

# EARLY IMPRESSIONS

## 2025-2026 SCHOOL CALENDAR

MONDAY, AUGUST 18, 2025 ..... **PAPERWORK DEADLINE**  
Fall Registration and Medical Forms

THURSDAY, AUGUST 21, 2025..... LAST DAY OF CAMP

THURSDAY, AUGUST 28, 2025..... **BACK TO SCHOOL ICE CREAM SOCIAL**  
1:00 PM – 3:00 PM

<p><b>DROP OFF SCHOOL SUPPLIES AND MEDICATION</b> <b>**** BRING YOUR STUDENT TO MEET THEIR CLASSROOM TEACHERS ****</b> <b>PICK UP CURRICULUM INFORMATION</b> <b>REFRESHMENTS</b></p>
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WEDNESDAY, SEPTEMBER 3, 2025 ..... **FIRST DAY OF SCHOOL**  
WELCOME TO SCHOOL

THURSDAY, OCTOBER 9, 2025 .....**SCHOOL PICTURE DAY**  
Official School Uniform Required

MONDAY, OCTOBER 13, 2025 ..... **NO CLASS**  
PROFESSIONAL DEVELOPMENT DAY

FRIDAY, OCTOBER 31, 2025 ..... **FAMILY FALL FEST**  
10:00 AM – 12:30 PM  
PARENT TRUNK-OR-TREAT  
**EARLY DISMISSAL 12:30 PM**

FRIDAY, NOVEMBER 21, 2025 ..... **PARENTS' NIGHT OUT**  
5:30 PM – 7:00 PM

WEDNESDAY, NOVEMBER 26, 2025 ..... FRIENDSGIVING FEAST

THURSDAY, NOVEMBER 27, 2025

FRIDAY, NOVEMBER 28, 2025 ..... THANKSGIVING RECESS/**NO CLASSES**

MONDAY, DECEMBER 1 – FRIDAY, DECEMBER 19, 2025 ..... WINTER SPIRIT DAYS  
\* DETAILS TO COME

FRIDAY, DECEMBER 12, 2025 ..... WINTER BLAST CELEBRATION

FRIDAY, DECEMBER 19, 2025 ..... HOLIDAY SING-ALONG / **EARLY DISMISSAL 12:00 PM**  
**STAFF HOLIDAY PARTY 12:00 PM – 2:00 PM**



MONDAY, APRIL 13 - FRIDAY, APRIL 17, 2026 .....SPRING SPIRIT WEEK  
\*DETAILS TO COME

MONDAY, MAY 4 - FRIDAY, MAY 8, 2026.....TEACHER APPRECIATION WEEK

THURSDAY, MAY 21, 2026 .....FAMILY POTLUCK PICNIC  
\*DETAILS TO COME  
11:00 AM – 12:30 PM  
**EARLY DISMISSAL 12:30 PM**

FRIDAY, MAY 22, 2026  
MONDAY, MAY 25, 2026 .....MEMORIAL DAY RECESS/**NO CLASSES**

TUESDAY, MAY 26 – WEDNESDAY, JUNE 3, 2026 .....E.I. SPIRIT WEEK  
\*DETAILS TO COME

WEDNESDAY, JUNE 3, 2026 .....**LAST DAY OF SCHOOL**

WEDNESDAY, JUNE 10, 2026 .....**FIRST DAY OF CAMP**

**~ CALENDAR SUBJECT TO CHANGE ~**

**\*\*\* LOOK FOR ADDITIONAL INFORMATION REGARDING  
SPECIAL PROGRAMS & ACTIVITIES EACH MONTH \*\*\***

## **2025 - 2026 TUITION RATES**

This change is effective immediately.

**Early Impressions'** tuition includes a successful, multi-method instructional approach to education designed to meet the individual learning styles of all children, Pre-School through Second Grade. Our hours of operation are **from 9:00 a.m. to 3:30 p.m.** A unique enrichment program, which includes **Spanish**, taught by a native Hispanic teacher, is included in your tuition at no extra cost

The full day rate allows your child to participate in our **EXTENDED TENDER CARE** programs: **DAYBREAKER** (7:30 a.m. - 9:00 a.m.) and **SUNSETTER** (3:30 p.m.-5:30 p.m.) at **NO ADDITIONAL CHARGE**. Two nutritious snacks are provided daily for all children. The half-day program rate includes all the above program offerings.

