



**"EDUCATING OUR FUTURE LEADERS"**

**Creative Academics Learning Center**

**13144 W 7 Mile Rd. Detroit, MI 48235**

**Office: (313)855-6262 Fax: (313)855-6260**

**CHILD CARE APPLICATION FOR ENROLLMENT**

**Parents, to protect and promote the health and safety of your child, please provide a complete response to every item on this form. The Michigan Department of Health, Child Care Licensure, requires this information. If any item is not applicable, please answer "N/A"**

**Student Information:**

Child's Name: \_\_\_\_\_

Primary Parent/Guardian Name: \_\_\_\_\_

Phone #: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ Email: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

DOB: \_\_\_/\_\_\_/\_\_\_ Sex: \_\_\_\_\_ Race: \_\_\_\_\_

Date of Application: \_\_\_\_\_

Primary Hours of Care Needed: \_\_\_\_\_ AM/PM to \_\_\_\_\_ AM/PM

Days of Week Care Needed (circle one): **Mon** **Tues** **Wed** **Thurs** **Fri** **ALL**

Does your child have any siblings or other household members also attending? **Yes** **No**

If "yes," please list their names: \_\_\_\_\_

Do you receive DHS Child Development and Care program assistance? **Yes** **No**

If "yes," what is your DHS CDC case number? \_\_\_\_\_

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5 Revised 3/2025



**Creative Academics Learning Center**

**Email: [creativeacademicslc2@gmail.com](mailto:creativeacademicslc2@gmail.com)**

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**Family Information:**

**Mother's Name:** \_\_\_\_\_

Address (if different from child): \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Cell Phone: (\_\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ Email: \_\_\_\_\_

Employer: \_\_\_\_\_ Position: \_\_\_\_\_

Work Phone: (\_\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

**Father's Name:** \_\_\_\_\_

Address (if different from child): \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Cell Phone: (\_\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ Email: \_\_\_\_\_

Employer: \_\_\_\_\_ Position: \_\_\_\_\_

Work Phone: (\_\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

**Guardian's Name:** \_\_\_\_\_

Address (if different from child): \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

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Cell Phone: ( ) - Email: \_\_\_\_\_

Employer: \_\_\_\_\_ Position: \_\_\_\_\_

Work Phone: ( ) - \_\_\_\_\_

Who has legal custody of the child? : **Mother Father Both Guardian Other :** \_\_\_\_\_

**Medical Information:**

**I hereby grant permission for the staff of this facility to contact the following medical personnel to obtain emergency medical care if warranted.**

Doctor: \_\_\_\_\_ Address: \_\_\_\_\_ Phone \_\_\_\_\_

Doctor: \_\_\_\_\_ Address: \_\_\_\_\_ Phone \_\_\_\_\_

**Does your child have any special dietary needs, physical needs, or any food allergies?** Yes No  
If yes, please list: \_\_\_\_\_

**Does your child have any developmental delays or physical disabilities?** Yes No  
If yes, please list: \_\_\_\_\_

**Does your child have any chronic illnesses or diseases that may affect their attendance?** Yes No  
If yes, please list: \_\_\_\_\_

**\*\*If "yes," please list all allergies (including animal allergies if applicable), \*\*special medical or dietary needs, or other areas of concern that we need to know to best care for your child:**

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

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**\*\*Please request and complete a Special Diet Statement Form along with your CACFP Food Program forms if your child has special dietary needs. This form must be signed by a physician to be accepted. Please complete a Medication Authorization/Release Form if your child will need medicine administered to them during class. This form must be signed by a physician to be accepted. Please provide an Epi-Pen if your child has severe allergies. If your child has diabetes or asthma, a Diabetic Management Plan/Asthma Management Plan must be complete and on file for the child to be in our care. This plan must be reviewed by your child's physician.**

**Emergency Contacts:**

The following names you provide will also be contacted if the parent or legal guardian cannot be reached – and are authorized to remove the child from the facility in case of illness, accident, or emergency. **You are required to list at least two emergency contacts.**

Name: \_\_\_\_\_ Relationship to child: \_\_\_\_\_

Primary Phone: \_\_\_\_\_ Secondary Phone: \_\_\_\_\_

Name: \_\_\_\_\_ Relationship to child: \_\_\_\_\_

Primary Phone: \_\_\_\_\_ Secondary Phone: \_\_\_\_\_

Name: \_\_\_\_\_ Relationship to child: \_\_\_\_\_

Primary Phone: \_\_\_\_\_ Secondary Phone: \_\_\_\_\_

**Admission Policy \* Please initial each statement\***

I understand that my child will participate in the educational program and class for which he/she is eligible based on age and educational progress. Class assignments are determined by my child's teachers and the center Director or Owner. \_\_\_\_\_

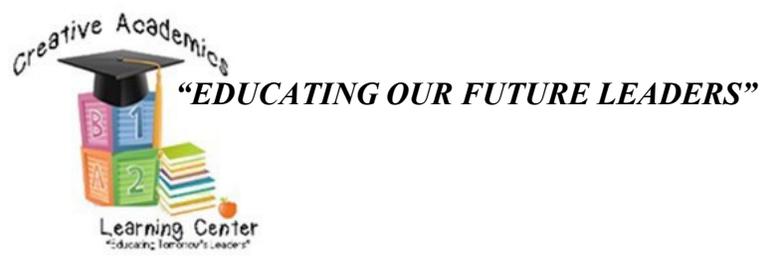
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If paying weekly tuition by cash, I agree to pay a registration fee of \$65.00 at the time of enrollment, understanding that the registration fee is non-refundable. As the parent or legal guardian, I agree to pay a weekly tuition fee applicable to my child's class on the first day of each enrolled week (**please be mindful that there are no credits for personal absences**). If tuition is not paid by Friday of each week, I understand a \$20 late fee will be added to my tuition total, and the full balance must be paid before my child may return the following week. \_\_\_\_\_

If paying weekly tuition by DHS's Child Development and Care Program subsidy payments, I agree that it is my responsibility to ensure the active status of my CDC case to ensure the payment of tuition. I understand that tuition is not considered paid/covered until Creative Academics Learning Center has received confirmation of acceptance in their billing system from DHS, and that if my CDC case has not yet been activated, is interrupted or canceled for any reason, I will be responsible for paying weekly tuition in cash until my CDC case's active status is restored. \_\_\_\_\_

Creative Academics Learning Center requires a two-week withdrawal notice. Withdrawal of my child without notice is not subject to prepaid tuition refunds, and I will be responsible for the tuition payment to cover the tuition period up to two weeks if the notice is not received. \_\_\_\_\_

**The following must be completed/provided, in addition to this application, before admission can be accepted and care may begin, NO EXCEPTIONS:**

- \_\_\_ Child Information Card (Per the State of MI nothing can be left blank; must write "none" in blanks)
- \_\_\_ Up to date Immunization Record with immunizations current
- \_\_\_ Current Health Appraisal completed and signed by a physician within 6 months of application
- \_\_\_ CACFP Food Program Participation and Income Eligibility Forms complete and signed
- \_\_\_ Acceptable form of tuition payment (DHS subsidy, cash, money order, or credit/debit card)
- \_\_\_ Registration Fee (if applicable)

**Discipline Policy**

1. Our staff will utilize age-appropriate positive methods of discipline to encourage self-control, self-direction, and self-esteem. When a conflict occurs among children, or with a child, there are several alternatives our staff will use to handle the situation:





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- Separate the child from the source
- Divert the child’s attention to a different activity
- Speak authoritatively to the child and explain what was done wrong and why the child is being taken away from the situation
- Suggest alternatives to avoid further conflict in the future

2. Our staff shall be prohibited from using the following means of punishment:

- Hitting, shaking, biting, pinching, or inflicting any form of corporal punishment
- Restricting a child’s movement by binding or tying him/her
- Deprive a child of meals, snacks, rest, or necessary toilet use
- Restricting a child in an enclosed area (closet, locker room, box, or similar cubicle)

3. Our staff will try the above methods to eliminate, minimize, and/or deter negative behaviors. When the staff has exhausted all attempts to stop negative behavior, the child’s parents or emergency person will be contacted to immediately pick-up the child. **Children who continually exhibit negative behavior may be permanently expelled from the center.**

Parent’s Signature \_\_\_\_\_ Date \_\_\_\_\_

**Sick/ Illness Policy**

Due to COVID-19, effective June 2020, we are required to follow strict policies and guidelines set forth by the State of Michigan and the Department of Health and Human Service to ensure the cleanliness and sanitization of our facility, and to protect the health and safety of all staff and students. In summary, our policy requires that we adhere to the following with NO EXCEPTIONS:

**Your child will not be able to attend class if the answer is “Yes” to any of the following:**

- Your child is exhibiting signs/symptoms of an upper respiratory infection (fever, cough, shortness of breath, body aches, sore throat)
- Your child has had symptoms of respiratory illness within the last 10 days
- Your child has traveled to locations with substantial community transmission or locations where crowds are restricted to a common location (cruise ship, airplane)
- Your child has traveled to a COVID-19 infected area within the last 10 days
- Your child has been in contact with a person who has tested positive for COVID-19 within the last 10 days
- Your child does not feel well enough to participate comfortably in the program activities
- Staff cannot adequately care for your child without compromising the care or health of others



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- Your child has any of the following symptoms:
  - Fever over 100 degrees F
  - Diarrhea
  - Vomiting
  - Runny nose with yellow or green mucus
  - Consistent coughing or sneezing
  - Rash or mouth sores
  - Severe itching of the scalp or visible rash, lice, or lice eggs on scalp
  - Signs or symptoms of possible severe illness (inconsolable crying, extreme irritability, lethargy, difficulty breathing or eating)
- Your child has any communicably contagious diagnosis from a physician including but not limited to:
  - Conjunctivitis (pink eye)
  - Strep throat
  - Chicken pox
  - Upper respiratory infection
  - Hand Foot and Mouth disease

Please understand that children who attend public school or childcare facilities are more prone to communicable diseases, and although most are not life threatening, it is imperative that you identify these symptoms early and **KEEP YOUR CHILD HOME** to prevent the spread of the disease to other students and staff. **If your child arrives to class with any of the above-mentioned symptoms, you will be required to pick them up immediately. If your child is not picked up within 2 hours of a send home request, you will be reported to Child Protective Services and the Detroit Police Department for child abandonment.**

**Any child sent home with a suspected illness or injury or absent without prior notice or excuse 2 or more days will not be permitted to return to class without a signed notice of good health (doctor’s note) from a licensed physician or health care facility.**

**Failure to provide a valid physician’s notice or any attempt to turn in a fraudulent physician’s notice will result in your child being terminated from our program immediately and we will file a report against you with the Department of Health and Human Services and MDCPS.**

**\*\*I, (print name) \_\_\_\_\_ understand the Sick/Illness policy as listed and agree to its terms.**

**Parent’s Signature: \_\_\_\_\_ Date: \_\_\_\_\_**



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## **Dress Code Policy**

Effective September 7, 2021 all students attending Creative Academics Learning Center full time during the regularly scheduled school year will be required to wear full uniforms, with the exception of students enrolled in our Infant or After School Latchkey classes. Acceptable uniform dress and colors are as follows:

**Polo Shirts:** Navy Blue, Light Blue or Yellow

**Sweaters:** Navy Blue or Black

**Pants/Shorts/Skirts:** Khaki, Navy Blue, or Black

**Shoes:** All students must have a pair of house shoes, slides, or crocs to wear in class only; it is suggested to leave this pair in their classroom cubby

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## **Classroom Supplies**

### **Infants**

- Diapers and wipes to be labeled and left in the classroom.
- 2 Extra complete changes of seasonally appropriate clothes to be left in classroom cubby.
- 1 or 2 Bottles/Sippy Cups to be labeled and left in classroom.
- Pacifier with a leash or attachable clip (if used)
- If you choose to provide breast milk, it must be in a sealed, labeled container

### **Twaddler/Toddlers/Pre-K**

- 1 Extra complete change of seasonally appropriate clothes to be left in classroom cubby.
- Pull-Ups and wipes to be labeled and left in the classroom.
- 1 child-sized blanket for nap time to be labeled and left in their cubby
- 1 pair of footies, crocs, or slippers to be labeled and left in their cubby (**outside shoes are not allowed to be worn inside the classroom for health and safety purposes. Students will change into their slippers when they arrive to class.**)



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**Tuition and Fees:**

\*Acceptable forms of payments are cash, DHS CDC subsidy, Visa, /Master Card debit/credit card payable thru the BrightWheel app. **(NO PERSONAL CHECKS)**

- Registration fee \$65 per child (\*no registration fee will be assessed if you pay for childcare services with DHS)
- Infants (6 weeks – 18 mths) \$220.00 /weekly
- Twaddlers (19 mths- 35 mths) \$200.00/weekly
- Toddlers (3yrs- 4yrs) \$180.00/weekly
- GSRP Pre-K (4yrs- 5yrs) FREE Monday-Friday 8:30am-4:30pm**
- GSRP Before/Afterschool Latchkey \$60.00/weekly
- Latchkey (School Aged;5yrs-12yrs) \$140.00/weekly
- Late Fee \$1 per minute; **\*To be paid via debit/credit on BrightWheel before or at time of pickup\***

**CHILD DEVELOPMENT AND CARE (CDC) SUBSIDY RECIPIENTS**

If you intend to use Child Development and Care benefits to cover your child’s weekly tuition, you are **REQUIRED** to provide a copy of your Child Development and Care Provider Notice.

The CDC Provider Notice is mailed to its applicants once they have been approved for program benefits. This notice will confirm the names of the children approved for benefits, the benefits’ start and end dates, and the number of hours your child is covered for benefit payments bi-weekly. This notice may also be found online on your MiBridges account. Please contact your Case Worker for more information on how to obtain this document.

**Please be advised that your child’s tuition will not be covered until this document is received.** It is your responsibility as an applicant to request CDC case status updates from your DHHS Case Worker. **If you would like your child to start prior to receiving your CDC Provider Notice, you will be responsible for paying the full cost of weekly tuition and the \$65 registration fee out of pocket up front before care services will begin.** If your Provider Notice is received after making tuition payments out of pocket, we will refund all tuition payments from the date that CDC program benefits began.



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### **PLEASE NOTE THE FOLLOWING:**

- ✓ No child can be left at Creative Academics Learning Center for more than **hours per 12 day** per State of Michigan Childcare regulations. Also, if we request that a child be sent home due to injury, illness, or unacceptable or uncontrollable behavior that interferes with care, **parents/guardians are allotted a maximum of 2 hours to have your child picked up from the center. If your child is left in our care over 12 hours in a school day, or over 2 hours after a send home request and you have not contacted us or made prior arrangements with the center, we WILL contact Child Protective Services and the Detroit Police Department to report your child as abandoned.**
- ✓ Full-time childcare service is assessed at 40 hours a week at a maximum of 10 hours per day. Prior approved additional hours will be assessed at a rate of \$5.00 per hour
- ✓ We do not have part-time enrollment. Your child must attend full-time at a minimum of 40 hours a week. Failure to meet full-time attendance requirements may cause your child to be removed from the program.
- ✓ Tuition rates will be adjusted to consider holidays and planned school closings or extended absences at the discretion of Management.
- ✓ Daily Rates: We currently only accept full time enrollment and DO NOT accept daily drop ins.
- ✓ Weekly Rates: Payment due the Monday of the week of service. **There is a \$10 late fee for all tuition not received by Friday.** Unless you have discussed your situation with the Director or Owner, your child cannot return until the tuition has been paid to current status. Failure to keep your child’s account current may cause your child to be removed from our program. **Also, please note any outstanding balance owed and not paid within 30 days will be turned over to a collection agency.**
- ✓ **Late Pick-Up Fee: If a child is picked up later than scheduled, a late fee of \$1 per minute will be assessed and must be paid at the time of pick up or the following morning at drop off.** Failure to pay late fees will result in your child being ineligible for check in and may cause them to be removed from the program.
- ✓ **All students must be signed in and out daily with accurate times reported accordingly.** We currently use the BrightWheel childcare app for signing students in/out in addition to a physical sign in sheet. The BrightWheel app can be downloaded on any android or iPhone, and families will receive an invite link upon completion of enrollment. Failure to accurately sign your child in/out daily may cause them to be removed from the program.
- ✓ **All parents/guardians of students are required to download and use the BrightWheel app DAILY.** This app is used to record students’ daily attendance, activities and routines in class, and as a means of communication between teachers and staff and the families of our students. We will send important information



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and deadlines regarding students via this app in lieu of physical mailings and flyers. Failure to download and utilize the app may cause your child to be removed from the program.

✓ **If we suspect that your child has been a victim of child abuse or neglect, we are REQUIRED by law to submit a report to MI Child Protective Services and DHS.**

Parent’s Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**Parent Handbook**

Our Parent Handbook will be emailed to you at the time of enrollment (if an email address is provided), and written copies are available upon request. The handbook includes the above-mentioned information as well as the following:

- Criteria for admission and withdrawal
- Schedule of operation, denoting hours, days, and holidays during which the center is open and services are provided
- Fee Policy
- Discipline Policy
- Food Service Program
- Program philosophy
- Typical daily routine
- Parent notification plan for accidents, injuries, and illnesses
- Exclusion policy

I, \_\_\_\_\_ (print full name) *certify that I have received, reviewed, and understand all of the above-mentioned items*

Parent’s Signature: \_\_\_\_\_ Date: \_\_\_\_\_



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**Authorization to Utilize Center’s Equipment**

I give permission for my child, (print name) \_\_\_\_\_, to use the center’s small and large muscle developing equipment. This includes utilizing all of the play equipment on the outside playground. I understand that Creative Academics Learning Center cannot be held liable in case of any accidents that may occur due to excessive play activities. The center will provide enough care providers to maintain the state ratio requirements at all times.

Parent’s Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**Parent Checklist:**

\*Please ensure you have turned in the following documents for enrollment approval:

**ALL APPLICATIONS:**

- Child Emergency Information Card/Form
- Complete Enrollment Packet
- Copy of Parent/Guardian Driver’s License/ State ID
- Copy of Social Security Card (if non-DHS/EHS/GSRP)
- Current Immunization Record for child
- Current complete Health Appraisal signed by physician.
- CACFP Food Program forms
- D.H.S. Provider Verification Request (if paying tuition with DHS CDC subsidy)
- DHS CDC Provider Notice (If paying with DHS; Must list Creative Academics as approved provider)
- \$65 Registration fee (to be paid via BrightWheel or cash/money order if paying out of pocket)
- 1st Week’s Tuition (to be paid via BrightWheel)

**GSRP Pre-K APPLICATIONS**

- Proof of Income (most recent check stubs, W2, or any other proof of income)
- Verification of Child’s Birth (birth certificate or Verification of Birth)
- Complete GSRP Intake Application (must be complete with Program Director via phone or in person)



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**Acknowledgments**

I have been given and read a copy of the Creative Academics Learning Center Parent Handbook as well as conducted an on-site visit of the facility (Parent Handbook will be sent to you via BrightWheel, hard copy available upon request only)

**Yes \_\_\_\_\_ No \_\_\_\_\_** If “no,” please provide a valid email address: \_\_\_\_\_

**\*I have provided my Social Security number along with a copy for my child’s file. I understand that I must keep my account current, and in the event my account goes into default, Creative Academic Learning Center may do what is necessary to collect my balance, which includes, but is not limited to court summons and garnishment. (ONLY COMPLETE IF PAYING CASH/CREDIT FOR TUITION)**

**SSN: \_\_\_\_\_ Signature: \_\_\_\_\_ Date: \_\_\_\_\_**

My Child may be photographed at Creative Academics Learning Center and/or any sponsored event given by the center

**Yes \_\_\_\_\_ No \_\_\_\_\_**

My Child may take approved field trips sponsored by Creative Academics Learning Center **Yes \_\_\_\_\_ No \_\_\_\_\_**

My Child is allowed to be exposed to small animals and creatures safe for petting or observing for the purpose of educating.

**Yes \_\_\_\_\_ No \_\_\_\_\_**

Creative Academics Learning Center may give my child emergency medical treatment if needed.

**Yes \_\_\_\_\_ No \_\_\_\_\_**

I give permission for my child to be placed in the Infant class at 6 weeks-24 months, Twaddler class at 24-36 months, Toddler class at 30-48 months, Pre-K class at 48-60 months, and Latchkey class at 60 months and older, and understand that my child’s class placement will be solely determined by their teachers, the Director, or the Owner of Creative Academics Learning Center.

**Yes \_\_\_\_\_ No \_\_\_\_\_**

***\*\*I have submitted the above items and have read, understood, and agreed to Creative Academics Learning Center policies and procedures as listed above and in the Parent Handbook***

Parent’s Name (please print): \_\_\_\_\_

Parent’s Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Director’s Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Date of Application: \_\_\_\_\_ Start Date: \_\_\_\_\_





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## **CREATIVE ACADEMICS LEARNING CENTER NOTICE OF PRIVACY PRACTICES**

**THIS NOTICE DESCRIBES HOW MENTAL, BEHAVIORAL, AND OTHER HEALTH CARE INFORMATION ABOUT YOU AND YOUR CHILD MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.**

**Parents or guardians are automatically authorized to discuss the health information of their minor children.**

This notice describes how we may use and disclose your protected health information to carry out treatment, payment, or health care operations and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information in some cases. Your "protected health information" means any of your written and oral health information, including demographic data that can be used to identify you. This is health information that is created or received by your health care provider, and that relates to your past, present or future physical or mental health condition.

- I. Uses and Disclosures of Protected Health information** - CALC may use your protected health information for purposes of providing treatment, obtaining payment for treatment, and conducting health care operations. Your protected health information may be used or disclosed only for these purposes unless CALC has obtained your authorization, or the use or disclosure is otherwise permitted by law without your authorization. Disclosures of your protected health information for the purposes described in this notice may be made in writing, orally, electronically, or by facsimile.
- A. Treatment.** We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. For example, we may disclose your protected health information to a case manager who is responsible for coordinating your care. We may also disclose your health information among our clinicians, counselors, social workers and other staff who work for CALC. In some cases, we may also disclose your protected health information to an outside treatment provider for purposes of the treatment activities of the other provider.
- B. Payment.** Your protected health information will be used, as needed, to obtain payment for the services that you were provided. We may disclose protected health information to your insurance company to determine whether you are eligible for benefits, reviewing your services to determine if they are medically necessary; reviewing your services for purposes of ensuring appropriateness of care or to justify the charges for your care.
- C. Operations.** We may need to use and disclose your protected health information for our business operations, as necessary to run our organization and make sure that our consumers are provided quality care. Health care operations include such activities as:
- Quality assessment and improvement activities.
  - Employee review activities.
  - Training programs include those in which interns in social work learn under supervision.
  - Accreditations, certification, licensing or credentialing activities.
  - Review and auditing, including compliance reviews, medical reviews, legal services and maintaining compliance programs.
  - Business management and general administrative activities.

In certain situations, we may also disclose customer information to another provider for their health care operations.



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**D. Other Uses and Disclosures.** As part of treatment, payment and healthcare operations, we may also use or disclose your protected health information for the following purposes:

- To remind you of an appointment.
- To inform you of potential treatment alternatives or options.
- To inform you of health-related benefits or services that may be of interest to you.
- To contact you to raise funds for CALC or an institutional foundation related to CALC. If you do not wish to be contacted regarding fundraising, please contact our Privacy Officer.

Uses and Disclosures Beyond Treatment, Payment, and Health Care Operations Permitted Without Authorization of Opportunity to Object - We will release information when we are required to do so by law. Examples of such releases would be for law enforcement or national security purposes, subpoenas or other court orders, communicable disease reporting, disaster relief, review of our activities by government agencies, to avert serious threat to health or safety or in other kinds of emergencies.

You may object to these disclosures. If you do not object to these disclosures or we can offer from the circumstances that you do not object or we determine, in the exercise of our professional judgment, that it is in your best interests for us to make disclosure of information that is directly relevant to the person's involvement with your care, we may disclose your protected health information as described.

III. Uses and Disclosures Which You Authorize - If you give us permission in writing, we may use your personal information. If you give us your permission, you have the right to revoke it. This must be in writing, too. We cannot take back any uses or disclosures already made with your mission.

Other than as stated above, we will not disclose your health information other than with your written authorization. You may revoke your authorization in writing at any time except to the extent that we have taken action in reliance upon the authorization.

IV. Your Rights - You have the following rights regarding your health information:

The right to inspect and copy your protected health information. In most cases, you have the right to inspect and obtain a copy of your medical information, you must submit a written request to the Privacy Officer whose contact information is listed on the last pages of this Notice. If you request a copy of your information, we may charge you a fee for the cost of copying, mailing or other costs incurred by us in complying with your request.

B. The right to request a restriction on uses and disclosures of your protected health information - You may ask us not to use or disclose certain parts of your protected health information for the purposes of treatment, payment or health care operations. Your request must state the specific restriction requested and to whom you want the restriction to apply.

CALC is not required to agree to a restriction that you may request. We will notify you if we deny your request to a restriction.



**Creative Academics Learning Center**

**“EDUCATING OUR FUTURE LEADERS”**

**Email: [creativeacademicslc2@gmail.com](mailto:creativeacademicslc2@gmail.com)**

**Revised 3/2025**

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**"EDUCATING OUR FUTURE LEADERS"**

**Creative Academics Learning Center**

13144 W 7 Mile Rd. Detroit, MI 48235

Office: (313)855-6262 Fax: (313)855-6260

**AKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES**

**Notice to Parent/Guardian;**

We are required to provide you with a copy of our Notice of Privacy Practices, which states how we may use and/or disclose your child's health information. Please sign this form to acknowledge receipt of the Notice. You may refuse to sign this acknowledgement, if you wish.

**I acknowledge that I have received a copy of this office's Notice of Privacy Practices.**

\_\_\_\_\_  
Please print your child's name here

\_\_\_\_\_  
Please print your name here

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

**FOR OFFICE USE ONLY**

We have made every effort to obtain written acknowledgment of receipt of our Notice of Privacy from this parent/guardian, but it could not be obtained because:

- The parent/guardian refused to sign.
- Due to an emergency, it was not possible to obtain an acknowledgement.
- We couldn't communicate with the parent/guardian.
- Other (Please provide specific details):

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

\_\_\_\_\_  
*Employee signature*

\_\_\_\_\_  
*Date*



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**HIPAA Acknowledgement of Receipt of the Notice of Privacy Practices 2014**  
*This form does not constitute legal advice and covers only federal, not state, law.*