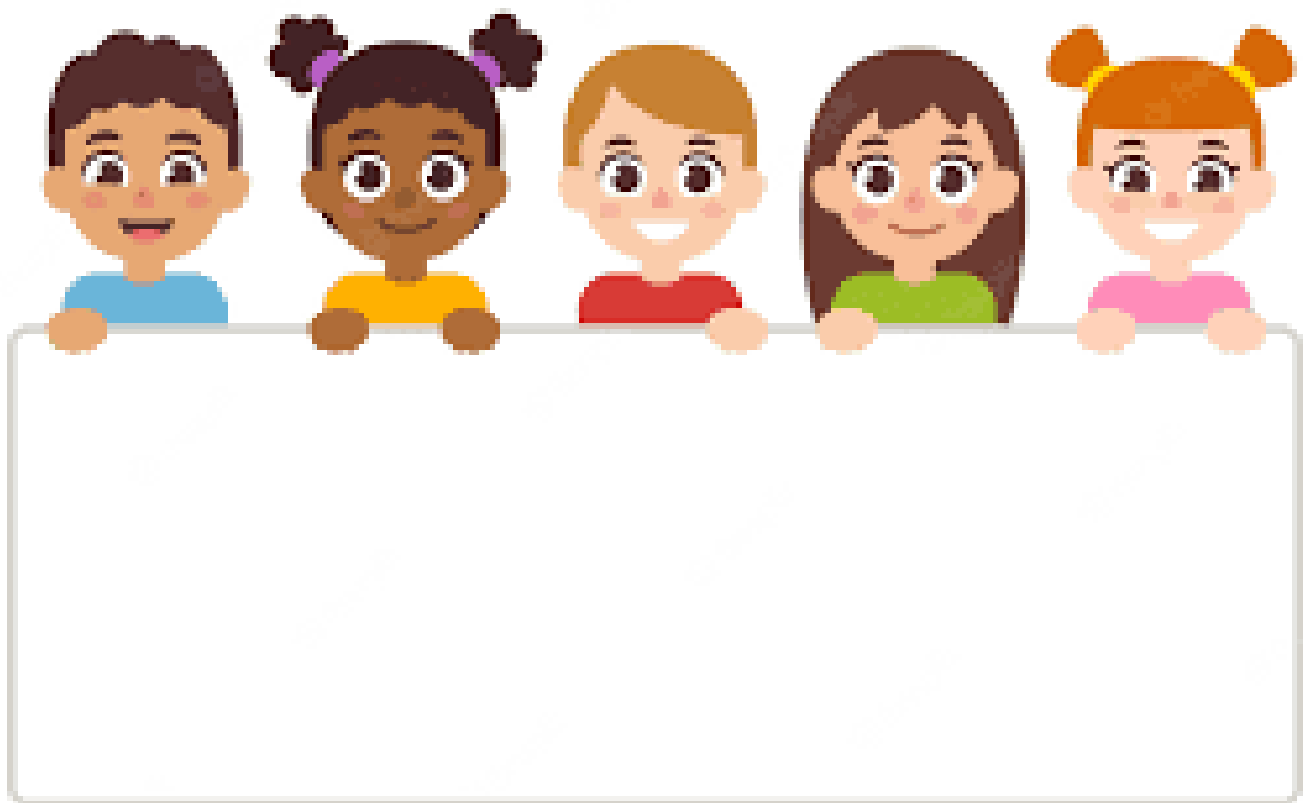


Hakuna Matatah Preschool and Childcare
Center
Enrollment Packets

“Where Learning and Care Meet”



Hakuna Matatah Preschool and Childcare Center
Childcare Parent Contract and Fee Schedule

Hakuna Matatah Preschool and Childcare Center is Dedicated to providing quality care for your child. In order to provide quality care we feel strongly that licensing requirements must be met, not only in regards to the environment, but also to the teacher and student ratio.

Teachers are paid an hourly rate, whether children are present or not. Therefore, we are asking that you read and sign the contract below.

Fee Schedule: Tuition payments are due on Mondays at the start of each week.

