Our teachers and staff are looking forward to meeting you and your child. This is an exciting time for your family and we are glad to be part of your child's educational journey! *We* are now ready to get your little Cardinals registered for preschool and the plan is as follows:

In order to complete your child(ren)'s student file, please fill out and return the following documents to our office:

1. Additional Child Information Questionnaire. This form gives us valuable information about your child that helps with teacher placement, medical needs and helpful information regarding eligibility and prioritization.
2. Health Appraisal- This is a state required form that must be turned in for all students. A three/four year old physical is due on or before the first day of school. This must be filled out by both the parent/guardian and your child's physician. Be sure to have the physician sign and date.
3. Concussion Awareness form - This form also needs to be completed, signed and dated by one parent. We keep this form in your child's folder for record keeping of any head bumps. (You will be notified of any head bumps at school)
4. Three signed Licensing and acknowledgement documents for Child Care Centers.
5. Filled out Child Information Record

Once these documents are completed and signed, you will need to drop them off at the Cardinal's Nest ALONG WITH A COPY OF THE FOLLOWING DOCUMENTS:

1. Your child's birth certificate
2. Your driver's license or state issued ID
3. Updated immunization record.
4. Student's IEP (if applicable)
5. Custody documents (if applicable)
6. Medical forms (if applicable)

*If any of the required documentation is not provided, your child will be considered incomplete and their enrollment will be placed on hold.

DROP OFF INFORMATION: Return completed packet and the above required documents to the Cardinal's Nest, 1490 N. Oak Road, Davison Mi 48423. Monday-Friday between 9:00 AM and 3:00 PM. For security and confidentiality reasons, please ring the doorbell at the main entrance and we will meet you to collect your packet. **DO NOT LEAVE COMPLETED PACKETS IN THE BIN OUTSIDE!**

If you have questions, please call our office at 810-591-0821 or email the Cardinal's Nest Preschool Director Lindsey Tate at ltate@davisonschools.org

Cardinal's Nest Additional Child Information

1. Child's full name: _____ DOB: _____
2. Does your child have a nickname they would like to be called at school? _____
3. How did you hear about our program? _____
4. By September 1st is your child: 3 years old or 4 years old
   Is your child bathroom independent? _____
5. Are you interested in the: ½ day A.M ½ day P.M. or Full day class?
   Are you interested in the: M/W/F T/TH or M-F schedule?
6. Has your child attended a previous daycare or preschool? ____ If so, where? _____
7. Please list the biological parents listed on the birth certificate
   Mother: _____
   Father: _____
8. Please list any step partanets, foster parents, legal guardians _____
   _____
   _____
9. Are there any court ordered custody papers to be aware of? _____
10. Who does the child live with? _____
11. Primary contact information:
    Name: _____
    Phone number: _____
    Address: _____
    Email address: _____
12. Do you live in the Davison school district? _____
    If out of district, which school district do you reside in? _____
13. Does your child take any medication on a regular basis? _____
    Will they need medication at school? _____
14. Does your child have any diagnosed allergies including food allergies? _____
    Does your child have any food intolerances? _____
15. Does your child receive Special Education services, have an IEP or IFSP? _____
    Do you have any concerns? _____
16. Is there anything else you would like us to know about your child?
    _____
    _____
    _____

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

_____ / /
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

Tests and Measurements

No	Yes	Was child tested for:	Test results:	Normal	Referred	Under Care
☐	☐	VISION	Visual Acuity			
			Muscle Imbalance			
		Date: / /	Other:			
☐	☐	HEARING	Audiometer			
			Other:			
		Date: / /				
☐	☐	URINALYSIS	Sugar			
			Albumin			
		Date: / /	Microscopic			
☐	☐	BLOOD LEAD LEVEL	Level _____ ug/dl ⇨			
		Date: / /				

No	Yes	Was child tested for:	Test results:	Normal	Referred	Under Care
☐	☐	HEIGHT & WEIGHT	Height			
			Weight			
☐	☐	Other: _____	Other			
☐	☐	HEMOGLOBIN / HEMATOCRIT	⇨			
☐	☐	BLOOD PRESSURE	Reading: _____			
☐	☐	TUBERCULIN	Type: _____			
		Date: / /	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	
	Type of Vaccine(s)	Date of Vaccine(s)
OTHER Vaccines Specify Date & Type	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.

****

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.

