



Clawson Childcare Center 2025-26 School Year  
Parental Agreement (*Transitional Kindergarten-5<sup>th</sup> Grade*)

Please check the box once you have read and agree to each statement, then sign and date below.

**Policies and Procedure Agreement**

I have been given a copy of the Clawson Childcare Center Policy and Procedure Handbook (found on website). I have read the Clawson Childcare Center Policy and Procedure Handbook. I understand and agree to adhere to and follow the policies and procedures therein.

**Discipline Policies**

I have read and understand the discipline policies of the Clawson Childcare Center as explained in the Clawson Childcare Handbook. I agree to allow only the policies stated therein to be used in disciplining my child.

**Admission and Withdrawal Policy**

I understand that all criteria for admission must be met in order for my child to attend the Clawson Childcare Center programs, and that if all criteria are not met by the first date of attendance my child's enrollment will be terminated. I understand that I may be asked to withdraw my child if any of the following should occur:

- ✓ The center is unable to provide services to meet the needs of the child(ren).
- ✓ The quality of care provided to the other children is jeopardized.
- ✓ There are, in the opinion of the District, irreconcilable differences concerning the center's policies between the parents and the center.
- ✓ I do not adhere to the policies found within the Clawson Childcare Center Handbook.

I understand that the Clawson Childcare Center reserves the right to terminate and/or deny re-enrollment for failure to adhere to the procedures and policies.

**Payment Agreement**

I agree to pay the applicable fees according to the programs I have selected and the payment schedule provided. I understand a \$10.00-dollar late payment will be applied to my account. I understand that if I need to change programs I must do so in writing and that changes are subject to availability. I understand that failure to pay will result in termination of contract. I understand that my registration fee is non-refundable and that my one-week deposit will be applied to my child's first week of attendance.

**Licensing Notebook**

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)

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

\_\_\_\_\_  
Date

**PLEASE TURN OVER AND FILL OUT PROGRAM SELECTION FORM COMPLETELY**



Clawson ChildCare Center  
**Before &/or After School Care Program Selection**

Child's Name		Address (City, State, & Zip Code)	
Date of Birth		Home Phone	
Mothers Name		Email Address	
Cell Phone/Home Phone		Address (only if different than child's)	
Fathers Name		Email Address	
Cell Phone/Home Phone		Address (only if different than child's)	
<b>Parent's Marital Status</b> <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Single		<b>Child resides with</b> <input type="checkbox"/> Mother <input type="checkbox"/> Father <input type="checkbox"/> Other _____	
<b>Person(s) Responsible for Payment</b> <input type="checkbox"/> Mother <input type="checkbox"/> Father <input type="checkbox"/> Other _____		<b>Driver's License #</b>	
<b>Grade</b>		<b>Attendance</b> <input type="checkbox"/> Monday through Friday <input type="checkbox"/> Other _____	
<b>Does your child receive special education services</b>	<b>Yes or No</b>	If yes what service does your child receive from the district? Are there any behaviors we should be aware of	

**PROGRAM CHOICE**

<b>Before &amp; After School Care* (3-5 days/wk) Transitional Kindergarten - 5<sup>th</sup> Grade</b>	<b>First Child</b>	<b>10% Sibling Discount</b>
<input type="checkbox"/> Before School (6:30-8:12am)	<input type="checkbox"/> \$50.00/week	<input type="checkbox"/> \$45.00/week
<input type="checkbox"/> After School (3:07-6:00pm)	<input type="checkbox"/> \$65.00/week	<input type="checkbox"/> \$58.50/week
<input type="checkbox"/> Before & After School	<input type="checkbox"/> \$90.00/week	<input type="checkbox"/> \$81.00/week
<input type="checkbox"/> 1/2 Day Add Additional \$20.00 to regular payment	<input type="checkbox"/> \$20.00	<input type="checkbox"/> \$18.00
<input type="checkbox"/> No School Day & Break Weeks	<input type="checkbox"/> \$50.00/Per Day	<input type="checkbox"/> \$45.00/Per Day

<b>Occasional Care (1-2 days/wk) All ages (24 hour notice)</b>	<b>First Child</b>	<b>10% Sibling Discount</b>
<input type="checkbox"/> Before School Occasional Care	<input type="checkbox"/> \$17.00/day	<input type="checkbox"/> \$15.30/day
<input type="checkbox"/> After School Occasional Care	<input type="checkbox"/> \$22.00/day	<input type="checkbox"/> \$19.80/day
<input type="checkbox"/> Before & After School Occasional Care	<input type="checkbox"/> \$27.00/day	<input type="checkbox"/> \$24.30/day
<input type="checkbox"/> 1/2 Day Occasional Care	<input type="checkbox"/> \$30.00/Per Day	<input type="checkbox"/> \$27.00/day
<input type="checkbox"/> No School Day & Break Weeks	<input type="checkbox"/> \$60.00/Per Day	<input type="checkbox"/> \$54.00/Per Day

**My child will attend on the first half day of school:     YES     NO**

**Registration Fee and First week payment is due at time of registration.**

<b>PAYMENT DUE</b>	Registration Fee (\$65 per child)	\$	Amount Paid	\$
	First Child One week	\$	Check No.	
	Second Child One Week	\$	PayPal	
	<b>Total</b>	\$	Money Order	

**Payments can be made by check to Clawson Public Schools or via PayPal**

# 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.

<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		Home Phone ( )	Parent/Legal Guardian's Name (Optional)	
Home Address (if not child's address)		Cell Phone ( )	Home Address (if not child's address)	
City	State	Zip Code	City	State Zip Code
Email Address (optional)			Email Address	
Employer Name		Work Phone ( )	Employer Name	
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. 7-18) Previous edition 6-17 may be used.

**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.	

**GOOD HEALTH STATEMENT**

I verify that my child \_\_\_\_\_ a) is in good health, b) that all of my child's immunizations are up to date, and c) that my child's immunization records are up to date and on file at my child's school. Any activity restrictions are listed below. I agree to notify the Clawson Childcare Center should any changes in my child's health occur.

Restrictions: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

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

\_\_\_\_\_  
Date

**GENERAL INFORMATION TO HELP US PROVIDE THE BEST CARE FOR YOUR CHILD**

What are your child's favorite activities? \_\_\_\_\_  
\_\_\_\_\_

Who does your child share a home with? Parents, siblings, pets, etc. \_\_\_\_\_  
\_\_\_\_\_

Does your child have any physical, emotional, or language difficulties that we should be aware of? \_\_\_\_\_  
\_\_\_\_\_

Is there anything in your child's family life that you think we should know in order to care for your child more effectively? \_\_\_\_\_  
\_\_\_\_\_

Does your child have any allergies or medical issues?  Yes  No If yes, please describe: \_\_\_\_\_  
\_\_\_\_\_

Is there anything else you would like us to know to help us to better care for your child? \_\_\_\_\_  
\_\_\_\_\_

**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

It is recommended this form be reviewed with the parent every 3 months if the medication is ongoing.

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