Greenville Public Schools
Preschool Enrollment
Contact: Keisha Peters (616) 754-3641  petersk@gpsmi.us

Child's Name: ________________________________

Enrollment Checklist- These materials must be turned in before your child will be enrolled
☐ Preschool Collaborative Application
☐ Income Verification (W-2, front page of last year’s taxes or pay stub)
☐ Copy of Birth Certificate
☐ Copy of Immunization Records
☐ Health Appraisal (must be submitted by the first day of school)
☐ Registration Form
☐ Child Information Record
☐ Transportation Form
☐ Photo Release Form
☐ Authorization to Disclose Information Form
☐ Permission Form
☐ Licensing Notebook Signature Page
☐ Substance Free Classroom Agreement

Academic File Checklist- This section is for teacher use only
☐ Free/Reduced Meal Application
☐ Parent Involvement Form
☐ ICHAT Form
☐ Central Registry Clearance Form
☐ ASQ
☐ Age Waiver (if applicable)
☐ Family Heritage Survey
☐ Home-Visit & Conference Form
☐ Risk Factor Documentation Form
☐ Referral Documentation (if applicable)
Authorization to Disclose Information

Student: __________________________ Date of Birth: ______________

I understand that services provided to my child may come from different agencies. In order to plan for and provide the best possible care for my child and our family, various professionals may need to share information about my child. This form is an authorization, or permission from me, for those professionals to share the information I would like shared. I understand that this information may be used to help decide if my child is eligible for services, how best to coordinate and provide those services, and the services for which we qualify.

The agencies and persons I have initialed below have my permission to share the information about my child and family that I have listed. This could be electronic, verbal, or written. I understand that information will NOT be shared without my authorization with anyone who does not have a valid reason for it or unless authorized under applicable federal and state laws. I understand that this information will not be shared with anyone who has not agreed to meet applicable confidentiality standards. I am aware that I can, without penalty, at any time, cancel this consent and not share information with these persons or agencies. My authorization to share information is voluntary and is good for 12 months. At any time I may, in writing, cancel this authorization to share information form.

<table>
<thead>
<tr>
<th>Agencies Authorized to Exchange Information (initial those that apply)</th>
<th>Info Codes (see back)</th>
<th>Initial</th>
<th>Agency/Person</th>
<th>Info Codes (see back)</th>
<th>Initial</th>
<th>Agency/Person</th>
</tr>
</thead>
<tbody>
<tr>
<td>Montcalm Area Intermediate School District (MAISD)</td>
<td></td>
<td></td>
<td>Physician Name/Address:</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>MAISD Local Education Agencies/Districts</td>
<td></td>
<td></td>
<td>Physician Name/Address:</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>SMILES Dental Support</td>
<td></td>
<td></td>
<td>Physician Name/Address:</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>EightCAP</td>
<td></td>
<td></td>
<td>Daycare Provider:</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other:</td>
<td></td>
<td></td>
<td>Other:</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other:</td>
<td></td>
<td></td>
<td>Other:</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Consent for Authorization to Disclose Information *(Initial one of the two statements.)*

☐ My signature below is my consent and agreement to the following:

- I have read and understand this consent form (or it has been read to me in a language I understand).
- I understand that my authorization or consent to allow the sharing of information about my child is voluntary and I may deny or revoke consent at any time, without penalty. Revocation of consent is not retroactive.
- I understand that information about my child will also be kept on a database that is subject to the same confidentiality provisions.
- I understand the confidentiality of information about my child is protected by state and federal law, including the Individuals with Disabilities Education Act (IDEA), the Family Educational Rights and Privacy Act (FERPA), and the Health Insurance Portability and Accountability Act (HIPAA). The protected health information (PHI) or personally-identifiable information (PII) in my child’s records cannot be disclosed, given, sold, or transferred in any way to any other agency/program (and its contractors or authorized representatives) not specified in this release unless otherwise specifically authorized by federal or state laws.
- I understand that authorizing the disclosure of health information is voluntary. I also understand that I may refuse to sign this authorization and that my refusal to sign will not affect my ability to obtain treatment or services, payment for services, or eligibility for benefits unless the information is necessary to demonstrate that I meet eligibility or enrollment criteria.
- I authorize the agencies designated and their representatives to engage in verbal or written communication in order to share records and information as indicated above.

