Auburn Elementary Busy Bee Program Registration Form 2017-2018
Auburn Manager 248-640-0081

Avondale School District
2940 Waukegan Street, Auburn Hills, Michigan 48326
(248) 285-2336

_____
Student's Grade

_____
Teacher

Child's Name: _____ Start Date: _____
Please Print First and Last Name

Date of Birth: _____ Sibling(s):_____

Address: _____ Home Phone Number: _____
Street City Zip (Required)

Mother's Name: _____ Father's Name: _____
(Please print) (Please print)

Mother's Work Phone Number: _____ Mother's Cell Phone Number: _____
(Required) (Required)

Father's Work Phone Number: _____ Father's Cell Phone Number: _____
(Required) (Required)

Please check the sessions you wish to enroll your child:

	AM Session	PM Session
Monday	_____	_____
Tuesday	_____	_____
Wednesday	_____	_____
Thursday	_____	_____
Friday	_____	_____

*Drop in
(Fee applied) ☐

Please note: You will be charged for all scheduled days. We base employees hours on the number of children enrolled.

Tuition:

AM Session:	7:00 – 8:32	$ 7.00	2nd child - $ 4.00	3rd child - $ 2.00
PM Session:	3:35 – 6:00	$ 9.00	2nd child - $ 6.00	3rd child - $ 4.00
Half-Day Session:	11:41 – 3:35	$ 17.00	2nd child - $ 14.00	3rd child – $ 12.00

*Drop- in fees:
Unscheduled drop- in sessions will be charged $2.00 additional to the tuition fees for that session.

$100.00 sign- up fee per child *(Registration fee $50.00 / Prepaid Tuition $50.00)* *Please consult the parent handbook.
(The Sign- up fee is non-refundable and must be paid in full before the first day your child attends the program.

Payments must be made through PaySchools Online Payment Processing System at www.avondale.k12.mi.us

*Busy Bee staffing is regulated by the State of Michigan Department of Human Services. Staffing is decided according to the number of students that are registered to be in the classroom on any particular day. *Drop -in is subject to availability .Therefore 24 hour notice is required.*

Tax ID # B 38-600304 **Parent/Guardians Signature: _____**

Mom's Email_____
Please Print Legibly

Dad's Email_____
Please Print Legibly

To be completed by the manager: Check box when payment is made: $50 Registration Fee ☐ $50 Pre-Paid tuition ☐

Date: _____ Received by: _____ Manager Notes: _____

CHILD INFORMATION RECORD

State of Michigan Department of Human Services - Bureau of Children and Adult 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

Father/Legal Guardian's Name	Home Phone ( )	Mother/Legal Guardian's Name	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 (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 Special Instructions (Attach additional sheets, if necessary.)					

BCAL-3731 (Rev. 7-12) Previous editions 9-09, 3-08, 10-07, & 1-06 may be used until 12/31/13. **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.	( )

I give permission to _____ , licensed by the Department of Human Services
(Provider's Name)

to secure emergency medical and/or emergency surgical treatment for the above named minor child while in care.

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

Department of Human Services (DHS) will not discriminate against any individual or group because of race, religion, age, national origin, color, height, weight, marital status, sex, sexual orientation, gender identity or expression, political beliefs or disability. If you need help with reading, writing, hearing, etc., under the Americans with Disabilities Act, you are invited to make your needs known to a DHS office in your area.

AUTHORITY: 1973 PA 116
COMPLETION: Required
PENALTY: Rule Violation Citation.

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Busy Bee Program – Medical Questionnaire

Child's Name: _____ Teacher: _____

Please check any of the following problems that may require the special attention of our staff:

Allergies or reactions (i.e., food, medications, etc.)	_____ Yes	_____ No
Hay fever, asthma or wheezing	_____ Yes	_____ No
Sleeping problems	_____ Yes	_____ No
Eczema or frequent skin rashes	_____ Yes	_____ No
Convulsion/Seizures	_____ Yes	_____ No
Emotional problems	_____ Yes	_____ No
Physical limitations	_____ Yes	_____ No
Heart trouble	_____ Yes	_____ No
Diabetes	_____ Yes	_____ No
Frequent colds, sore throats, ear infections	_____ Yes	_____ No
Trouble with passing urine or bowel movements	_____ Yes	_____ No
Shortness of breath	_____ Yes	_____ No
Speech problems	_____ Yes	_____ No
Dental problems	_____ Yes	_____ No

If you checked "Yes" to any of the above; is there a plan for this condition on file in the school office? ___ Yes ___ No

Chicken Pox: Please check the following which applies.
_____ My child has had Chicken Pox
_____ My child was vaccinated against Chicken Pox
_____ I have completed a waiver for the vaccination of Chicken Pox

Are your child's immunizations up to date? _____ Date of last Tetanus shot _____

Does your child take medication regularly? _____ Yes _____ No
If yes, list medication _____ Reason for medication _____

Is there any condition (vision, hearing or other) for which we could help by seating or other action?
_____ Yes _____ No If yes, please explain _____

Should your child's activity be restricted because of any physical defect of illness?
_____ Yes _____ No If yes, please check and explain degree of restriction.
_____ Classroom _____ Playground _____ Gym Explain _____

I certify that my child is in good health. _____ Yes _____ No If no, please explain
_____

Parent/Guardian Signature: Date: