

St. Francis Xavier Child Development Center

Preschool-Childcare-Latchkey

RATE SHEET

Registration Fee Fall Session: \$100.00/Family
Registration for Summer session: \$100.00/Family

Preschool Tuition

2-day- \$190.00/month

Tuesday and Thursday

8:00 am – 11:00 am OR 12:00 pm – 3:00 pm

3-Day- \$240.00/month

Monday, Wednesday and Friday

8:00 am - 11:00 am OR 12:00 pm – 3:00 pm

Childcare Rates

\$5.50

Latchkey Rates

\$15.00 day/child

Absent fees do not apply to latchkey

Summer Child Care

5.50 Hour (2 ½ to 12 years of age)

Infant and Toddler Rates

\$6.00 per hour

Acceptable forms of payment: credit card

Tuition for Infant and Toddler room does not include diapers and formula

All payments will be made in our FACTS program

I understand and agree to the rates stated above: _____ initial here

I understand that every family will be responsible to sell 3 Grand Raffle tickets for the annual school fundraiser. _____ initial here

Name: _____

Child(ren) Names: _____

Date: _____

Please return to the CDC office along with Enrollment Paperwork

St. Francis Xavier Child Development Center Contract
Preschool - Child Care - Latchkey - Infant Care

Child's Name: _____ Age: _____ D.O. B. _____

Parishioner: Yes _____ No _____ Parish _____

Address: _____ City: _____ State: _____

Phone Number: _____ E-Mail: _____

Preschool

2 Day(3 year olds) AM _____ PM _____
3 Day(4/5 year olds) AM _____ PM _____

**Child Care/Infant/ or Latchkey
Arrival and Departure Times**

Monday- _____
Tuesday- _____
Wednesday- _____
Thursday- _____
Friday- _____

- Registration Fee of \$100.00
- Infant and Toddler and Childcare absences are at full rate
- Billing is done every two weeks. Preschool will be billed once a month
- A \$10.00 late pick up fee will be charged for every 10 minutes past 5:30pm
- An outstanding bill of \$500.00 or more will result in termination of services

Parents agree to:

- Notify the center of child's arrival and departure each day (time sheet)
- Must have and follow a weekly schedule – No Drop In's without seeking approval from staff member.
- Understand our Licensing Notebook is located in the CDC office and is available for your review at anytime
- Notify the center in advance of absences and any delay in pick up time.
- Keep your child home if they are ill. Must be fever free for 24 hours
- Comply with policies as stated in the handbook and have completed all necessary enrollment paperwork.
- Understand during the course of school, students may be photographed for various publications, website, facebook page, newsletters.
- Fill out medication permission slip required by the Department of Social Services
- Understands at the time your child turns 30 months they will move out of the infant and toddler room and into the CDC room.
- Understand at the time your child reaches 33 months of age they will be moved to a 1 to 10 ratio
- Understand children will be utilizing the pre-school playground. School age children will utilize the St. Francis School playground.
- Read and understand the Priority Enrollment agreement
- 3 Tickets for the St. Francis Gala Auction mandatory sale \$100.00 each

A parent or legal guardian must sign this agreement before attending any part of the center.

Contract _____ Info Card _____ Health Form _____ Inventory Sheet _____ Registration Fee _____

DATE PAPERWORK RECEIVED: _____

VERIFIED PARISHIONER: _____

Revised 2-8-2023

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)					
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)		2 nd Phone (if applicable) ()	Home Address (if not child's address)		2 nd 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 <input type="checkbox"/> No <input type="checkbox"/> If yes, explain:					
(Attach additional sheets, if necessary.) CCL-3731 (Rev. 3/17/2022)					

Previous editions 7-18 & 4-21 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. 3.	()	2.	()
	()	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.	

MDHHS-3305, HEALTH APPRAISAL

Michigan Department of Health and Human Services (MDHHS)
(Revised 7-24)

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 1. Section 4 may be certified by the transcription of information from the certificate of immunization. The remaining sections are to be completed by a doctor, nurse, dentist, dental therapist, and dental hygienist.

(BE SURE TO BRING YOUR CHILD'S IMMUNIZATION RECORDS TO THE EXAMINATION).

SECTION 1 – PERSONAL

Child's Name (Last, First, Middle) _____ Date of Birth (mm/dd/yy) _____

Address (Number, Street, City, Zip Code) _____ Today's Date (mm/dd/yy) _____

Parent/Guardian (Last, First, Middle) _____ Home/Cell Phone Number _____

Address (Number, Street, City, Zip Code) _____ Work Phone Number _____

SECTION 2 – HEALTH HISTORY

Yes	No	Resolved	Is your child having any of the problems listed below?	Birth History
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	1. Allergies or Reactions (for example, food, medication or other)	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	2. Anaphylaxis	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	3. Does your child take any medication(s) regularly?	If yes, list medications
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	4. Hay Fever, Asthma, or Wheezing	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	5. Eczema or Frequent Skin Rashes	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	6. Convulsions/Seizures	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	7. Heart Trouble	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	8. Diabetes	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	9. Frequent Colds, Sore Throats, Earaches (4 or more per year)	Are there any current or past diagnosis(es) <input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	10. Trouble with Passing Urine or Bowel Movements	If yes, describe

<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	11. Shortness of Breath	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	12. Speech Problems	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	13. Menstrual Problems	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	14. Dental Problems Date of Last Exam OR Date of Last Assessment	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	15. Other (describe)	

Reason for Medication

Concussion History

Parent/Guardian Signature

Date

Was the health history reviewed by a health professional?

Examiner's Initials

Yes No

SECTION 3 - PHYSICAL EXAMINATION, INSPECTION, TESTS AND MEASUREMENTS

Required for Child Care and Head Start / Early Head Start

Test and Measurements

Yes	No	Was child test for	Tests and results	Normal	Referred	Under Care
<input type="checkbox"/>	<input type="checkbox"/>	Vision	Visual Acuity	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
		Date	Muscle Imbalance	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
			Other	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	Hearing	<input type="checkbox"/> Audiometer (R= Right, L=Left)			
		Date	<input type="checkbox"/> OAE (R= Right, L=Left)			
			<input type="checkbox"/> Other (R= Right, L=Left)			
<input type="checkbox"/>	<input type="checkbox"/>	Urinalysis	Sugar	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
			Albumin	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
			Microscopic	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	Blood Lead Level	Level ug/dl	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
		Date				

Note: All children in Medicaid need to be tested at 1 and 2 years of age, or once between 3 and 6 years of age if not previously tested. All children, regardless of Medicaid status, should be tested at those same ages if they live in an area where lead risk is high.

<input type="checkbox"/>	<input type="checkbox"/>	Height & Weight	Height	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
			Weight	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	Other	Other	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	Hemoglobin/Hematocrit	➡	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	Blood Pressure	Reading	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Complete pediatric tuberculosis risk assessment available at:

https://www.michigan.gov/documents/mdhhs/4._MI_Pediatric_TB_Risk_Assessment_661537_7.pdf OR
feel free to use the attached QR code instead of the full link text.



Examinations and/or Inspections

Essential Findings Deviating from Normal

Exam Date

SECTION 4 – IMMUNIZATIONS

Statements such as "UP-TO-DATE" or "COMPLETE" will not be accepted. Admission to school may be denied based on this information.*

Vaccines (Select Type)	Date Administered (mm/dd/yy)		
Hepatitis B (HepB)	1.	2.	3.
	4.		
DTaP/DTP/DT/Td	1.	2.	3.
	4.	5.	6.
Tdap	1.		
Haemophilus Influenzae type b (HIB)	1.	2.	3.
	4.		
Polio (IPV/OPV)	1.	2.	3.
	4.	5.	
Pneumococcal Conjugate (PCV)	1.	2.	3.
	4.		
Rotavirus (RV1/RV5)	1.	2.	3.
Measles, Mumps, Rubella (MMR/MMRV)	1.	2.	3.
Varicella (Chickenpox), (Var, MMRV)	1.	2.	
Hepatitis A (HepA)	1.	2.	3.

Influenza (IIV/LAIV)	1. 4.	2.	3.
Meningococcal (MCV4, MenABCWY)	1.	2.	3.
Meningococcal B (Bexsero, Trumenba, MenABCWY)	1.	2.	3.
Human Papillomavirus (HPV)	1.	2.	3.

Additional 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?

If yes, date

Yes No

Parent/Guardian refused recommended immunizations at visit.

I certify that the immunization dates are true to the best of my knowledge

Health Professional Signature Title

Date

SECTION 5 - RECOMMENDATIONS (Required for Child Care and Head Start/Early Head Start)

Is there any defect of vision, hearing, or other condition for which the school could help by seating or other actions?

Yes No

If yes, explain

Should the child's activity be restricted because of any physical defect or illness?

Yes No

Check all that apply

<input type="checkbox"/> Classroom	<input type="checkbox"/> Playground	<input type="checkbox"/> Gymnasium
<input type="checkbox"/> Swimming Pool	<input type="checkbox"/> Competitive Sports	<input type="checkbox"/> Other

If yes, explain degree of restriction(s)

Other Recommendations

SECTION 6 - DENTAL EXAM OR ASSESSMENT RECOMMENDATIONS

Child's Name

Type of Service

Dental Exam

Dental Assessment

Findings (Check all that apply)

No findings

Treated Decay

Untreated Decay

Recommendations (Check one)

Routine Care

Referral for dental treatment

Referral for urgent dental care

Provider Signature

Date

Check one

Dentist

Dental Therapist

Dental Hygienist

SECTION 7 - PHYSICIAN'S SIGNATURE

Examiner's Name (Print)

Degree or License

Telephone Number

Examiner's Signature

Date

Address

City

State Zip Code

MI

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 preventative and primary health care, including medical, dental, and mental health. The schedule must incorporate the well-childcare 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.

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