☐ My signature below indicates that I do NOT authorize any information to be shared at this time:

Signature of Student or Parent/Guardian __________________________ Initials __________ Date Signed __________

Authorization Obtained By: __________________________

Witness __________________________ Date Signed __________
**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.

<table>
<thead>
<tr>
<th>For Provider Use Only:</th>
<th>Date of Admission</th>
<th>Date of Discharge</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Name of Child (Last, First, Middle Initial)</th>
<th>Child's Date of Birth</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Address (Number and Street, Building/Apartment Number)</th>
<th>City</th>
<th>State</th>
<th>Zip Code</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Parent/Legal Guardian's Name</th>
<th>Home Phone ( )</th>
<th>Parent/Legal Guardian's Name (Optional)</th>
<th>Home Phone ( )</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Home Address (If not child's address)</th>
<th>Cell Phone ( )</th>
<th>Home Address (If not child's address)</th>
<th>Cell Phone ( )</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>City</th>
<th>State</th>
<th>Zip Code</th>
<th>Email Address</th>
<th>City</th>
<th>State</th>
<th>Zip Code</th>
<th>Email Address</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Employer Name</th>
<th>Work Phone ( )</th>
<th>Employer Name</th>
<th>Work Phone ( )</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Name of Child's Physician or Health Clinic</th>
<th>Physician's or Health Clinic's Phone Number ( )</th>
</tr>
</thead>
</table>

Hospital Preferred for Emergency Treatment (optional)

Allergies, Special Needs and Special Instructions (Attach additional sheets, if necessary.)

---

**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.)

<table>
<thead>
<tr>
<th>1.</th>
<th>( )</th>
<th>( )</th>
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<tbody>
<tr>
<td>2.</td>
<td>( )</td>
<td>( )</td>
</tr>
<tr>
<td>3.</td>
<td>( )</td>
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</tr>
</tbody>
</table>

**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.)

<table>
<thead>
<tr>
<th>1.</th>
<th>( )</th>
<th>2.</th>
<th>( )</th>
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<tbody>
<tr>
<td>3.</td>
<td>( )</td>
<td>4.</td>
<td>( )</td>
</tr>
</tbody>
</table>

**Parent/Legal Guardian Initials:**

I give permission to ____________________________, licensed by the Department of Licensing and Regulatory Affairs to secure emergency medical 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 ____________

---

<table>
<thead>
<tr>
<th>Date Card Reviewed</th>
<th>Parent or Legal Guardian Initials</th>
<th>Date Card Reviewed</th>
<th>Parent or Legal Guardian Initials</th>
<th>Date Card Reviewed</th>
<th>Parent or Legal Guardian Initials</th>
<th>Date Card Reviewed</th>
<th>Parent or Legal Guardian Initials</th>
</tr>
</thead>
</table>

LARA is an equal opportunity employer/program.

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BCAL-3731 (Rev. 6-17) Previous editions 4-16, 6-15 and 7-12 may be used until September 30, 2018.
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

<table>
<thead>
<tr>
<th>#</th>
<th>Is your child having any of the problems listed below?</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Allergies or Reactions (for example, food, medication or other)</td>
</tr>
<tr>
<td>2</td>
<td>Hay Fever, Asthma, or Wheezing</td>
</tr>
<tr>
<td>3</td>
<td>Eczema or Frequent Skin Rashes</td>
</tr>
<tr>
<td>4</td>
<td>Convulsions/Seizures</td>
</tr>
<tr>
<td>5</td>
<td>Heart Trouble</td>
</tr>
<tr>
<td>6</td>
<td>Diabetes</td>
</tr>
<tr>
<td>7</td>
<td>Frequent Colds, Sore Throats, Earaches (4 or more per year)</td>
</tr>
<tr>
<td>8</td>
<td>Trouble with Passing Urine or Bowel Movements</td>
</tr>
<tr>
<td>9</td>
<td>Shortness of Breath</td>
</tr>
<tr>
<td>10</td>
<td>Speech Problems</td>
</tr>
<tr>
<td>11</td>
<td>Menstrual Problems</td>
</tr>
<tr>
<td>12</td>
<td>Dental Problems: Date of Last Exam Date Date</td>
</tr>
<tr>
<td>Other</td>
<td>Other (please describe):</td>
</tr>
</tbody>
</table>