Davison Community Schools

Where Kids Come First and Futures Begin

Administrative Offices *1490 N. Oak Road* *Davison, Michigan 48423*

August 2018

Dear Parents or Guardians:

Michigan recently became the 39th state to enact a law requiring all school districts and sports-related organizations to provide educational materials about concussion awareness and the risks of concussions to each student. The law also required parents or guardians to sign a form acknowledging that they have received Concussion Awareness information from the school district. This signed form must be kept on file with the district until the student turns 18.

Attached to this letter, please find educational material about concussion awareness and a Concussion Awareness Educational Material Acknowledgement Form. Please take a few minutes to read and sign the attached materials so that they may be returned to school and placed in your child's file in order to comply with the law.

Concussions are a very serious brain injury caused by a blow, bump or jolt to the head. According to the Centers for Disease Control, U.S. emergency rooms annually treat an estimated 173,285 sports and recreation-related concussions among children and adolescents, with the highest number of injuries occurring in boys' football and girls' soccer.

For more information about concussions or the new Concussion Awareness law, please contact your child's building principal or my office at 591-0913. The Michigan Department of Community Health has also launched a very helpful website with resources for coaches, parents and athletes at www.michigan.gov/sportsconcussions.

Sincerely,

Holly Halabicky

Holly Halabicky
Executive Director of Student Services

JD\Letters\Concussion Letter to Parents 2018

Eric Lieske
Superintendent
(810) 591-0801
Fax (810) 591-7813

Kevin Brown
Assistant Superintendent
(810) 591-0808
Fax (810) 591-0082

Holly Halabicky
Executive Director of Student Services
(810) 591-0913
Fax (810) 591-2674

www.davisonschools.org

Educational Material for Parents and Students (Content Meets MDCH Requirements)
Sources: Michigan Department of Community Health, CDC and the National Operating Committee on Standards for Athletic Equipment (NOCSAE)

UNDERSTANDING CONCUSSION

Some Common Symptoms

Headache	Balance Problems	Sensitive to Noise	Poor Concentration	Not "Feeling Right"
Pressure in the Head	Double Vision	Sluggishness	Memory Problems	Feeling Irritable
Nausea/Vomiting	Blurry Vision	Haziness	Confusion	Slow Reaction Time
Dizziness	Sensitive to Light	Fogginess	"Feeling Down"	Sleep Problems
		Grogginess		

WHAT IS A CONCUSSION?

A concussion is a type of traumatic brain injury that changes the way the brain normally works. A concussion is caused by a fall, bump, blow, or jolt to the head or body that causes the head and brain to move quickly back and forth. A concussion can be caused by a shaking, spinning or a sudden stopping and starting of the head. Even a "ding," "getting your bell rung," or what seems to be a mild bump or blow to the head can be serious. A concussion can happen even if you haven't been knocked out.

You can't see a concussion. Signs and symptoms of concussions can show up right after the injury or may not appear or be noticed until days or weeks after the injury. If the student reports any symptoms of a concussion, or if you notice symptoms yourself, seek medical attention right away. A student who may have had a concussion should not return to play on the day of the injury and until a health care professional says they are okay to return to play.

IF YOU SUSPECT A CONCUSSION:

1. **SEEK MEDICAL ATTENTION RIGHT AWAY** – A health care professional will be able to decide how serious the concussion is and when it is safe for the student to return to regular activities, including sports. Don't hide it, report it. Ignoring symptoms and trying to "tough it out" often makes it worse.

2. **KEEP YOUR STUDENT OUT OF PLAY** – Concussions take time to heal. Don't let the student return to play the day of injury and until a heath care professional says it's okay. A student who returns to play too soon, while the brain is still healing, risks a greater chance of having a second concussion. Young children and teens are more likely to get a concussion and take longer to recover than adults. Repeat or second concussions increase the time it takes to recover and can be very serious. They can cause permanent brain damage, affecting the student for a lifetime. They can be fatal. It is better to miss one game than the whole season.

3. **TELL THE SCHOOL ABOUT ANY PREVIOUS CONCUSSION** – Schools should know if a student had a previous concussion. A student's school may not know about a concussion received in another sport or activity unless you notify them.