Tuition is listed at a weekly rate unless otherwise noted.

### **FULL DAYS: ROOM 1**

**THREE DAYS.....\$300.00**  
**FOUR DAYS.....\$365.00**  
**FIVE DAYS.....\$365.00**

### **FULL DAYS: Preschool**

**THREE DAYS.....\$300.00**  
**FOUR DAYS.....\$355.00**  
**FIVE DAYS.....\$355.00**

### **HALF DAYS: ROOMS 1-5**

**9:00 a.m. - 12:30 p.m.**

**THREE-FIVE HALF DAYS.....\$60.00 per day**

### **EXTRA DAYS**

**\$75.00 per day based on availability.**

### **KINDERGARTEN, FIRST GRADE, and SECOND GRADE**

**FIVE FULL DAYS ONLY.....\$355.00**

**Discounted Tuition:** A \$25.00 weekly discount will be given to the second child in the family providing both children attend five full days. The discount will be calculated only for the child with the lowest program rate.

Early Impressions offers monthly and bi-weekly payments.  
Payments can be made with cash, check, cashier's check, money order, or with a credit card.

Please note: All credit card payments will have a \$10 processing fee for each transaction.

**\*RATES SUBJECT TO CHANGE\***

## **EARLY IMPRESSIONS TUITION PAYMENT SCHEDULE 2025-2026**

*The tuition for the school year has been adjusted accordingly so that there are ten equal payments for the school year. Your rate will depend on your weekly schedule of days and the age of your child.*

***Regarding tuition, parents are responsible for making their payments by the following due dates. The first payment is due, Thursday, August 28th. Payments are due on Wednesdays unless noted otherwise. There will be a two-day grace period.***

*Parents may make payments any time during each time period, but the entire payment must be paid by the Friday after the due date. Please plan for whatever works best for your family budget. Please write your child's name on all forms of payments. Thank you!*

### **PAYMENT DUE DATES:**

*Thursday, August 28, 2025*

*Wednesday, September 24, 2025*

*Wednesday, October 22, 2025*

*Wednesday, November 19, 2025*

*Wednesday, December 17, 2025*

*Wednesday, January 21, 2026*

*Wednesday, February 18, 2026*

*Wednesday, March 18, 2026*

*Wednesday, April 15, 2026*

*Wednesday, May 13, 2026*

***Sibling rate of tuition:*** *A \$25 weekly discount will be given to each additional child, in the family, providing all children attend five full days of school.*

# CHILD INFORMATION RECORD

## State of Michigan - Department of Licensing and Regulatory Affairs - 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.

<b>For Provider Use Only:</b>		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
Parent/Legal Guardian's Name			Home Phone (    )	Parent/Legal Guardian's Name (Optional)
Home Address (if not child's address)			Cell Phone (    )	Home Address (if not child's address)
City	State	Zip Code	City	State
Email Address (optional)			Email Address	
Employer Name			Work Phone (    )	Employer Name
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. 7-18) Previous edition 6-17 may be used.

**See Reverse Side**

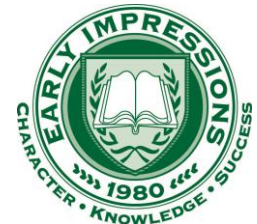
<b>Emergency Contact &amp; Release of Child:</b> List all individuals, including parents/legal guardians, in order of preference, to be contacted in an emergency. If possible, include at least one person other than the parents/legal guardians to be contacted in an emergency and to whom the child can be released. The second phone number column can be left blank. (If more individuals, attach additional sheets.)		
1.	(    )	(    )
2.	(    )	(    )
3.	(    )	(    )
<b>Release of Child Only:</b> 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. (    )

<b>Parent/Legal Guardian Initials:</b>	
_____ I give permission to _____, licensed by the Department of Licensing and Regulatory Affairs to secure emergency medical treatment for the above named minor child while in care.	

<b>I certify that I accurately completed this form and if anything changes, I will notify the provider by updating this form.</b>	
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.	

BCAL-3731 (Rev. 7-18) Previous edition 6-17 may be used.