Birth History:

Is there any current or past diagnosis(es)? Yes No

If yes, please describe:

Was the health history reviewed by a health professional? Yes No

Reason for Medication

Was the child taking any medication(s) regularly?

If yes, list medications:

Parent/Guardian Signature ________________________________ Date ________________________________

Examiner's Initials ________________________________

SECTION II - PHYSICAL EXAMINATION, INSPECTION, TESTS AND MEASUREMENTS

Required for Child Care and Head Start / Early Head Start

Tests and Measurements

Was child tested for: | Test results: | Normal | Referred | Under Date | Yes | Was child tested for: | Test results: | Normal | Referred | Under Date |
<table>
<thead>
<tr>
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</tr>
</thead>
<tbody>
<tr>
<td>VISION</td>
<td>Visual Acuity</td>
<td>Other:</td>
<td></td>
<td></td>
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<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hearing</td>
<td>Audimeter</td>
<td>Other:</td>
<td></td>
<td></td>
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<td></td>
<td></td>
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<td></td>
</tr>
<tr>
<td>Urinalysis</td>
<td>Sugar</td>
<td>Other:</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Blood Lead Level</td>
<td>Level</td>
<td>ug/d</td>
<td></td>
<td></td>
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<td></td>
<td></td>
<td></td>
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</tr>
</tbody>
</table>

**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 DERIVING FROM NORMAL:

Exam Date: ________________________________

Rev. July 2015
**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.

<table>
<thead>
<tr>
<th>VACCINES (Circle Type)</th>
<th>DATE ADMINISTERED</th>
<th>VACCINES (Circle Type)</th>
<th>DATE ADMINISTERED</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hepatitis B (HepB)</td>
<td>1 3</td>
<td>Hepatitis A (HepA)</td>
<td>1 2</td>
</tr>
<tr>
<td></td>
<td>2 4</td>
<td>Influenza (IV/IAV)</td>
<td>1 3</td>
</tr>
<tr>
<td>DTap/DTP/Td/Td</td>
<td>2 5</td>
<td>Meningococcal (MCV4 / MPSV4)</td>
<td>1 2</td>
</tr>
<tr>
<td></td>
<td>3 6</td>
<td>Human Papillomavirus (HPV9/HPV1/HPV2)</td>
<td>1 3</td>
</tr>
<tr>
<td>Tdap</td>
<td>1</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Haemophilus Influenza b (Hib)</td>
<td>1 3</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Polio (IPV/OPV)</td>
<td>1 3</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>2 4</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Pneumococcal Conjugate (PCV7/PCV13)</td>
<td>1 3</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Rotavirus (RV1/RV3)</td>
<td>2 3</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Measles, Mumps, Rubella (MMR)</td>
<td>1 2</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Varicella (Chickenpox)</td>
<td>1 2</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

History of Chickenpox Disease?  Yes ☐  No ☐  Other ☐

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

Health Professional’s Signature

SECTION IV - 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? 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: ☐ Classroom ☐ Playground ☐ Gymnasium ☐ Swimming Pool ☐ Competitive Sports ☐ Other

Other Recommendations

SECTION V - DENTAL EXAMINATION AND RECOMMENDATIONS (OPTIONAL)

I have examined __________________________’s teeth. As a result of this examination, my recommendation for treatment is:

______________________________

Dentist’s Signature

PHYSICIAN’S SIGNATURE

Examiner’s Signature

Examiner’s Home (Print or Type)

Degree or License

Number & Street

City

State

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.

LICENSING NOTEBOOK

Greenville Public Schools GSRP and Junior Jackets Preschools maintain a licensing notebook for your review.

The notebook—

1) Includes all licensing inspection reports, special investigation reports and all related corrective action plans.
2) Will be available for your review during regular business hours

Licensing inspection and special investigation reports from the past two years are available on the Bureau of Children and Adult Licensing website at: www.michigan.gov/michildcare.

Please sign this document and return it to preschool so there will be a signed notification on file for each parent.

______________________________  ______________________________
Signature                                          Date
Greenville Public Schools Preschool

Permission Form

I give permission for my child, _________________________________, to participate in the following:

Attend and participate in field trips:
By school transportation □ Yes □ No
Walking field trips □ Yes □ No
Be transported to school sponsored Activities by your local school district:
□ Yes □ No

Participate in parties and holiday Celebrations (when scheduled):
□ Yes □ No

________________________________________
Parent/Guardian Signature

________________________________________
Date
PHOTO RELEASE FORM
GREENVILLE PUBLIC SCHOOLS PRESCHOOL PROGRAM PHOTOGRAPHY/ VIDEOTAPE PERMISSION FORM

Consent is hereby given to the Greenville Public Schools Preschool Programs to photograph/video the following members of my family:

Name: ___________________________________________ Birthdate: __________

Name: ___________________________________________ Birthdate: __________

Name: ___________________________________________ Birthdate: __________

Name: ___________________________________________ Birthdate: __________

These photographs/videos may be used for the purpose of:

☐ Parent/Staff Training

☐ PowerPoint/Videotape presentation

☐ Scrapbooks

☐ Newspaper

☐ MCGSC website

☐ Brochures – To be distributed through Montcalm and neighboring counties

☐ Social Networking

☐ All of the above

I recognize I have the rights to request to review any photographs or video before they are released to the media or used in a presentation.

_________________________________________  _______________________
Parent/Guardian Signature                  Date
Greenville Public Schools
Preschool Enrollment
Student Registration / Emergency Form

Student Information:

Last: ___________________________ First: ___________________________ Middle: ___________________________

Address (no PO Boxes):
_____________________________________________________________________________________

City: __________________________ State: Michigan Zip: __________________________

Mailing Address (if different):
_____________________________________________________________________________________

Home Phone: __________________________ Birth City & State: __________________________

☐ Male ☐ Female Birth date: ___/___/___ Grade Entering: ______

Primary Language spoken in the home: __________________________ (Contact teacher if other than English)

Ethnicity
Is the student Hispanic/Latino (choose only one)
☐ No, not Hispanic/Latino
☐ Yes, Hispanic/Latino- (A person of Cuban, Mexican, Puerto Rican, South/Central American, or other Spanish culture or origin, regardless of race)

Race
The question to the left is about ethnicity, not race. No matter what you selected, please continue to answer the following by marking one or more boxes indicating what you consider your student’s race to be.
American Indian/Alaska Native ☐ Asian American ☐
Native Hawaiian/Pacific Islander ☐ Black/African Amer. ☐
White ☐

Family Information:
Student Resides with:
Name __________________________ Relationship __________________________

Is this home your rent or own? ☐ Yes ☐ No

Father/Step-Father Name: __________________________ Birthdate: ___/___/___

Address (if different than primary residence):
_____________________________________________________________________________________

City: __________________________ State: __________________________ Zip Code: __________________________

Home Phone: __________________________ Work Phone: __________________________ Cell Phone: __________________________

Employer & Occupation: __________________________ Email address: __________________________

Mother/Step-Mother Name: __________________________ Birthdate: ___/___/___

Address (if different than primary residence):
_____________________________________________________________________________________

City: __________________________ State: __________________________ Zip Code: __________________________

Home Phone: __________________________ Work Phone: __________________________ Cell Phone: __________________________

Employer & Occupation: __________________________ Email address: __________________________

Please complete both sides of form
Greenville Public Schools
Preschool Enrollment

