BUSY BEE SUMMER CAMP

Busy Bee will be held at:

Auburn Elementary School 2900 Waukegan St., Auburn Hills, MI 48326



Name :	
	(Please print first and last)
Home Phone:	Home Address:
Parents/Gu Information	
Mother's Name:	Work Phone:
Mother's Email:	Cell Phone:
Father's Name:	Work Phone:
Father's Email:	Cell Phone:
Please circle the Students must be according to age. Camp Prici \$75 Camp Registre \$65 per day, per c	ation Fee (per child) \$225 per week per first child (full-time, 5 days a week)
Summer Sc select the days you ☐ June 16, 2025 ☐ June 23, 2025 ☐ June 30, 2025	Full Week Monday Tuesday Wednesday Thursday Friday OFF
☐ July 7, 2025 ☐ July 14, 2025 ☐ July 21, 2025 ☐ July 28, 2025 ☐ Aug. 4, 2025	(Structured Learning - must commit to full week) ENROLL TODAYI Contact: Aleesha Hart Busy Bee / Summer Camp Director 248.537.6402 (office) 248.285.2336 (cell) aleesha.hart@avondaleschools.org

Registration Ends: May 10, 2025 • *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 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	on	Date of	Discharge				
Name of Child (L	ast, First, Middle Init	ial)		•				Child's	s Date of Birth
Address (Number	er and Street, Building	g/Apartment N	lumber)		City		State	Zip Co	ode
Parent/Legal Gu	ardian's Name		Primary Phone	e	Parent/Legal G	uardian's Name (Optiona	l) Prima	ry Phone
Home Address (if not child's address)		2 nd Phone (if ap	oplicable)	Home Address	(if not child's add	ress)	2 nd Ph	one (if applicable)
City		State	Zip Code		City		State	Zip Co	ode
Email Address (optional)				Email Address	(optional)		L	
Employer Name		,	Work Phone		Employer Name	9		Work (Phone)
Name of Child's	Physician or Health (Clinic			Physician's or F	lealth Clinic's Pho	one Nur	mber	
Hospital Preferre	ed for Emergency Tre	atment (option	nal)						
Allergies, Specia (Attach additional she	al Needs and/or Specets, if necessary.)	ial Instructions	s? No □ Yes □	☐ If yes, e	explain:				
CCL-3731 (Rev. 6/7/2	2024) Previous editions 7-1	8, 4-21, & 3-22 m	ay be used					s	ee Reverse Side
possible, include a	act & Release of Child it least one person othe nber column can be left	r than the paren	ts/legal guardiar	ns to be co	ntacted in an eme				
1.					()			()	
2.					()			()	
3.					()			()	
Release of Child C	Only: List all individuals, o	other than the pa	rents/legal guardi	ans, to who	om the child may be	e released. (If more in	ndividuals	s, attach additio	nal sheets.)
1.		()	2.				()	
3.		()	4.				()	
5. ())	6.				()		
Parent/Legal Gua	ardian Initials:								
	ermission to re emergency medical tr	eatment for the	above named m	inor child v		Department of Life	long Edu	ucation, Advan	cement, and
	curately completed thi	is torm and if a	nything change	es, 1 will n	otity the provide				
Signature of Pare	nt or Guardian					Date Sig	jned		
Date Card Reviewed	Parent or Legal Guardian Initials	Date Card Reviewed	Parent or Guardian	-	Date Card Reviewed	Parent or Lega Guardian Initial		Date Card Reviewed	Parent or Legal Guardian Initials

Busy Bee Program- Medical Questionnaire

Child's Name: Te	eacher:	
Please check any of the following problems that may require the spec	cial attention of o	ur 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
Are your child's immunizations up to date? Date of last Does your child take medication regularly?YesNo If yes, list medication Reason for medication		
Should your child's activity be restricted because of any physicalYesNoClassroomPlaygroundG PLEASE EXPLAIN	ym	:s?
Parent/Guardian Signature: Attention Parents!! This information helps us help your child! Plea		ıks. Please