SIGNS OBSERVED BY PARENTS:

- Appears dazed or stunned
- Is confused about assignment or position
- Forgets an instruction
- Can't recall events prior to or after a hit or fall
- Is unsure of game, score, or opponent
- Moves clumsily
- Answers questions slowly
- Loses consciousness (even briefly)
- Shows mood, behavior, or personality changes

CONCUSSION DANGER SIGNS:

In rare cases, a dangerous blood clot may form on the brain in a person with a concussion and crowd the brain against the skull. A student should receive immediate medical attention if after a bump, blow, or jolt to the head or body s/he exhibits any of the following danger signs:

- One pupil larger than the other
- Is drowsy or cannot be awakened
- A headache that gets worse
- Weakness, numbness, or decreased coordination
- Repeated vomiting or nausea
- Slurred speech
- Convulsions or seizures
- Cannot recognize people/places
- Becomes increasingly confused, restless or agitated
- Has unusual behavior
- Loses consciousness (even a brief loss of consciousness should be taken seriously.)

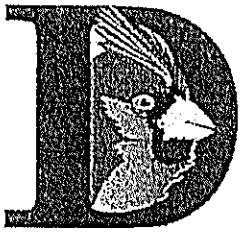
HOW TO RESPOND TO A REPORT OF A CONCUSSION:

If a student reports one or more symptoms of a concussion after a bump, blow, or jolt to the head or body, s/he should be kept out of athletic play the day of the injury. The student should only return to play with permission from a health care professional experienced in evaluating for concussion. During recovery, rest is key. Exercising or activities that involve a lot of concentration (such as studying, working on the computer, or playing video games) may cause concussion symptoms to reappear or get worse. Students who return to school after a concussion may need to spend fewer hours at school, take rests breaks, be given extra help and time, spend less time reading, writing or on a computer. After a concussion, returning to sports and school is a gradual process that should be monitored by a health care professional.

Remember: Concussion affects people differently. While most students with a concussion recover quickly and fully, some will have symptoms that last for days, or even weeks. A more serious concussion can last for months or longer.

To learn more, go to www.cdc.gov/concussion.

Parents and Students Must Sign and Return the Educational Material Acknowledgement Form



CONCUSSION AWARENESS

EDUCATIONAL MATERIAL ACKNOWLEDGEMENT FORM

By my name and signature below, I acknowledge in accordance with Public Acts 342 and 343 of 2012 that I have received and reviewed the Concussion Fact Sheet for Parents and/or the Concussion Fact Sheet for Students provided by Davison Community Schools.

_____	_____
Student Name Printed	Parent or Guardian Name Printed
_____	_____
Student Name Signature	Parent or Guardian Name Signature
_____	_____
Date	Date

Return this signed form to the school in which your student attends. The district will keep this form on file for the duration of participation or age 18.

Students and parents please review and keep the educational materials available for future reference.

Parent Notification Record of Incident at School

Date: _____ Notification made to: _____ Notification made by: _____

Date: _____ Notification made to: _____ Notification made by: _____

Date: _____ Notification made to: _____ Notification made by: _____

Date: _____ Notification made to: _____ Notification made by: _____

Cardinal's Nest Preschool Program Policies

To avoid misunderstandings regarding our policies, we ask that you read the following information and then sign the bottom portion.

Absences- Due to staffing requirements by our state license and in order to keep our adult to child ratio If your child will not be in attendance for the day, please call the Cardinal's Nest at (810) 591-0821 to report any absences. We will not deduct tuition if your child is absent from school.

Bathroom Independence- Preschool children should be able to use the bathroom independently. Please make sure your child is wearing clothing they can easily get in and out of without assistance. If your child is not bathroom independent, they may not be ready for preschool at this time.

Emergency Numbers- Parents must leave a current and working phone number where they can be reached, as well as two additional names and telephone numbers to call in the event the parents cannot be contacted. If your phone numbers changes or any other information changes, please notify the office immediately. Failure to do so may result in dismissal from our program.

Enrollment- Our center is open to any child, 3 years old on or before September 1st, providing space is available and the center can meet the needs of the child. Before your child attends school, the following must be complete:

- The State of Michigan – Department of Licensing and Regulatory Affairs- Child Care Licensing Information Record
- Health Appraisals completed by Physician
- Acknowledgement of Preschool Policies

Your child's physician must complete the Health Appraisal form before attendance is permitted ***for all preschool children***. This is mandated by the State of Michigan.

Field Trip: Permission forms must be filled out for **each** field trip your child plans to attend this school year. Failure to have a signed permission form will result in your child not being able to attend.

ALL students- Please bring a full sized backpack and a water bottle labeled with the child's name daily.

Full Day Preschool Students- Cold lunches, labeled with the child's name, need to be provided by parents for preschool children, as well as 2 snacks for each day in attendance. Please note that we are a peanut, tree nut free school.

Sleep Equipment- Please send a blanket and pillow for daily rest period. Every Friday, take your child's blanket home, launder, and return any sleep equipment the following week.

