LAPEER COMMUNITY SCHOOLS
District of Choices

KIDS & COMPANY
3145 West Genesee Street, Lapeer MI 48446
phone (810) 667-2454 fax (810) 245-1090
www.lapeerschools.org

LCS Tuition Preschool Parent Checklist

Please remember, you must have ALL paperwork completed and turned in, along with the registration fee in order to be enrolled into the program.

Included in this packet:

___ Preschool Payment Schedule

___ Registration Form

___ Child Information Card

___ All Purpose Permission Form

___ Parent Notification of Licensing Notebook

___ Health Appraisal

Documents Parent Provides:

___ Child's Birth Certificate

___ Immunization Record (up-to-date)

Available upon request. Can be found on our website at www.lapeerschools.org

___Parent Handbook

___Early Childhood Curriculum Guide

Kids & Company

2025-2026 Preschool Payment Schedule

All Payments are due on the first day of the month starting September 1

Payment Plans

Semi-Annual

	September 1	December 1
3 Year-old Program: Tuesday-Thursday	$420.00	$420.00
4 Year-old Program: Monday-Thursday	$480.00	$480.00

8 Payment Plan		Due First Day of The Month
3 Year-old Program: Tuesday-Thursday	$105.00	September 1
	$105.00	October 1
	$105.00	November 1
	$105.00	December 1
	$105.00	January 1
	$105.00	February 1
	$105.00	March 1
	$105.00	April 1
4 Year-old Program: Monday-Thursday	$120.00	September 1
	$120.00	October 1
	$120.00	November 1
	$120.00	December 1
	$120.00	January 1
	$120.00	February 1
	$120.00	March 1
	$120.00	April 1

Methods of Payment:

We accept cash, check or online payment through payschools.
Please drop cash/check payment off in the Kids & Company office or into the payment drop box outside our office door.
Or mail to address below:

Kids and Company
3145 W. Genesee St
Lapeer, MI 48446

Make all checks payable to: Lapeer Community Schools

(Please put the child's first and last name on the Memo line of your check)

Kids & Company

Located at: Rolland Warner Middle School - 3145 W. Genesee St. Lapeer, MI 48446 - (810) 667-2454

LCS Tuition Preschool Registration Form

Today's Date_____/_____/_____

Child's Name: _____ Date of Birth _____/_____/_____

Address: _____City_____ Zip_____

Name of Mother/Guardian: _____ Cell Phone: (____) _____-_____

Work Phone: (____) _____-_____Email: _____

Name of Father/Guardian: _____ Cell Phone: (____) _____-_____

Work Phone: (____) _____-_____Email: _____

Schedule Information:

Class days and times are dependent on enrollment and subject to change.

Indicate your choice by checking box

3 Year Old Program (children must by 3 by October 31)

Tues/Wed/Thu	8:45-11:45 AM	☐ $840/Year (payment plans available)
Tues/Wed/Thu	12:45-3:45 PM	☐ $840/Year (payment plans available)

4 Year Old Program (children must be 4 by October 31)

Mon/Tue/Wed/Thu	8:45-11:45 AM	☐ $960/Year (payment plans available)
Mon/Tue/Wed/Thu	12:45-3:45 PM	☐ $960/Year (payment plans available)

$75 non-refundable family registration fee is due to hold a spot.

Fees are payable by check, cash or online through payschools. Make checks out to Lapeer Community Schools.

Parent/Guardian Signature: _____ **Date:** _____

Please indicate any health concerns or special needs that you feel our child's teacher should be aware of:

_____

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.)			

See Reverse Si

CCL-3731 (Rev. 3/17/2022) Previous editions 7-18 & 4-21 may be used

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 L Guardian In

LARA is an equal opportunity employer/program.

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

CCL-3731 (Rev. 3/17/2022) Previous editions 7-18 & 4-21 may be used

Kids & Company

ALL PURPOSE PERMISSION FORM

All Kids and Company Programs

Please initial next to each statement you give permission for and sign the bottom.

I grant permission for my child_____ to participate in the program activities as listed below. Program activities include:

_____ 1. Walking field trips on school property

_____ 2. Photographing or videotaping my child for in-school use only for promotional and personal use for parents (gifts or scrapbook).

_____ 3. Photographing my child for the local newspaper or marketing to promote Kids and Company events. (No names are ever used)

_____ 4. Posting photos of my child on the Kids and Company web pages for promotional use by Kids and Company. (No names are ever used)

_____ 5. Watching PG rated Children Movies, during Kids and Company hours.

_____ 6. Going with staff to a restroom for toilet training.

_____ 7. Riding a Lapeer Community Schools bus or GLTA for any field trip. (Parents will always be notified in advance of any field trip)

_____ 8. Allowing staff to give or apply sunscreen and chap stick to my child as needed (parent to provide sunscreen & chap stick). Special needs regarding sunscreen?

_____

_____ 9. Transport my child to safety on a Lapeer Schools bus or walk to evacuation site in the event the building is deemed unsafe and needs to be evacuated. This also includes drills.

_____ 10. *For School Age Programs Only:* According to the Michigan Department of Human Services, school age programs operating in a school building are exempt from compliance of the 1997 edition of Public Playground Safety regulations and regular inspections. Before and After School Age Programs are exempt from licensing rules 400.5117 (7-9). www.michigan.gov/childcare

_____ 11. I have read and understand all policies and procedures in the Kids and Company Parent Handbook. I agree to adhere to all Kids and Company policies and I understand that violation of any of these policies could result in termination from the program.

_____ _____

Parent Signature Date

PARENT NOTIFICATION OF THE LICENSING NOTEBOOK

Child Care Organizations Act, 1973 Public Act 116

Michigan Department of Licensing and Regulatory Affairs

Child Care Licensing Bureau

CENTER MUST CHECK ONE

☒ The center keeps a licensing notebook containing a summary sheet, all licensing inspections and special investigations, and related corrective action plans for the last 5 years. The licensing notebook is available to parents/guardians during regular business hours. Reports from at least the past three years are available at **www.michigan.gov/michildcare**.

☐ 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**.

I have read the above statement issued by _____
Name of Child Care Center

Child(ren)'s Name(s):	

Parent Name _____

Parent Signature _____ Date _____

LARA is an equal opportunity employer/program.

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 – Parent Completes

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 – Parent Completes Signs Last

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

Parent/Guardian Signature _____ Date / /

Birth History:

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

If yes, please describe:

If yes, list medications:

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 – Dr. Completes Signs Back

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 _____ 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 Date: / /	Type: _____ 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:

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

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.

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

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.

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.