Busy Bee Summer Camp - 2024 Registration Form

NAME: _____
(Please print first and last)

Home Phone Number: _____ Home Address: _____

Mothers Name: _____ Fathers Name: _____
(First and last) (First and last)

Mothers Work Phone Number: _____ Cell Number: _____
(Required) (Required)

Fathers Work Phone Number: _____ Cell Number: _____
(Required) (Required)

MOTHER'S EMAIL: FATHER'S EMAIL

Busy Bee will be held at: Auburn Elementary
2900 Waukegan St, Auburn Hills, MI 48326

Busy Bee Programs – Please circle grade they just completed: K 1 2 3 4 5 6

Students must be 5 years old to 12 years old. Students in grades K through 6 will be grouped according to age. Ratios in each program will be 1 adult to 18 children.

$75 camp registration fee (per child)
$45 per day per child

Aleesha Hollis Busy Bee Coordinator
248-537-6402 (office)
248-285-2336 (cell)
aleesha.hollis@avondaleschools.org

Tuition: Pre-Pay **3 days a week minimum**
$ 185.00 per week per first child (full – time 5 days a week)
(2nd FULL TIME child from same family will be $85.00)
(3rd FULL TIME child from same family will be $60.00)

X DAYS YOU NEED US! OR X ENTIRE WEEK!

	Entire Week	Monday	Tuesday	Wednesday	Thursday	Friday
June 10, 2024	_____	_____	_____	_____	_____	_____
June 17, 2024	_____	_____	_____	_____	_____	_____
June 24, 2024	_____	_____	_____	_____	_____	_____
July 1, 2024	_____	_____	_____	_____	_OFF_	_OFF _
July 8 , 2024	_____	_____	_____	_____	_____	_____
July 15, 2024	_____	_____	_____	_____	_____	_____
July 22, 2024	_____	_____	_____	_____	_____	_____
July 29, 2024	_____	_____	_____	_____	_____	_____

ENROLL TODAY!! Registration Ends: MAY 10, 2024

****Registration and 1st week must be paid in full prior to start date****

Registration Fee Paid:_____ Date:_____ First week paid: _____ Date_____

Sibling Name:_____ Sibling Name:_____

CHILD INFORMATION RECORD

State of Michigan - Department of Licensing and Regulatory Affairs - Child Care Licensing Bureau

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? Yes ☐ No ☐ If yes, explain: (Attach additional sheets, if necessary.)	

CCL-3731 (Rev. 3/17/2022) Previous editions 7-18 & 4-21 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 Busy Bee, 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.

CCL-3731 (Rev. 3/17/2022) Previous editions 7-18 & 4-21 may be used

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:

Seasonal Allergies	____Yes	____No
Allergy	____Yes	____No
Hay fever, asthma or wheezing	____Yes	____No
Convulsion/Seizure	____Yes	____No
Physical Limitations	____Yes	____No
Heart Trouble	____Yes	____No
Diabetes	____Yes	____No
Shortness of breath	____Yes	____No
Speech problems	____Yes	____No
Transplants	____Yes	____No
Special Needs	____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
Is the child in good health? ___Yes ___No

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 _____

Should your child's activity be restricted because of any physical defect of illness?
_____Yes _____No _____Classroom _____Playground _____Gym
PLEASE EXPLAIN _____

Parent/Guardian Signature:_____ Date:_____

Attention Parents!! This information helps us help your child! Please fill in all blanks. Please use NONE or UNKNOWN not N/A

FARE Food Allergy Research & Education — FOOD ALLERGY & ANAPHYLAXIS EMERGENCY CARE PLAN

Name: _____ D.O.B.: _____

Allergy to: _____

Weight: _____ lbs. Asthma: ☐ **Yes (higher risk for a severe reaction)** ☐ **No**

NOTE: Do not depend on antihistamines or inhalers (bronchodilators) to treat a severe reaction. USE EPINEPHRINE.

Extremely reactive to the following allergens: _____

THEREFORE:

☐ If checked, give epinephrine immediately if the allergen was LIKELY eaten, for ANY symptoms.

☐ If checked, give epinephrine immediately if the allergen was DEFINITELY eaten, even if no symptoms are apparent.

FOR **ANY** OF THE FOLLOWING:

SEVERE SYMPTOMS

LUNG
Shortness of breath, wheezing, repetitive cough

HEART
Pale or bluish skin, faintness, weak pulse, dizziness

THROAT
Tight or hoarse throat, trouble breathing or swallowing

MOUTH
Significant swelling of the tongue or lips

SKIN
Many hives over body, widespread redness

GUT
Repetitive vomiting, severe diarrhea

OTHER
Feeling something bad is about to happen, anxiety, confusion

OR A COMBINATION of symptoms from different body areas.

1. **INJECT EPINEPHRINE IMMEDIATELY.**
2. **Call 911.** Tell emergency dispatcher the person is having anaphylaxis and may need epinephrine when emergency responders arrive.

