nd Legoland 12:00-5:00
- August 7th Spencer Park 10:30-4:00
- August 9th Selfridge Airforce Base 12:30-4:00
- August 14th Spencer Park 10:30-4:00
- August 16th C.J. Barrymore's 10:00-4:00
- August 21st Spencer Park 10:30-4:00
- August 23rd Airtime 9:30-1:00

Parent's Signature: _____Date: _____

Communication through Shutterfly Website

Sometimes items are needed for the trips that we will be taking and sometimes due to weather the trips will have to be changed or cancelled. Sometimes we may not cross paths before or after pick-up so we would like to be able to contact you with reminders on the items that are needed the day before the trip. Please let me know the most proficient way to contact you with reminders.

Please enter email addresses for all parents/guardians/grandparents who you would like kept informed.

E-MAIL _____

E-MAIL _____

E-MAIL _____

E-MAIL _____

E-MAIL _____

E-MAIL _____

Shutterfly Website

www.SummerDaze2018.shutterfly.com

If you have any questions creating an account or downloading the app on the Apple App Store, call Center Line Parks & Recreation at 586-757-1610.

Camp T-Shirt

Camp T-Shirt MUST be worn on ALL Field Trips. One shirt is included in camp registration. If you lose your shirt you will need to purchase a new one.

Child's Name: _____ Circle One:

Child:	Small	Medium	Large	X-Large
Adult:	Small	Medium	Large	X-Large