



Central Lake Public Schools
Early Childhood Programs

Welcome to our Early Childhood Program!

We are excited to partner with your family and look forward to supporting your child's growth, learning, and development.

To complete your child's enrollment, please review the packet and return all required documents before your child's start date. These documents help us maintain compliance with Michigan child care licensing requirements, support your child's health and safety, and ensure we can provide appropriate care based on your child's individual needs.

The following items are required before your child can attend our program:

- ☐ **Program Registration Packet** including **Tuition Agreement**
- ☐ **Child Information Record**
- ☐ **Immunization Record:** completed by your child's physician or local health department
 - ☐ *Immunization Waiver if you are opting out of immunizations*
- ☐ **Health Appraisal:** completed by your child's physician
- ☐ **Education Benefits Form**

We appreciate your partnership and look forward to working with you and your family as the year progresses.

Thank you,
Stephanie Stedman
Early Childhood Program Director
Central Lake Public Schools
231-544-3141 ext 54331
sstedman@centrallake.org



**Central Lake Public Schools
Early Childhood Programs
Program Registration Packet
2026**



CLPS Early Childhood Programming is offered in partnership by Central Lake Public Schools with support from the Cleo M. Purdy Endowment, and the Great Start to Readiness Program (GSRP) through CharEm ISD.

Welcome!

We are honored that you have chosen Central Lake Public (CLPS) Early Childhood Programs (ECP). The early childhood years are vital to a child's development and our staff look forward to partnering with you through this exciting time!

CLPS ECP serves families with children ages 6 weeks to 4 years old in five classroom settings: Infant, Toddler, Twos, Threes, and Great Start Readiness Program (GSRP) Preschool. Our Child Care classroom's hours run Monday through Friday from 7:30am-5:00pm. Our GSRP classroom follows the CLPS District Calendar and school day hours from 7:55am-2:55pm.

Please note that childcare slots are offered based on staffing ratios; you may be asked to adjust your drop off or pick up schedule based on these requirements we must meet in accordance with licensing.

CLPS Child Care Rates

With the continued support of the CLEO Purdy Endowment Fund, we strive to keep our tuition rates affordable, accessible, and under market rate.

Daily Rate: \$36 Weekly Rate: \$180



Throughout her life, Cleo M. Purdy believed in the power of early education and experiences to build strong kids, families, and communities. After more than a decade of giving during her life, at the end of her life, Cleo M. Purdy made an amazing gift to the Community Foundation for the benefit of Central Lake's young children and their families by creating a permanent fund to carry on this vision. With her gift, the Community Foundation is partnering with people and organizations in Central Lake to award grants to various organizations working with children and families. Cleo's gift is helping families grow stronger.

Licensing Record Available Online

All licensed childcare centers in Michigan must maintain licensing records which include all inspection reports, special investigation reports, and all related Corrective Action Plans (CAP) developed on and after May 27, 2010 until the license is closed. Effective 7/27/22, CLPS ECP will not keep a physical copy of the licensing records on site however the records and content is available online and can be accessed at any time. Reports made and submitted within the last three years can be accessed at www.michigan.gov/michildcare.

Family Information

Child's Name: _____ DOB: _____

Mailing Address: _____

Guardian 1 Name: _____

Phone number(s): _____

Email(s): _____

Guardian 2 Name: _____

Phone number(s): _____

Email(s): _____

Please list other children or expected children in the family:

Requested Schedule

Effective January 1, 2023, part time or alternative schedules can be selected to ensure care is provided to as many families as possible in our community. Any new enrollee will be offered the below scheduling options:

- Monday/Wednesday/Friday
- Tuesday/Thursday
- Monday-Friday

In order to plan for staffing and maintain adult to child ratios, please provide an estimated schedule and times below.

Monday:	YES	NO	(Drop off time: _____ Pick up time: _____)
Tuesday:	YES	NO	(Drop off time: _____ Pick up time: _____)
Wednesday:	YES	NO	(Drop off time: _____ Pick up time: _____)
Thursday:	YES	NO	(Drop off time: _____ Pick up time: _____)
Friday:	YES	NO	(Drop off time: _____ Pick up time: _____)

I understand that based on the schedule provided above and my tuition agreement, I am responsible for payment to CLPS Early Childhood Programming. All changes to this schedule must be made in writing via email or Brightwheel to the Program Director, Stephanie Stedman at sstedman@centrallake.org.