- Consider giving additional medications following epinephrine:
  - » Antihistamine
  - » Inhaler (bronchodilator) if wheezing
- Lay the person flat, raise legs and keep warm. If breathing is difficult or they are vomiting, let them sit up or lie on their side.
- If symptoms do not improve, or symptoms return, more doses of epinephrine can be given about 5 minutes or more after the last dose.
- Alert emergency contacts.
- Transport patient to ER, even if symptoms resolve. Patient should remain in ER for at least 4 hours because symptoms may return.

MILD SYMPTOMS

NOSE
Itchy or runny nose, sneezing

MOUTH
Itchy mouth

SKIN
A few hives, mild itch

GUT
Mild nausea or discomfort

FOR **MILD SYMPTOMS** FROM **MORE THAN ONE** SYSTEM AREA, GIVE EPINEPHRINE.

FOR **MILD SYMPTOMS** FROM **A SINGLE SYSTEM** AREA, FOLLOW THE DIRECTIONS BELOW:

1. Antihistamines may be given, if ordered by a healthcare provider.
2. Stay with the person; alert emergency contacts.
3. Watch closely for changes. If symptoms worsen, give epinephrine.

MEDICATIONS/DOSES

Epinephrine Brand or Generic: _____

Epinephrine Dose: ☐ 0.1 mg IM ☐ 0.15 mg IM ☐ 0.3 mg IM

Antihistamine Brand or Generic: _____

Antihistamine Dose: _____

Other (e.g., inhaler-bronchodilator if wheezing): _____

_____

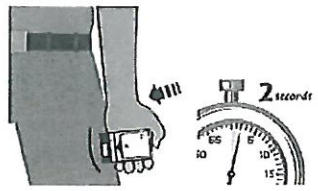
PATIENT OR PARENT/GUARDIAN AUTHORIZATION SIGNATURE DATE PHYSICIAN/HCP AUTHORIZATION SIGNATURE DATE

FORM PROVIDED COURTESY OF FOOD ALLERGY RESEARCH & EDUCATION (FARE) (FOODALLERGY.ORG) 5/2018

FARE Food Allergy Research & Education — FOOD ALLERGY & ANAPHYLAXIS EMERGENCY CARE PLAN

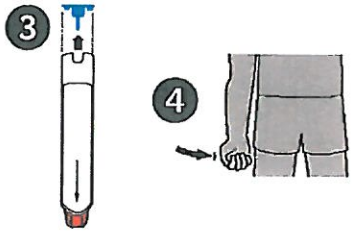
HOW TO USE AUVI-Q® (EPINEPRHINE INJECTION, USP), KALEO

1. Remove Auvi-Q from the outer case.
2. Pull off red safety guard.
3. Place black end of Auvi-Q against the middle of the outer thigh.
4. Press firmly until you hear a click and hiss sound, and hold in place for 2 seconds.
5. Call 911 and get emergency medical help right away.



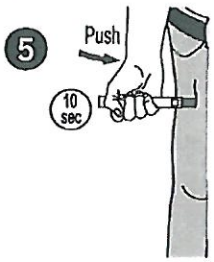
HOW TO USE EPIPEN® AND EPIPEN JR® (EPINEPHRINE) AUTO-INJECTOR AND EPINEPHRINE INJECTION (AUTHORIZED GENERIC OF EPIPEN®), USP AUTO-INJECTOR, MYLAN AUTO-INJECTOR, MYLAN

1. Remove the EpiPen® or EpiPen Jr® Auto-Injector from the clear carrier tube.
2. Grasp the auto-injector in your fist with the orange tip (needle end) pointing downward.
3. With your other hand, remove the blue safety release by pulling straight up.
4. Swing and push the auto-injector firmly into the middle of the outer thigh until it 'clicks'.
5. Hold firmly in place for 3 seconds (count slowly 1, 2, 3).
6. Remove and massage the injection area for 10 seconds.
7. Call 911 and get emergency medical help right away.



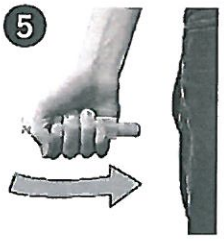
HOW TO USE IMPAX EPINEPHRINE INJECTION (AUTHORIZED GENERIC OF ADRENACLICK®), USP AUTO-INJECTOR, IMPAX LABORATORIES

1. Remove epinephrine auto-injector from its protective carrying case.
2. Pull off both blue end caps: you will now see a red tip.
3. Grasp the auto-injector in your fist with the red tip pointing downward.
4. Put the red tip against the middle of the outer thigh at a 90-degree angle, perpendicular to the thigh.
5. Press down hard and hold firmly against the thigh for approximately 10 seconds.
6. Remove and massage the area for 10 seconds.
7. Call 911 and get emergency medical help right away.



HOW TO USE TEVA'S GENERIC EPIPEN® (EPINEPHRINE INJECTION, USP) AUTO-INJECTOR, TEVA PHARMACEUTICAL INDUSTRIES

1. Quickly twist the yellow or green cap off of the auto-injector in the direction of the "twist arrow" to remove it.
2. Grasp the auto-injector in your fist with the orange tip (needle end) pointing downward.
3. With your other hand, pull off the blue safety release.
4. Place the orange tip against the middle of the outer thigh (upper leg) at a right angle (perpendicular) to the thigh.
5. Swing and push the auto-injector firmly into the middle of the outer thigh until it 'clicks'.
6. Hold firmly in place for 3 seconds (count slowly 1, 2, 3).
7. Remove and massage the injection area for 10 seconds.
8. Call 911 and get emergency medical help right away.



ADMINISTRATION AND SAFETY INFORMATION FOR ALL AUTO-INJECTORS:

1. Do not put your thumb, fingers or hand over the tip of the auto-injector or inject into any body part other than mid-outer thigh. In case of accidental injection, go immediately to the nearest emergency room.
2. If administering to a young child, hold their leg firmly in place before and during injection to prevent injuries.
3. Epinephrine can be injected through clothing if needed.
4. Call 911 immediately after injection.

OTHER DIRECTIONS/INFORMATION (may self-carry epinephrine, may self-administer epinephrine, etc.):

Treat the person before calling emergency contacts. The first signs of a reaction can be mild, but symptoms can worsen quickly.

EMERGENCY CONTACTS — CALL 911

RESCUE SQUAD: _____

DOCTOR: _____ PHONE: _____

PARENT/GUARDIAN: _____ PHONE: _____

OTHER EMERGENCY CONTACTS

NAME/RELATIONSHIP: _____ PHONE: _____

NAME/RELATIONSHIP: _____ PHONE: _____

NAME/RELATIONSHIP: _____ PHONE: _____

FORM PROVIDED COURTESY OF FOOD ALLERGY RESEARCH & EDUCATION (FARE) (FOODALLERGY.ORG) 1/2019

MEDICATION PERMISSION AND INSTRUCTIONS
CHILD CARE HOMES AND CENTERS
Department of Licensing and Regulatory Affairs
Child Care Licensing Bureau

If you are giving or applying any medication to a child in care, the following must be completed by the parent for **each** medication. An interruption in medication will require a new permission form.

TO BE COMPLETED BY PARENT

I give my permission for Avondale Busy Bee (Caregiver, Facility) to give or apply the medication

_____ (Specify, prescribed medication/over the counter product), to my child _____ (Child's Name), as follows:

DIRECTIONS:

1. Date to Begin Giving Medication	2. Date to Stop Medication
3. Times Medication is to be Given	4. Amount (dosage) of Medication Each Time Given
5. Storage of Medication	
6. Other Directions, if Any	
Signature of Parent	Date

TO BE COMPLETED BY THE CAREGIVER GIVING THE MEDICATION:

DATE	TIME	AMOUNT GIVEN	CAREGIVER'S NAME	CAREGIVER'S SIGNATURE
It is recommended this form be reviewed with the parent every 3 months if the medication is ongoing.				

LARA is an equal opportunity employer/program.

Busy Bee Parent Agreement

Acceptance of State and District Policies and Procedures

I have received a Parent Handbook and agree to comply with all of the policies and procedures described within. I understand that a State of Michigan licensing notebook and an Emergency Procedure notebook is available to review during regular business hours. I also understand that not following State and District policies and procedures or behavioral issues may result in dismissal from the program. I acknowledge I am responsible for my bills and understand that I am billed each week for the week I am in. I must pay for the current week on MONDAY OF THAT WEEK or they can't return to the program. I also understand that not paying my bills each week may result in dismissal from the program. All past due bills will incur a $10 LATE FEE! All unpaid bills will be taken to small claims court. All court costs are the responsibility of the person who owes the bill.

Date: _____

Child's Name: _____

School: _____

Parent's Signature: _____

Parent's Signature: _____

Parent email (primary): _____

Parent email (secondary): _____

Please return this with all your paperwork. It MUST be attached to your registration form. Thank you!

**By signing this form you give us permission to communicate by email. **

Busy Bee Photo Release Form

Busy Bee Photos

"Capturing special moments."

Please be advised that your child maybe photographed at various Busy Bee events. Please indicate if your child's photos can appear in our newsletter and/or our Busy Bee Facebook page.

- ◯ Yes, I give my permission
- ◯ No, I do not give my permission

Student's Name: _____

Parent/Guardian Name: _____
(Print)

Parent/Guardian Signature: _____

Date Signed: _____

Authorization for the Application of Sunscreen

I,_____, do hereby authorize Avondale Busy Bee staff to topically apply to my child,_____, the sunscreen listed below for the dates listed below:

6/10/24 through 8/2/24

☐ _____.

(Name of sunscreen provided, labeled and given to my child's teacher)

Parent Signature_____ Date: _____

Date received:_____ Staff signature:_____

Busy Bee Summer Camp

** Once forms are complete they must be emailed to the Busy Bee Coordinator at aleesha.hollis@avondaleschools.org**

If you have any questions, please contact
Aleesha Hollis
248-537-6402 (office)
248-285-2336 (cell)

You will receive notification of acceptance to the Busy Bee Summer Camp. Make sure to check your email for a welcome email and invoice/invite from PROCARE