Billing will be done on Tuesday and all late fees will be added if tuition has not been paid in full as directed. A late fee of **\$35.00** will be charged on Tuesday, if tuition has not been received at that time, an additional **\$50.00** will be added if tuition has not been paid by Wednesday. Hours Of Operation are from 7:00am to 6:00 pm. Extended hours are available for those families in need. There will be a late charge of **\$5 per minute** if children are not picked up at the contract time. Please be on time to pick up your child(ren). Payments are accepted via cash, debit card and checks, however, returned checks will be charged a \$35.00 nsf fee and we will not be able to accept payments via check again.

3 years of age and older :

Full time 5 days/week - \$200.00

2.5 years of age and under:

Full time 5 days/week - \$225.00

Infants 1.5 ears of age and under:

Full time 5 days/week - \$275.00

Drop in rate

1 eight hour day **Preschoolers** \$60.00 **Infants** \$75.00

Parents who elect to the drop in schedule will not hold a daily spot, but only charge for the days your child is here, please call ahead for availability, fee for ages 3 years to 12, rate slightly higher for infants.

Extended hours are available and the rate will change for those hours.

Registration fee is \$60.00 and will be waived if parents sign a contract after the tour.

DHS Recipients

Parent receiving benefits from DHS will be responsible for copays to cover the tuition agreements

Enrollment

_____ tuition will be _____ per _____
(Child's Name)

_____ tuition will be _____ per _____
(Child's Name)

_____ tuition will be _____ per _____
(Child's Name)

_____ tuition will be _____ per _____
(Child's Name)

_____ tuition will be _____ per _____
(Child's Name)

(Parent's Signature)

(Date of Contract)

Hakuna Matatah Preschool and Childcare Center

"Immunizations"

Copies of your child's current immunization or waivers are needed to complete the enrollment package. You or your Dr's office can submit either a copy in writing or send via email to:

hakunamatatahchildcare@yahoo.com.

6/14/2020

Hakuna Matatah Preschool and Childcare Center
Covid -19 Preparedness and Response Plan

Welcome back staff and parents. I hope everyone is doing well and managing successfully at this time. Due to the Covid-19 virus, the CDC has called for all providers to put a plan together to help stop the spread of the virus as we prepare to return to work, and still provide quality care for your little ones. We will do all that we can to protect our staff and families from being infected while attending our facility. Please bear with us as we implement these changes in our efforts to protect our staff, children and parents.

Implementing our Covid-19 Preparedness and response Plan

1. All children and staff will be monitored at arrival in the morning with a temperature check in the coat area before entering the classrooms.
2. Children showing symptoms including,

COUGHING, SNEEZING, SHORTNESS OF BREATH, RUNNY NOSE, DIARRHEA/VOMITING OR TEMPERATURE OF 100.4 or greater will NOT BE ALLOWED TO STAY. Children who develop symptoms while in our care will be isolated in the coat area, while still being monitored by staff. A parent or family members will be notified to please pick up the child immediately. A Doctor's clearance will be needed to return. Unfortunately a child displaying virus symptoms with siblings attending will call for isolation and doctors clearance as well for return.

3. All staff will wear a mask and apron while interacting with children. Gloves were already being used and we will continue to do so with diapering and serving of food as well.
4. Our staff will constantly clean and disinfect our space through the Day.

Drop off

1. As we attempt to help stop the spread of the COVID-19 virus, we are asking that all parents PLEASE DO NOT ENTER THE BUILDING.
Our staff will greet you at the door and begin a temperature check, and you are free to return to your car and wait for your thumbs up to proceed.
2. Please keep in mind we are social distancing so please remain in your car until the family ahead of you has left the door. When approaching the door PLEASE WEAR YOUR MASK we want to protect our parents as well as our staff.

As we remain open during this time there may be changes to this plan. However, our efforts and attempts are imperative in stopping the spread of this virus. Anytime you exit your home, we are all at risk and we/Hakuna Matatah Preschool and Childcare Center and staff will not be held responsible. In our efforts to provide the safest environment and continue to provide quality care please bear with us and as always,
Thank you for allowing us to care for your little ones.