Non-Custodial Parent Name: ____________________________ Birthdate: ___/___/___

Address (if different than primary residence): ____________________________

City: ____________________________ State: ___________ Zip Code: ___________

Home Phone: ______________ Work Phone: ______________ Cell Phone: __________

Employer & Occupation: ____________________________ Email address: ____________________________

If the child does not reside with parents, please fill in the following information

Guardian Name: ____________________________ Birthdate: ___/___/___

Address (if different than primary residence): ____________________________

City: ____________________________ State: ___________ Zip Code: ___________

Home Phone: ______________ Work Phone: ______________ Cell Phone: __________

Employer & Occupation: ____________________________ Email address: ____________________________

In the case that a parent cannot be contacted, please list the name of at least two emergency contacts below

Contact Name: ____________________________ Phone Number: ______________

Contact Name: ____________________________ Phone Number: ______________

Contact Name: ____________________________ Phone Number: ______________

Contact Name: ____________________________ Phone Number: ______________
Substance Free Classroom Agreement

A substance free classroom is defined as one where the following is prohibited: all use of cigarettes, cigars or burning tobacco in any form (including vaping), use and possession of alcohol and other drugs, which are prohibited by state law and/or Greenville Public Schools district policy. These requirements apply to all classroom guests in common areas as well as all school facilities and/or activities and include field trip activities.

Parents and staff are expected to abide by the Substance Free Classroom Agreement to the following standards:

1. The use or possession of alcohol and illegal drugs is not permitted within the substance free classroom. This policy applies to all areas of the substance free classroom, including, but not limited to the following: classrooms, hallways, bathrooms, stairwells, and field trip activities.
2. Parents and staff may not enter the classroom under the influence of alcohol or other drugs. Problematic behaviors that result from parents and staff being under the influence of alcohol and/or drugs are also prohibited. Such behaviors will be considered a violation of this agreement.
3. Classroom guests are aware of and abide by all classroom rules and regulations, including this agreement.
4. Substance Free, as defined above, is responsible for supporting a substance free classroom. Staff must express concerns to the building administrator about any classroom guest(s) who may be violating the substance free classroom standards.
5. Violations of the Substance Free Classroom agreement will be handled as follows:
   a. An incident report will be filed with the building administrator.
   b. Classroom guest(s) will not be allowed to participate in future classroom activities.

I have read, understand and agree to abide by the terms and conditions of the Substance Free Classroom Agreement. I understand that this agreement shall remain in effect through my child’s participation in a Greenville Public Schools preschool program. I understand that any violation may result in administrative action, which may include my inability to participate in classroom activities.

Parent/Guardian Signature: __________________________ Date: ____________

Staff Signature: __________________________ Date: ____________
MONTCALM AREA INTERMEDIATE SCHOOL DISTRICT (MAISD)
TRANSPORTATION INFORMATION
2019-2020

Please complete the requested information and return this form to your child’s teacher.

Child’s Name ___________________________ Date of Birth ___________________________

Name of Parent(s) With Whom Child Resides _______________________________________

Address _______________________________________________________________________

Street City Zip Code

Phone Number ___________________________

If you do not have a phone, please list a name and number for messages:

Name ___________________________ Phone Number ___________________________

If you have children attending an MAISD School, please indicate the grade and elementary school they will attend in 2018-2019: ______________________________________

When your child attends the Great Start Readiness Program at ______________, you may wish to have your child picked up and dropped off at home. You may prefer to have your child transported to and from a childcare provider, __________________________ will pick up and deliver to the childcare provider if that person resides in the Montcalm School District. We need this information for the Transportation Director so bus routes can be set for next school year.

_____ My child does not need transportation provided by the school.

_____ My child will be picked up and dropped off at the address listed above.

_____ My child will be picked up at this address: __________________________

                                                                                   

_____ My child will be dropped off at this address: __________________________        

                                                                                   

_____ I do not know at this time the places my child will be picked up and dropped off. I will let the Transportation Department know by calling _____________ as soon as I have this information.

The name of my childcare provider is ____________________________________________