Assumption Nursery School and Toddler Center

22150 Marter Road, St. Clair Shores, MI 48080 • Telephone: (586) 772-4477 • Fax: (586) 772-6946

2026-2027 ENROLLMENT APPLICATION

CHILD INFORMATION

Child's Name: _____ (F or M) Date of Birth _____

Parent/Guardian Name & Phone: _____ Parent/Guardian Name & Phone: _____

Address: _____ City, State, Zip: _____

Email Address _____ Email Address _____

CHOICE OF PROGRAM

All programs are available Monday – Friday
Half Day: 8:30 a.m. – 11:30 a.m.
School Day: 8:30 a.m. – 3:30 p.m.
Extended: 7:00 a.m. – 5:30 p.m.

Half Day programs may add 30 minutes to include lunch (12:00 pick-up) at a rate of $10/half hour.

All School and Extended Day programs include a morning instructional program.

Minimum number of days per week:
Young Fives: 3 days per week
All other programs: 2 days per week

If a nap is not selected for three - five year-olds in the School and Extended Day programs; a 30-minute (4/5 year-olds) or 45-minute (3 year-olds) rest period is given.

Age/Classroom

- ☐ Toddler (must be 12 months old)
- ☐ Transition (must be 30 months old)
- ☐ Three year-old preschool (must be 3 by Sept. 1 and **potty-trained**)
- ☐ Four year-old preschool (must be 4 by Sept. 1 and **potty-trained**)
- ☐ Young Fives Developmental Program (must be 5 between March 1 and December 31 of 2026)

Program Choice:

- ☐ AM Half Day (8:30 am – 11:30 am)
- ☐ School Day (8:30 am – 3:30 pm)
- ☐ Extended Day (7:00 am – 5:30 pm)

Please check one of the following:

- ☐ Yes, My Child Naps (2 hour)
- ☐ No Nap** (30-45 min. rest)

(**preschool and young fives only)

Number of days requested: _____ **Circle days:** M T W Th F **Are your days flexible?** YES NO

Child Arrival Time: _____ **Child Departure Time:** _____

Is your child taking medication on a regular basis? Yes _____ No_____ Explain_____

Does your child have allergies? * Yes____No_____ If Yes, List: _____

Does your child require any special care? Yes____No_____ Explain: _____

How did you hear about our school?
Friend_____ Family_____ Advertisement_____ Word of mouth_____ Other_____

***If necessary, please complete the following forms: Food Allergy Questionnaire, Food Allergy Action Plan, or Medicine Permission Form.**

PARENT INFORMATION

Parent's Name: _____ Parent's Name: _____

Occupation: _____ Occupation: _____

Business Address: _____ Business Address: _____

_____ _____

Business Phone: _____ Business Phone: _____

E-mail address: _____ E-mail address: _____

Marital Status of the parents (circle one): Single Married Divorced Separated Widow

If applicable: _____ _____

Legal Custody*: Mother/Father/Both Physical Custody*: Mother/Father/Both

* Michigan Dept. of Human Services requires a Court Order be on file if a parent is prohibited from picking up a child.

REGISTRATION INFORMATION

The following forms are required to complete the enrollment process:

- Enrollment Application
- Child Information Record (**all fields must be completed**)
- Health Appraisal Form and Vaccination Records or Waiver (from physician)
- Registration Fee: $175 (non-refundable)
- Waiver for Preschool if child is not 3 or 4 by September 1
- Allergy Action Plan if child has food allergies

Please initial below:

1. _____ I agree to send a lunch for my child any day my child will attend beyond 11:30 a.m.

I give permission to Assumption Nursery School to apply when necessary (circle all that apply):

2. _____ Sunscreen Lip Balm Diaper Cream

3. _____ I understand that the above items are supplied by the parents or guardian.

4. _____ I have received a copy of the 2026/2027 ASSUMPTION PARENT HANDBOOK and I agree to the terms and general policies set forth by the Assumption Nursery School and Toddler Center.

I give permission for Assumption Nursery School and the commercial media, acting through their authorized employee or agents and in their discretion, to use, reuse, publish, republish, and copyright audio or visual reproductions of the student/child's voice or image, alone or with other persons, and with or without the use of the student/child's name.

5. _____ YES / NO (**circle choice and initial**)

6 _____ I understand that if I pick up after 5:30p.m., there will be a charge of $1 for every 1 minute after 5:30p.m. After 3 late pick-ups, I will be charged $3 per minute.

ENROLLMENT AGREEMENT

Parent/Guardian Signature: _____ Date: _____

Parent/Guardian Signature: _____ Date: _____

Office Use:

Room #:_____ Receipt #:_____ Date:_____ Initials:_____

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 ☐ Yes ☐ 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 Assumption Nursery School _____, 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

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Tuition Rates

2026/2027 School Year

	Toddler Must be 12 months old Minimum 2 days/week			Transition At least 30 months old Minimum 2 days/week			Preschool/Young Fives Threes – 36 months by September 1; minimum 2 days/week Fours – 48 months by September 1; minimum 2 days/week Young 5's – 60 months – between March 1 – December 31; (minimum 3 days per week)		
Number of Days/week	Half Day 8:30-11:30a.m.	School Day 8:30-3:30p.m	Extended Day 7:00 am-5:30pm	Half Day 8:30-11:30a.m.	School Day 8:30-3:30p.m.	Extended Day 7:00am-5:30pm	Half Day 8:30-11:30a.m.	School Day 8:30-3:30p.m.	Extended Day 7:00am-5:30pm
2	$132	$192	$256	$102	$160	$228	$78	$150	$206
3	$161	$247	$343	$142	$219	$306	$108	$184	$268
4	$201	$310	$432	$176	$272	$397	$140	$216	$326
5	$239	$362	$504	$206	$315	$448	$161	$238	$404
Additional ½ hour (lunch)	$10	n/a	n/a	$10	n/a	n/a	$10	n/a	n/a

WEEKLY RATES – TUITION IS BILLED MONTHLY

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

Birth History:

Are there any current or past diagnosis(es) ☐ Yes ☐ No

If yes, please describe:

If yes, list medications: ⇨

_____ / / _____

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

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

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	
OTHER Vaccines Specify Date & Type	Type of Vaccine(s)	Date of Vaccine(s)
	1	
	2	
	3	

History of Chickenpox Disease? ☐ Yes ☐ No If yes, date:

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.

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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.