Half-Day Preschool Students: 1 snack, labeled with the child's name, needs to be provided by parents for preschool children each day in attendance. Please note that we are a peanut, tree nut free school.

Latchkey - A.M. Latchkey will be offered from 6:00am- 9:00am and P.M. latchkey will be offered from 3:00pm-6:00pm (please sign up for latchkey services separately on the DCER website).

Late Pick-Up- Charges will be assessed for late pick-up. If a child is not picked up by the dismissal time of their program, a late pick-up fee of $10 per quarter hour (per child) will be assessed. Habitual abuse of this practice or non-payment of assessed fees may result in dismissal from our program.

Medication- If medication will be administered to your child during the school day, we will need an authorization form to administer medication, the medical plan provided by your physician and the medication needed for your child. This includes any daily medication, rescue inhalers, Emergency pens such as an Epi-pen or Auvi-Q.

Payments- Payments must be made by the beginning of each four week session. There will be 10 payments to register for. Please make sure to register for all 10 sessions by the due date. If you do not register for each of the 10 sessions individually, your child's name will NOT be added to, the roster and your child will not be able to attend

Payment policy: ALL FEES MUST BE PAID IN FULL AT THE TIME OF REGISTRATION

Withdrawal/Refund policy:

-There will be NO refunds issued to those who withdraw after the registration deadline and/or for students who are no shows. We appreciate your understanding. Thank you!

-There is a $5 cancellation fee that will be collected for processing a refund if the customer's request is before the registration deadline.

Playground Use- Your preschool/latchkey student will be occasionally using the playground. Some areas are designed for school age children. If your child is under 4, he/she will use the equipment designated for preschool students only. The equipment meets the standard and safety requirements per state licensing.

Schedule- We operate within Davison schools, if for any reason administration deems necessary due to a storm advisory, *snow days*, mechanical problems, plumbing issues, etc., the Cardinal's Nest will also be closed. This includes both latchkey and preschool programs. There is no refund for unscheduled school closings.

Sign-In/Sign-Out- In both the preschool and latchkey programs, parents (or designated pick up person) must accompany their children to the appropriate classroom. Parents must also sign their children in and out of the program per state licensing.

I have read the above information, and acknowledge that I have access to the Parent Handbook at https://www.davisonschools.org/domain/1470 and agree to abide by the policies and procedures therein.

Signature Parent/ Legal Guardian	Print Child's Name	Date

ACKNOWLEDGEMENT OF PARENT HANDBOOK
CARDINAL'S NEST PRESCHOOL PROGRAM
(R.400.8146)

This parent handbook outlines the policies and procedures of the Cardinal's Nest Preschool Program as required by (R.400.8146) licensing. An understanding of and adherence to the policies and procedures will ensure positive parent-school relations and that the children's needs are adequately met. To ensure that your child's needs are adequately met, children enrolled in the Great Start Readiness Program will be screened by the Ages and Stages (ASQ), and the program will be assessed using the Preschool Quality Assessment (PQA) twice a year. The child outcome data from the Teaching Strategies Gold (TSG) will be assessed three times a year. Therefore, the preschool requires that all parents and/or guardians of children enrolled in Cardinal's Nest Preschool Programs read, sign, and return to the teacher the statement that follows:

- Criteria for admission and withdrawal.
- Schedule of operation, denoting hours, days, and holidays during which the preschool is open and services are provided.
- Fee policy
- Discipline policy
- Food service program
- Program Philosophy
- Typical daily routine
- Parent notification plan for accidents, injuries, incidents, illnesses
- Exclusion policy for child illnesses
- Notice of the availability of the preschool's licensing notebook.
    - The licensing notebook contains all the licensing inspection and special investigation reports and related corrective action plans since May 28, 2010.
    - The licensing notebook is available to parents during regular business hours.
    - Licensing inspection and special investigation reports from at least the past two years are available on the child care licensing website at www.michigan.gov/michildcare.

I certify that I have received all of the above items.

Parent/Guardian Signature:_____ Date:_____

*To access the Cardinal's Nest Parent Handbook, please visit https://www.davisonschools.org/domain/1470

Parent Notification of the Licensing Notebook

Davison Schools Cardinal's Nest Preschool Program 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, 2010 until the license is closed. 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 Community and Health Systems website at www.michigan.gov/michildcare.

Parent/Guardian Signature:_____ Date:_____

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.)			

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.

BCAL-3731 (Rev. 7-18) Previous edition 6-17may be used.