Guardian Signature _____ Date _____

Parental Consent

Please *initial* the areas you wish to give permission and write *NO* for the areas that you DO NOT give permission

- _____ I give permission for my child's name and photo to be used in print or online, this includes other partnering organizations that visit our program
- _____ I give permission for staff to apply topical, non-prescription medications including but not limited to sunscreen, baby wipes, insect repellent, diaper ointment and lotion on my child. I will supply these items to the program.
- _____ I give permission for staff to secure emergency medical treatment for my child
- _____ I was provided and/or have access to the Program Handbook and understand it is my responsibility to uphold program policies. I am aware that the Handbook can be accessed at any time via the Early Childhood Parent Board located in the Early Childhood Wing of the Central Lake Public School Elementary building
- _____ I give my child permission to go on walks or in strollers off the CLPS campus with Program Staff

I understand that unless I revoke my permission in writing, Central Lake Public Schools Early Childhood Program has permission for all the above initialed activities.

Guardian Signature _____ Date _____



Central Lake Public Schools

Early Childhood Programs

Guardians shall pay childcare fees based on the rates specified below. Childcare fees will not be adjusted for late arrival or early pickup.

I understand that by contracting with Central Lake Public Schools Early Childhood Programs:

- My child will be provided childcare at the rate of **\$36 dollars** per day
- I will pay biweekly tuition via Brightwheel, Cash, or Check
- I will notify the program by **7:30am** if my child will be absent
- I will notify the school if my weekly schedule changes

Based on my enrollment form, my child is contracted for the following days of the week:

Monday Tuesday Wednesday Thursday Friday

The total amount I am financially responsible for bi-weekly is: _____

Guardian Signature: _____ Date: _____

CLPS ECP Staff Signature: _____ Date: _____

CHILD INFORMATION RECORD

State of Michigan

Department of Lifelong Education, Advancement, and Potential – 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 strikethrough, 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	2nd Phone (if applicable)
Home Address (if not child's address)	City	State Zip Code
Email Address (optional)	Employer Name	Work Phone
Parent/Legal Guardian's Name (optional)	Primary Phone	2nd Phone (if applicable)
Home Address (if not child's address)	City	State Zip Code
Email Address (optional)	Employer Name	Work Phone

Name of Child's Physician or Health Clinic	Physician's or Health Clinic's Phone Number
Preferred Hospital for Emergency Treatment (optional)	Allergies, Disabilities and/or Special Instructions? Attach additional sheets if necessary.

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).

1st Individual:	Phone:	2nd Phone:
2nd Individual:	Phone:	2nd Phone:
3rd Individual:	Phone:	2nd Phone:

Release of Child Only: List all individuals, other than the parents or legal guardians, to whom the child may be released to (if more individuals, attach additional sheets).

1st Individual:	Phone:
2nd Individual:	Phone:
3rd Individual:	Phone:

Parent/Legal Guardian Initials: I, _____ (initial here), give permission to _____ Central Lake Public Schools _____ (child care provider), licensed by the Department of Lifelong Education, Advancement, and Potential, 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:
----------------------------------	-------

Date Record Reviewed	Parent / Guardian Initials	Date Record Reviewed	Parent / Guardian Initials	Date Record Reviewed	Parent / Guardian Initials
----------------------------	----------------------------------	----------------------------	----------------------------------	----------------------------	----------------------------------

Individuals with disabilities may contact the MiLEAP ADA Coordinator to request an alternative format to these materials. Please visit www.Michigan.gov/ADA for a list of state ADA Coordinators.	MiLEAP is an equal opportunity employer/program.
---	--

HEALTH APPRAISAL

Michigan Department of Health and Human Services

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, dentist, dental therapist, and dental hygienist.

(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)	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 I – HEALTH HISTORY

Yes	No	Resolved	#	Is your child having any of the problems listed below?	Birth History
☐	☐	☐	1	Allergies or Reactions (for example, food, medication or other)	
☐	☐	☐	2	Anaphylaxis	
☐	☐		3	Does your child take any medication(s) regularly?	If yes, list medications
☐	☐	☐	4	Hay Fever, Asthma, or Wheezing	
☐	☐	☐	5	Eczema or Frequent Skin Rashes	
☐	☐	☐	6	Convulsions/Seizures	
☐	☐	☐	7	Heart Trouble	
☐	☐	☐	8	Diabetes	
☐	☐	☐	9	Frequent Colds, Sore Throats, Earaches (4 or more per year)	Are there any current or past diagnosis(es) ☐ Yes ☐ No
☐	☐	☐	10	Trouble with Passing Urine or Bowel Movements	If yes, please describe
☐	☐	☐	11	Shortness of Breath	
☐	☐	☐	12	Speech Problems	
☐	☐	☐	13	Menstrual Problems	
☐	☐	☐	14	Dental Problems Date of Last Exam _____ OR Date of Last Assessment _____	
☐	☐	☐		Other (please describe) _____	