Parent Signature

Date

Thank you
And Stay Safe
Stefanie Boyd

Hakuna Matatah Preschool and Childcare Center
Discipline Policy

Hakuna Matatah Preschool and Childcare Center exist for the purpose of providing Christian Educational Ministry in loving, nurturing and safe atmosphere.

The bible challenges us to Train up a child in the way he should go: when is old he will not depart from it "(Proverbs22;6)". Loving, firm fair and consistent discipline promotes child's developmental needs. This efforts should be supported in a consistent manner both in the child's home and while at school. All school rules are explained to the student/children in the classroom and in the play areas by the staff and must be followed at all times. Preschool rules

are enforced for the safety and well being of all children, staff members, parents, guardians, Volunteers deserve the respect, cooperation and visitors. All teachers/staff/volunteers deserve the respect, cooperation and submission to their authority. Respect must also be given to the right of others and their property at all times to maintain a productive learning atmosphere. In accordance with State of Michigan Licensing rules, the staff of Hakuna Matatah Preschool and Childcare Center does not punish children by striking them, using mental punishment/cruelty or any form of corporal punishment.

All of the following means of punishment are prohibited: (a) Hitting, spanking, shaking, biting, pinching, or inflicting other forms of corporal punishment. (b) Placing any substances in a child's mouth, including but not limited to, soap, hot sauce, or vinegar. (c) Restricting a child's movement by binding or tying him or her. (d) Inflicting mental or emotional punishment, such as humiliating, shaming, or threatening a child. (e) Depriving a child of meals, snacks, rest, or necessary toilet use. (f) Excluding a child from outdoor play or other gross motor activities. (g) Excluding a child from daily learning experiences. (h) Confining a child in an enclosed area, such as a closet, locked room, box, or similar enclosure. (i) Time out must not be used for children under 3 years of age.

Modification Clause:

This policy may be modify whenever any of the circumstances covered in this "Policy Agreement" changes. Such modifications may only be made in writing, (30 day notice) And must be signed by the parties involved in order to be binding and effective.

Parent/ Guardian Signature

Date



Hakuna Matatah

PRESCHOOL AND CHILDCARE CENTER

I, _____, parent of children attending **Hakuna Matatah Preschool & Childcare Center**, acknowledge and agree to the following: • I understand that my children whose name(s) are listed below may be photographed at **Hakuna Matatah Preschool & Childcare Center** during regular daycare hours, field trips, and activities. • I understand that these photographs may be used in arts & crafts and for children to take home as memorabilia. They may also be used for the purpose of promoting and marketing **Hakuna Matatah Preschool & Childcare Center** and may be used on but not limited to; **Hakuna Matatah Preschool & Childcare Center's** website, Facebook, Instagram, print advertising, etc. A first name may be mentioned and surnames will be omitted.

The following are the names of my children attending **Hakuna Matatah Preschool & Childcare Center** : 1. _____

2. _____

3. _____

4. _____

☐ Yes, I confirm that I have read and understand the above, and agree to have my child(ren)'s photos used for the purpose of keeping parents informed of **Hakuna Matatah Preschool & Childcare Center** happenings and for the purpose of marketing for **Hakuna Matatah Preschool & Childcare Center**

☐ No, I do not wish to have my child (ren)'s photographs published

Name (print) _____ Date: _____

Signature: _____

Hakuna Matatah Preschool & Childcare Center
26140 W 7 mile Road
Redford, MI 48240
(313) 694-3140
hakunapreschoolchildcare.com

CHILD INFORMATION RECORD

State of Michigan - Department of Lifelong Education, Learning, 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 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? No <input type="checkbox"/> Yes <input type="checkbox"/> If yes, explain: (Attach additional sheets, if necessary.)					

CCL-3731 (Rev. 6/7/2024) Previous editions 7-18, 4-21, & 3-22 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. ()	
5.		()		6. ()	

Parent/Legal Guardian Initials:	
_____ I give permission to _____, 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 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

CCL-3731 (Rev. 6/7/2024) Previous editions 7-18, 4-21, & 3-22 may be used

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

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

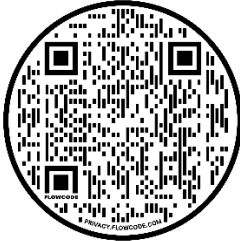
SECTION I – HEALTH HISTORY

Yes	No	Resolved	#	Is your child having any of the problems listed below?	Birth History
<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"/>		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, please 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"/>		Other (please describe) _____	

Reason for Medication		
Concussion History		
Parent/Guardian Signature	Date	Was the health history reviewed by a health professional? <input type="checkbox"/> Yes <input type="checkbox"/> 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
<input type="checkbox"/>	<input type="checkbox"/>	Vision Date _____	Visual Acuity			
			Muscle Imbalance			
			Other			
<input type="checkbox"/>	<input type="checkbox"/>	Hearing Date _____	<input type="checkbox"/> Audiometer (R= Right, L=Left)	R/L	R/L	
			<input type="checkbox"/> OAE (R= Right, L=Left)	R/L	R/L	
			<input type="checkbox"/> Other (R= Right, L=Left)	R/L	R/L	
<input type="checkbox"/>	<input type="checkbox"/>	Urinalysis	Sugar			
			Albumin			
			Microscopic			
<input type="checkbox"/>	<input type="checkbox"/>	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.						
<input type="checkbox"/>	<input type="checkbox"/>	Height & Weight Other _____	Height			
			Weight			
			Other _____			
<input type="checkbox"/>	<input type="checkbox"/>	Hemoglobin/Hematocrit	⇒			
<input type="checkbox"/>	<input type="checkbox"/>	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	3	Hepatitis A (HepA)	1	3
	2	4		2	
DTaP/DTP/DT/Td	1	4	Influenza (IIV/LAIV)	1	3
	2	5		2	4
	3	6	Meningococcal MenACWY (MCV4)	1	3
				2	
Tdap	1		Meningococcal B (Bexsero, Trumenba)	1	3
				2	
<i>Haemophilus Influenzae</i> type b (HIB)	1	3	Human Papillomavirus (9vHPV, 4vHPV, 2vHPV)	1	3
	2	4		2	
Polio (IPV/OPV)	1	4	Additional Vaccines Specify Date & Type	Type of Vaccine(s)	Date of Vaccine(s)
	2	5		1	
	3			2	
			3		
Pneumococcal Conjugate (PCV7/PCV13)	1	3	Indicate and attach physician diagnosis or laboratory evidence of immunity as applicable.		
	2	4			
Rotavirus (RV1/RV5)	1	3	*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.		
	2				
Measles, Mumps, Rubella (MMR/MMRV)	1	3			
	2				
Varicella (Chickenpox), (Var, MMRV)	1	2			
History of Chickenpox Disease? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, date _____			Parent/Guardian refused recommended immunizations at visit: <input type="checkbox"/>		
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		
<input type="checkbox"/>	<input type="checkbox"/>	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: _____	
<input type="checkbox"/>	<input type="checkbox"/>	Should the child's activity be restricted because of any physical defect or illness? If yes, check and explain degree of restriction(s):	
		<input type="checkbox"/> Classroom	<input type="checkbox"/> Playground
		<input type="checkbox"/> Swimming Pool	<input type="checkbox"/> Competitive Sports
			<input type="checkbox"/> Gymnasium
			<input type="checkbox"/> Other
Other Recommendations			

SECTION V – DENTAL EXAM OR ASSESSMENT RECOMMENDATIONS (OPTIONAL)

Child's Name	Has received <input type="checkbox"/> Dental Exam <input type="checkbox"/> Dental Assessment
Findings and Recommendation (Check all that apply)	
<input type="checkbox"/> No Urgent Needs	<input type="checkbox"/> Routine Care Needed
<input type="checkbox"/> Restorative/Urgent Needs for Dental Care	<input type="checkbox"/> Untreated Decay
	<input type="checkbox"/> Treated Decay
	<input type="checkbox"/> Further Referral for Specialist
Signature	Date
Check One <input type="checkbox"/> Dentist <input type="checkbox"/> Dental Therapist <input type="checkbox"/> 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.