## CHILD DATA APPLICATION

Child's Name \_\_\_\_\_ Date \_\_\_\_\_ Birthdate \_\_\_\_\_

1. What would you like most for your child to experience with us? \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_
2. What does your child enjoy doing the most? \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_
3. In addition to yourself, who also cares for your child? \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_
4. Does your child have any medical or physical needs? Explain: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_
5. Does your child have any allergies and/or dietary restrictions? If so, does your child need an EPI Pen or other medication? Explain: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_
6. Does your child have Hay fever, Asthma or Wheezing? If so, does your child need a Nebulizer or Inhaler? \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_
7. What foods does your child like best? \_\_\_\_\_  
\_\_\_\_\_
8. What is your child's sleeping arrangements? Check appropriate items:  
\_\_\_ own room, \_\_\_ shares room \_\_\_ sleeps in crib \_\_\_ sleeps in bed.
9. Does your child take naps? \_\_\_\_\_ How long? \_\_\_\_\_

-Please turn over for more questions-

10. Does your child need a favorite item, such as a blanket or toy, for a nap? \_\_\_\_\_  
If so, does he/she have a special name for it? \_\_\_\_\_
11. What words are spoken in your home for toileting? \_\_\_\_\_
12. How does your child express anger or react to frustration? \_\_\_\_\_  
\_\_\_\_\_
13. Does your child have any particular fears? \_\_\_\_\_  
\_\_\_\_\_
14. How does your child react to change, such as being left by parents? \_\_\_\_\_  
\_\_\_\_\_
15. What are your child's play preferences: creative, dramatic or construction? \_\_\_\_\_  
\_\_\_\_\_
16. List the ages and gender of children with whom your child plays with outside of school: \_\_\_\_\_
17. How do you discipline your child? \_\_\_\_\_  
\_\_\_\_\_
18. When did your child begin to use language? \_\_\_\_\_
19. Has your child had previous school or camp experience? If yes, please list names of schools and/or camps. \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_
- If yes, was the experience favorable? \_\_\_\_\_
20. How many hours on a weekly basis is your child permitted to watch television? \_\_\_\_\_
21. Is there anything else in your child's experience you would like to tell us so that we can better meet your child's needs? \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Parent's signature \_\_\_\_\_ Date \_\_\_\_\_

**INFORMATION REVIEWED/UPDATED**

Initials/Date	Initials/Date	Initials/Date	Initials/Date	Initials/Date	Initials/Date
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School Year 2025-2026

**ACKNOWLEDGMENT OF RECEIPT OF HANDBOOK**

CHILD'S NAME \_\_\_\_\_

AFTER READING THE EARLY IMPRESSIONS PARENT HANDBOOK, PLEASE SIGN, DATE AND RETURN THIS PAGE TO THE OFFICE. THANK YOU!

- I have received and read a copy of the Parent Handbook from Early **Impressions**.
- I understand that the Handbook reflects the current policies and procedures of **Early Impressions** and that it replaces and supersedes any prior policies, procedures or Handbooks.
- I agree that I will comply with the policies and procedures contained in this Handbook, and understand that these policies and procedures may be amended, modified, terminated or replaced by **Early Impressions**.
- I have read, understand, and agree to abide by the Tuition Payment Policy, on page 6, as outlined in this handbook.
- I will inform staff of any medical conditions, allergies, or other information necessary to keep my child safe during the time he/she is at school.
- In case of illness or emergency, I will be accessible by phone while my child is in school.
- I understand that it is my responsibility to keep my child's emergency card up to date with current contact information.
- I understand that it is my responsibility to keep my child's Health Form and yearly physical exam up-to-date, and to update student records.

\_\_\_\_\_  
Signature of Parent(s)/Guardian(s) or Responsible Adult

\_\_\_\_\_  
Signature of Parent(s)/Guardian(s) or Responsible Adult

\_\_\_\_\_  
Printed Name

\_\_\_\_\_  
Printed Name

\_\_\_\_\_  
Relationship to Child

\_\_\_\_\_  
Relationship to Child

\_\_\_\_\_  
Date

\_\_\_\_\_  
Date

**MDHHS-3305, HEALTH APPRAISAL**  
 Michigan Department of Health and Human Services (MDHHS)  
 (Revised 7-24)

**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 1. Section 4 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).**

**SECTION 1 – 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 2 – 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"/>	<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, 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"/>	15. Other (describe)	

Reason for Medication

Concussion History

Parent/Guardian Signature

Date

Was the health history reviewed by a health professional?