Reason for Medication		
Concussion History		
Parent/Guardian Signature	Date	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

Test and Measurements						
Yes	No	Was child tested for	Tests and results	Normal	Referred	Under care
☐	☐	Vision Date _____	Visual Acuity			
			Muscle Imbalance			
			Other			
☐	☐	Hearing Date _____	☐ Audiometer (R= Right, L=Left)	R/L	R/L	
			☐ OAE (R= Right, L=Left)	R/L	R/L	
			☐ Other (R= Right, L=Left)	R/L	R/L	
☐	☐	Urinalysis	Sugar			
			Albumin			
			Microscopic			
☐	☐	Blood Lead Level Date _____	Level _____ ug/dl			
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.						
☐	☐	Height & Weight Other _____	Height			
			Weight			
			Other _____			
☐	☐	Hemoglobin/Hematocrit	⇒			
☐	☐	Blood Pressure	Reading _____			
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 III – IMMUNIZATIONS

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

Vaccines (Circle Type)	Date Administered mm/dd/yy	Vaccines (Circle Type)	Date Administered mm/dd/yy	
Hepatitis B (HepB)	1	Hepatitis A (HepA)	1	
	2		2	
DTaP/DTP/DT/Td	1	Influenza (IIV/LAIV)	1	
	2		2	
	3	Meningococcal MenACWY (MCV4)	1	3
Tdap	1	Meningococcal B (Bexsero, Trumenba)	1	3
			2	
<i>Haemophilus Influenzae</i> type b (HIB)	1	Human Papillomavirus (9vHPV, 4vHPV, 2vHPV)	1	3
	2		2	
Polio (IPV/OPV)	1	Additional Vaccines Specify Date & Type	Type of Vaccine(s)	Date of Vaccine(s)
	2		1	
	3		2	
Pneumococcal Conjugate (PCV7/PCV13)	1	Indicate and attach physician diagnosis or laboratory evidence of immunity as applicable.	3	
	2		4	
Rotavirus (RV1/RV5)	1	*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.	3	
	2			
Measles, Mumps, Rubella (MMR/MMRV)	1		3	
	2			
Varicella (Chickenpox), (Var, MMRV)	1	2		
History of Chickenpox Disease? ☐ Yes ☐ No If yes, date _____		Parent/Guardian refused recommended immunizations at visit: ☐		
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)

Yes	No	
☐	☐	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 EXAM OR ASSESSMENT RECOMMENDATIONS (OPTIONAL)

Child's Name _____	Has received ☐ Dental Exam ☐ Dental Assessment	
Findings and Recommendation (Check all that apply)		
☐ No Urgent Needs	☐ Routine Care Needed	☐ Treated Decay
☐ Restorative/Urgent Needs for Dental Care	☐ Untreated Decay	☐ Further Referral for Specialist
Signature _____		Date _____
Check One ☐ Dentist ☐ Dental Therapist ☐ Dental Hygienist		

PHYSICIAN'S SIGNATURE

Examiner's Signature	Date	Examiner's Name (Print)	Degree or License
Number & Street	City	MI Zip Code	Telephone Number

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.

The Michigan Department of Health and Human Services will not exclude from participation in, deny benefits of, or discriminate against any individual or group because of race, sex, religion, age, national origin, color, height, weight, marital status, partisan considerations, or a disability or genetic information that is unrelated to the person's eligibility.

EDUCATION BENEFITS FORM SY 2026 - 2027

District: _____ School: _____

Part A: STUDENT INFORMATION - Complete for each student Pre-K through 12th Grade

Student's Last Name	Student's First Name	Grade Level	School	Identify H if Homeless M if Migrant R if Runaway F if Foster

Part B: BENEFITS RECEIVED (if applicable)

If any member of your household receives Food Assistance Program (FAP), Family Independence Program (FIP), or FDPIR, provide the name and case number for the person who receives benefits. Bridge Card Numbers and Medicaid Numbers are NOT ACCEPTABLE case numbers.