Provider Verification Needed

Before MDHHS can pay your child care provider, you must complete this form.

Here's what you need to do:

1 Choose a child care provider.

- If you need help, search for licensed providers online at <https://Greatstarttoquality.org> or call **877-614-7328** for assistance.
- If your child care provider is a License Exempt provider and is not currently enrolled with the State of Michigan, they must complete the Child Development and Care (CDC) License Exempt Provider Application. The application can be found online at: <https://www.Michigan.gov/childcare>.

2 Sign and submit this form to MDHHS.

- **Submit online** at <https://Michigan.gov/mibridges>
- **Mail your form** in the envelope we sent you
- **Turn in your form** at your local MDHHS office

MDHHS will send you and your child care provider notices once the form is processed. If approved, the child care provider can begin billing.

Provider Details

<input type="text"/>	<input type="text"/>	<input type="text"/>
Case Name	Case Number	Specialist

Child Care Provider Information

<input type="text"/>	<input type="text"/>
Provider	Provider ID #

Provider Address (Street address, City, State, ZIP Code)

<input type="text"/>	<input type="text"/>
Provider Phone Number	Provider Email

Where are the child(ren) listed below cared for?

<input type="checkbox"/> Licensed Child Care Center	<input type="checkbox"/> Licensed Group Home	<input type="checkbox"/> Licensed Family Home
<input type="checkbox"/> Home where child lives	<input type="checkbox"/> Provider's home	← If the provider is license-exempt and not related to the child(ren), care must be provided in the child(ren)'s home.

Child information

Please list all child(ren) in the family needing care.

← Need more room to write? Attach a list for additional children. Be sure to include the same information.

Name of child	Date of birth	Date child care began	Is the child related to the provider?	If yes, how are they related?
<input type="text"/>	<input type="text"/> / <input type="text"/> / <input type="text"/>	<input type="text"/> / <input type="text"/> / <input type="text"/>	<input type="text"/> Y <input type="text"/> N	<input type="text"/>
<input type="text"/>	<input type="text"/> / <input type="text"/> / <input type="text"/>	<input type="text"/> / <input type="text"/> / <input type="text"/>	<input type="text"/> Y <input type="text"/> N	<input type="text"/>
<input type="text"/>	<input type="text"/> / <input type="text"/> / <input type="text"/>	<input type="text"/> / <input type="text"/> / <input type="text"/>	<input type="text"/> Y <input type="text"/> N	<input type="text"/>
<input type="text"/>	<input type="text"/> / <input type="text"/> / <input type="text"/>	<input type="text"/> / <input type="text"/> / <input type="text"/>	<input type="text"/> Y <input type="text"/> N	<input type="text"/>

<input type="checkbox"/>	By checking this box, I understand I am giving my local MDHHS office permission to discuss all aspects of my CDC program information with my child's(ren) child care provider listed on this form. Checking this box is voluntary.
--------------------------	---

Sign Here

I have told the truth; I understand that I can be held criminally/financially responsible for providing false information on this form. I certify that I have read and agree to all rules in the CDC Handbook posted online at [Michigan.gov/childcare](https://www.Michigan.gov/childcare).

<input type="text"/>	For more information and requirements, see the CDC Handbook at https://www.Michigan.gov/childcare . If you need help, contact your MDHHS specialist.
Signature of Parent or Substitute Parent	Date

The Michigan Department of Health and Human Services (MDHHS) does not discriminate against any individual or group on the basis of race, national origin, color, sex, disability, religion, age, height, weight, familial status, partisan considerations, or genetic information. Sex-based discrimination includes, but is not limited to, discrimination based on sexual orientation, gender identity, gender expression, sex characteristics, and pregnancy.

This institution is an equal opportunity provider.

Michigan Department of Health and Human Services