Examiner's Initials

Yes       No

### SECTION 3 - PHYSICAL EXAMINATION, INSPECTION, TESTS AND MEASUREMENTS

Required for Child Care and Head Start / Early Head Start

#### Test and Measurements

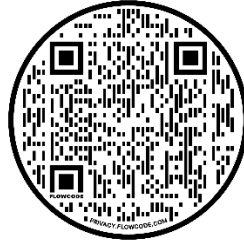
Yes	No	Was child test for	Tests and results	Normal	Referred	Under Care
<input type="checkbox"/>	<input type="checkbox"/>	Vision	Visual Acuity	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
		Date	Muscle Imbalance	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
			Other	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	Hearing	<input type="checkbox"/> Audiometer (R= Right, L=Left)			
		Date	<input type="checkbox"/> OAE (R= Right, L=Left)			
			<input type="checkbox"/> Other (R= Right, L=Left)			
<input type="checkbox"/>	<input type="checkbox"/>	Urinalysis	Sugar	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
			Albumin	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
			Microscopic	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	Blood Lead Level	Level                      ug/dl	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
		Date				

**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	Height	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
			Weight	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	Other	Other	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	Hemoglobin/Hematocrit	➔	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	Blood Pressure	Reading	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Complete pediatric tuberculosis risk assessment available at:

[https://www.michigan.gov/documents/mdhhs/4.\\_MI\\_Pediatric\\_TB\\_Risk\\_Assessment\\_661537\\_7.pdf](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 4 – IMMUNIZATIONS

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

Vaccines (Select Type)	Date Administered (mm/dd/yy)		
	1.	2.	3.
Hepatitis B (HepB)	1.	2.	3.
	4.		
DTaP/DTP/DT/Td	1.	2.	3.
	4.	5.	6.
Tdap	1.		
<i>Haemophilus Influenzae</i> type b (HIB)	1.	2.	3.
	4.		
Polio (IPV/OPV)	1.	2.	3.
	4.	5.	
Pneumococcal Conjugate (PCV)	1.	2.	3.
	4.		
Rotavirus (RV1/RV5)	1.	2.	3.
Measles, Mumps, Rubella (MMR/MMRV)	1.	2.	3.
Varicella (Chickenpox), (Var, MMRV)	1.	2.	
Hepatitis A (HepA)	1.	2.	3.

Influenza (IIV/LAIV)	1.	2.	3.
	4.		
Meningococcal (MCV4, MenABCWY)	1.	2.	3.
Meningococcal B (Bexsero, Trumenba, MenABCWY)	1.	2.	3.
Human Papillomavirus (HPV)	1.	2.	3.

**Additional Vaccines Specify Date & Type**

Type of Vaccine(s)	Date of Vaccine(s)
1.	
2.	
3.	

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.

History of Chickenpox Disease? If yes, date  
 Yes       No

Parent/Guardian refused recommended immunizations at visit.

I certify that the immunization dates are true to the best of my knowledge

Health Professional Signature      Title      Date

**SECTION 5 - RECOMMENDATIONS** (Required for Child Care and Head Start/Early Head Start)

Is there any defect of vision, hearing, or other condition for which the school could help by seating or other actions?

Yes       No

If yes, explain

Should the child's activity be restricted because of any physical defect or illness?

Yes       No

Check all that apply

- |  |   |                                    |
|--|---|------------------------------------|
| <input type="checkbox"/> Classroom     | <input type="checkbox"/> Playground         | <input type="checkbox"/> Gymnasium |
| <input type="checkbox"/> Swimming Pool | <input type="checkbox"/> Competitive Sports | <input type="checkbox"/> Other     |

If yes, explain degree of restriction(s)

Other Recommendations

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**SECTION 6 - DENTAL EXAM OR ASSESSMENT RECOMMENDATIONS**

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Child's Name

Type of Service

 Dental Exam Dental Assessment

Findings (Check all that apply)

 No findings Treated Decay Untreated Decay

Recommendations (Check one)

 Routine Care Referral for dental treatment Referral for urgent dental care

Provider Signature

Date

Check one

 Dentist Dental Therapist Dental Hygienist

---

**SECTION 7 - PHYSICIAN'S SIGNATURE**

---

Examiner's Name (Print)

Degree or License

Telephone Number

Examiner's Signature

Date

Address

City

State Zip Code

MI

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 (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.