Name: _____ Case Number: _____

Part C: HOUSEHOLD SIZE	Part D: ANNUAL HOUSEHOLD INCOME - Select the appropriate range of combined annual income for all people in the household (Include all income before taxes)		
☐ 1 →	☐ At or below \$20,748	☐ Between \$20,749 and \$29,526	☐ At or above \$29,527
☐ 2 →	☐ At or below \$28,132	☐ Between \$28,133 and \$40,034	☐ At or above \$40,035
☐ 3 →	☐ At or below \$35,516	☐ Between \$35,517 and \$50,542	☐ At or above \$50,543
☐ 4 →	☐ At or below \$42,900	☐ Between \$42,901 and \$61,050	☐ At or above \$61,051
☐ 5 →	☐ At or below \$50,284	☐ Between \$50,285 and \$71,558	☐ At or above \$71,559
☐ 6 →	☐ At or below \$57,668	☐ Between \$57,669 and \$82,066	☐ At or above \$82,067
☐ 7 →	☐ At or below \$65,052	☐ Between \$65,053 and \$92,574	☐ At or above \$92,575
☐ 8 →	☐ At or below \$72,436	☐ Between \$72,437 and \$103,082	☐ At or above \$103,083

*** Special Instructions for households with more than 8 people: DO NOT check the boxes above. Instead, fill in items below:**

Household size (# people): _____ Total annual income: _____

Part E: CERTIFICATION - The head of household or adult designee who completed this form must complete this certification section

I certify (promise) that all information on this form is true and that all income is reported to the best of my knowledge. I understand that this form may impact the amount of State or Federal funding allocated to my local school district. I understand that the information I have provided may be verified.

(Signature) _____ (Printed Name) _____ (Date) _____

(Address) _____ (City) _____ (Zip) _____

(Email Address) _____ (Home Phone) _____ (Work Phone) _____

Do NOT fill out this section. This is for school use only.

Status: F _____ R _____ N _____ Determining Official's Signature: _____ Date: _____

INSTRUCTIONS FOR COMPLETING THE EDUCATION BENEFITS FORM

This form is used to determine eligibility for state benefits for which your child(ren)'s school may qualify. Please complete, sign, and return this form to your child's school.

If any member of your household receives benefits from the Food Assistance Program (FAP), Family Independence Program (FIP), or FDPIR, please follow these instructions:

Part A: Student Information – For each student in the household Pre-K through 12th grade, list the last name, first name, grade level, school, and H if homeless, M if Migrant, R if Runaway or F if a Foster Child.

Part B: Benefits Received – If any household member, including adults, receives Food Assistance Program (FAP), Family Independence Program (FIP), or Food Distribution Program on Indian Reservations (FDPIR), provide the name and case number. Bridge Card Numbers and Medicaid Numbers are NOT ACCEPTABLE case numbers.

Part C: Household Size - Check the box for the total number of individuals living in your household. This should include all children and adults, related and un-related, that live in a single dwelling and share income and expenses.

Part D: Annual Household Income – Skip this part

Part E: Certification - Sign the form. Print your name and date.

If your household does not receive benefits from the Food Assistance Program (FAP), Family Independence Program (FIP), or FDPIR, please follow these instructions:

Part A: Student Information - For each student in the household Pre-K through 12th grade, list the last name, first name, grade level, school, and H if homeless, M if Migrant, R if Runaway or F if a Foster Child.

Part B: Benefits Received – Skip this part

Part C: Household Size – Check the box for the total number of individuals living in your household. This should include all children and adults, related and un-related, that live in a single dwelling and share income and expenses.

Part D: Annual Household Income – Moving across the same row as the household size check box, check the box that shows the range of annual income for all people in your household. Make sure to include all of the following income sources: work, welfare, child support, alimony, pensions, retirement, Social Security, SSI, VA benefits, child income and/or all other income. The amount should be before any deductions for taxes, insurance, medical expenses, child support, etc.

Part E: Certification - Sign the form. Print your name, date, and contact information.

Childcare Experience

- Who has cared for your child other than parents/guardian?
- Has your child been in a childcare setting?

Daily Habits

- Please describe your child's waking and bedtime routines:
- Favorite indoor and outdoor activities?
- Is your child sensitive to sensory activities? (water, sand, sounds?)

Eating Habits

- Where does your child eat meals?
- What time of day does your child eat meals and or snacks?
- Does your child have any food allergies?

Temperament

- How does your child respond to new children? Adults?
- How does your child like to be comforted? (pacifier, special blanket, being held)