use NONE or UNKNOWN not N/A



FOOD ALLERGY & ANAPHYLAXIS EMERGENCY CARE PLAN

PIC	LACE TURE
Allergy to:	ERE
Weight: Ibs. Asthma:	
NOTE: Do not depend on antihistamines or inhalers (bronchodilators) to treat a severe reaction. USE EPINEPHRINE.	
Extremely reactive to the following allergens:	
THEREFORE:	
\Box If checked, give epinephrine immediately if the allergen was LIKELY eaten, for ANY symptoms.	
\Box If checked, give epinephrine immediately if the allergen was DEFINITELY eaten, even if no symptoms are apparent.	
SEVERE SYMPTOMS MILD SYMPTOMS	
LUNG HEART THROAT MOUTH Shortness of Pale or bluish Tight or hoarse Significant runny nose, mild itch nature.	GUT Mild usea or comfort
SKIN Many hives over body, widespread redness 1. INJECT EPINEPHRINE IMMEDIATELY. OR A COMBINATION of symptoms from different body areas. OR A COMBINATION of symptoms from different body areas. 1. INJECT EPINEPHRINE IMMEDIATELY. SYSTEM AREA, GIVE EPINEPHRINE. FOR MILD SYMPTOMS FROM A SINGLE SY AREA, FOLLOW THE DIRECTIONS BELO 1. Antihistamines may be given, if ordered by healthcare provider. 2. Stay with the person; alert emergency control 3. Watch closely for changes. If symptoms we give epinephrine.	/STEM DW: / a
2. Call 911. Tell emergency dispatcher the person is having anaphylaxis and may need epinephrine when emergency responders arrive. MEDICATIONS/DOSES Epinephrine Brand or Generic:	
Consider giving additional medications following epinephrine: » Antihistamine » Inhaler (bronchodilator) if wheezing Epinephrine Dose: □ 0.1 mg IM □ 0.15 m).3 mg IM
• 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 	

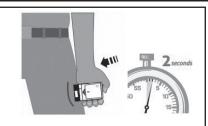
remain in ER for at least 4 hours because symptoms may return.



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

- Remove the EpiPen® or EpiPen Jr® Auto-Injector from the clear carrier tube.
- 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**

- 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.
- 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.
- 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). 6.
- 7. Remove and massage the injection area for 10 seconds.
- Call 911 and get emergency medical help right away.

ADMINISTRATION AND SAFETY INFORMATION FOR ALL AUTO-INJECTORS:

- 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.
- 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 — CA	LL 911	OTHER EMERGENCY CONTACTS		
RESCUE SQUAD:		NAME/RELATIONSHIP:	PHONE:	
DOCTOR:	PHONE:	NAME/RELATIONSHIP:	PHONE:	
PARENT/GUARDIAN:	PHONE:	NAME/RELATIONSHIP:	PHONE:	

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 PA	ARENT				
I give my permission for			F ''' \		to give or apply the medication
		(Caregiver,			
(Specify, prescribed	medication/over the co	ounter product)	, to my ch	ild (Child's	Name) , as follows
		,		(-	,
DIRECTIONS: 1. Date to Begin Giving Medicat	ion		2 Date to	Stop Medication	
1. Date to begin diving medical	IOH		Z. Date to	Stop Medication	
3. Times Medication is to be Giv	ven		4. Amount	(dosage) of Medication Each	Time Given
5. Storage of Medication					
0.00					
6. Other Directions, if Any					
Signature of Parent				[1	Date
·					
TO BE COMPLETED BY					T
DATE	TIME	AMOUNT GIV	VEN	CAREGIVER'S NAME	CAREGIVER'S SIGNATURE
				0	
It is	s recommended this for	rm be reviewed with th	ie parent every	3 months if the medication is	ongoing.
		LARA is an equal opp	oortunity emplo	yer/program.	
			٠.	- · · -	

TO BE COMPLETED BY THE CAREGIVER GIVING MEDICATION:

DATE	TIME	AMOUNT GIVEN	CAREGIVER'S NAME	CAREGIVER'S SIGNATURE



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 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:	VI I II II 2
Date Signed:	



<u>Authorization for the Application of Sunscreen</u>

	_ do hereby authorize Avondale Busy Bee staff to the sunscreen listed below
for the dutes listed below.	2025/2026
(Name of sunscreen p	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.hart@avondaleschools.org**

If you have any questions, please contact
Aleesha Hart
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