## MEDICATION ALERT!

Dear Parents:

\*If your child requires an EPI, AUVI-Q, or TWINJECT PEN, or an INHALER and /or NEBULIZER for allergies and/or asthma, we require an ALLERGY ACTION PLAN PACKET to be completed. This packet contains some forms that require BOTH your signature and your child's physician's signature, while other forms require only your signature.

If your child will need any of these medications, PLEASE CALL THE OFFICE (248-357-1740) **ASAP** to request these forms. We need them completed and returned to the office with all your other forms by MONDAY, August 18, 2025.

If your child needs *Early Impressions* to administer ANY oral medication, there is a PRESCRIPTION MEDICATION PERMISSION AND INSTRUCTION FORM that must be completed. *Early Impressions* will only administer medication that is prescribed by a physician and is labeled by a licensed pharmacist.

Thank you so much!

*Early Impressions*

\*If you are a current *Early Impressions* student or camper with an ALLERGY ACTION PLAN PACKET on file, you must update the forms before the first day of school, if you have not already done so. All forms expire after one year.



**FARE**  
Food Allergy Research & Education

# FOOD ALLERGY & ANAPHYLAXIS EMERGENCY CARE PLAN

**PLACE  
PICTURE  
HERE**

Name: \_\_\_\_\_ D.O.B.: \_\_\_\_\_

Allergic 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.**

**Special Situation/Circumstance - If this box is checked, the child has an extremely severe allergy to the following food(s) \_\_\_\_\_.**  
**Even if the child has MILD symptoms after eating (ingesting) this food(s), Give Epinephrine immediately.**

## 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 BODY SYSTEM, GIVE EPINEPHRINE.**

**FOR MILD SYMPTOMS FROM A SINGLE BODY SYSTEM (E.G. SKIN, GI, ETC.), 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

HEALTHCARE PROVIDER AUTHORIZATION SIGNATURE

DATE



**FARE**  
Food Allergy Research & Education

# FOOD ALLERGY & ANAPHYLAXIS EMERGENCY CARE PLAN

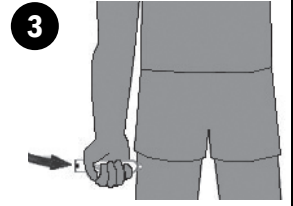
### HOW TO USE AUVI-Q® (EPINEPHRINE INJECTION, USP), KALEO

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



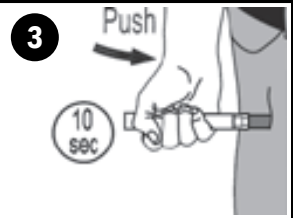
### HOW TO USE EPIPEN®, EPIPEN JR® (EPINEPHRINE) AUTO-INJECTOR AND EPINEPHRINE INJECTION

1. (AUTHORIZED GENERIC OF EPIPEN®), USP AUTO-INJECTOR, MYLAN AUTO-INJECTOR, MYLAN
2. Remove the EpiPen® or EpiPen Jr® Auto-Injector from the clear carrier tube.
3. Grasp the auto-injector in your fist with the orange tip (needle end) pointing downward. 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'. Hold firmly in place for 3 seconds (count slowly 1, 2, 3).
5. Remove and massage the injection area for 10 seconds. Call 911 and get emergency medical help right away.



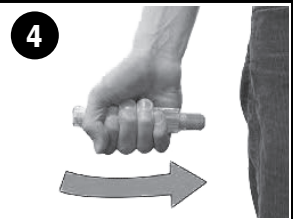
### HOW TO USE IMPAX EPINEPHRINE INJECTION (AUTHORIZED GENERIC OF ADRENACLICK®), USP AUTO-INJECTOR, AMNEAL PHARMACEUTICALS

1. Remove epinephrine auto-injector from its protective carrying case.
2. Pull off both blue end caps: you will now see a red tip. Grasp the auto-injector in your fist with the red tip pointing downward.
3. Put the red tip against the middle of the outer thigh at a 90-degree angle, perpendicular to the thigh. Press down hard and hold firmly against the thigh for approximately 10 seconds.
4. Remove and massage the area for 10 seconds. 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. With your other hand, pull off the blue safety release.
3. Place the orange tip against the middle of the outer thigh at a right angle to the thigh.
4. Swing and push the auto-injector firmly into the middle of the outer thigh until it 'clicks'. Hold firmly in place for 3 seconds (count slowly 1, 2, 3).
5. Remove and massage the injection area for 10 seconds. Call 911 and get emergency medical help right away.



### HOW TO USE SYMJEPI™ (EPINEPHRINE INJECTION, USP)

1. When ready to inject, pull off cap to expose needle. Do not put finger on top of the device.
2. Hold SYMJEPI™ by finger grips only and slowly insert the needle into the thigh. SYMJEPI™ can be injected through clothing if necessary.
3. After needle is in thigh, push the plunger all the way down until it clicks and hold for 2 seconds.
4. Remove the syringe and massage the injection area for 10 seconds. Call 911 and get emergency medical help right away.
5. Once the injection has been administered, using one hand with fingers behind the needle slide safety guard over needle.



### 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.):

**Epinephrine first, then call 911.** Monitor the patient and call their emergency contacts right away.

### EMERGENCY CONTACTS – CALL 911

RESCUE SQUAD: \_\_\_\_\_

DOCTOR: \_\_\_\_\_ PHONE: \_\_\_\_\_

PARENT/GUARDIAN: \_\_\_\_\_ PHONE: \_\_\_\_\_

### OTHER EMERGENCY CONTACTS

NAME/RELATIONSHIP: \_\_\_\_\_ PHONE: \_\_\_\_\_

NAME/RELATIONSHIP: \_\_\_\_\_ PHONE: \_\_\_\_\_

NAME/RELATIONSHIP: \_\_\_\_\_ PHONE: \_\_\_\_\_



# Early Impressions\*

## AUTHORIZATION for Epi Pen, INHALER and/or NEBULIZER Medication

Dear Parents,

I have read and understand the conditions which govern the administration of oral medication, including EpiPens, inhalers, and/or nebulizers by Early Impressions School, (L & A Educational Services, Inc.), its staff, teachers, and employees. I agree to abide by these requirements.

Parent's Signature \_\_\_\_\_

Date \_\_\_\_\_

STUDENT'S NAME \_\_\_\_\_

Name of Drug \_\_\_\_\_

Dosage \_\_\_\_\_

Time \_\_\_\_\_

For Period \_\_\_\_\_

to \_\_\_\_\_

Date

Date

Reason the medication must be given during the school day \_\_\_\_\_

Describe the diagnosis and anticipated effect \_\_\_\_\_

Possible reactions or symptoms \_\_\_\_\_

Additional Comments \_\_\_\_\_

PRE-SCHOOL \* JUNIOR KINDERGARTEN \* KINDERGARTEN \* LOWER ELEMENTARY \* SUMMER DAY CAMP  
25000 WEST TEN MILE ROAD SOUTHFIELD, MICHIGAN 48033  
248-357-1740 \* [WWW.EARLYIMPRESSIONSSCHOOL.COM](http://WWW.EARLYIMPRESSIONSSCHOOL.COM)

\*Early Impressions & Summer Impressions are registered assumed names of L & A Educational Services, Inc.

**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**

**Early Impressions**

I give my permission for \_\_\_\_\_ to give or apply the medication  
 (Caregiver, Facility)  
 \_\_\_\_\_, to my child \_\_\_\_\_, as follows:  
 (Specify, prescribed medication/over the counter product) (Child's Name)

**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.

## School Supply List



	2 Crayola 24 ct. crayons
	2 Crayola 10 ct. broadline classic markers
	8 AVERY or SCOTCH permanent bond glue sticks
	4 Play-Doh containers 3 oz.
	1 Washable watercolor paint set
	1 pencil box with lid 8 5/8" x 5 3/4"
	1 one inch 3-ring binder w/clear sleeve on the front
	3 large boxes of tissues
	6 containers of CLOROX wipes
	3 large packages of unscented baby wipes
	1 box of gallon size Ziploc storage bags
	1 large refill container of antibacterial hand soap
	1 6-pack of paper towels
	LABELED Backpack
	LABELED Insulated Lunchbox
	LABELED <i>Spill proof</i> , insulated water bottle
	LABELED Extra set of clothes including undergarments
	LABELED crib sheet, travel size pillow and blanket (ages 2-5)
	LABELED pack of diapers or pull-ups (If applicable)

Please ONLY label the items mentioned, all supplies are shared.

**THANK YOU FOR ALL YOUR CONTRIBUTIONS.**

**WE LOOK FORWARD TO A GREAT SCHOOL YEAR!**