

A BRIGHT START CHILD CARE LEARNING CENTER APPLICATION FOR ENROLLMENT

Date Application Completed: _____ Date of Child's Enrollment: _____

CHILD INFORMATION

Date of Birth: _____
Name: (First) _____ (Middle) _____ (Last) _____ (Nickname) _____
Address: _____ (City) _____ (Zip Code) _____
Child lives with: Mother Father Grandparents Other If "Other", Explain Relationship: _____

PARENT/ GUARDIAN INFORMATION

Mother/Guardian Name: _____
Address: _____
Home Phone: _____
Cell Phone: _____
Employer: _____
Work Phone: _____
E-Mail Address: _____

Father/Guardian Name: _____
Address: _____
Home Phone: _____
Cell Phone: _____
Employer: _____
Work Phone: _____
E-Mail Address: _____

CHILD RELEASE CONTACTS

My child can be released to the following individuals and in the event of an emergency and the parent/guardian cannot be reached. A Bright Start Child Care Learning Center can contact the following individuals, as authorized by the person who signs this application.

NAME (First & Last)	RELATIONSHIP (To Child)	ADDRESS	PHONE NUMBER
1.			
2.			
3.			
4.			

HEALTH CARE NEEDS

For any child with health care needs such as allergies, asthma, or other chronic conditions that require specialized health services, a medical action plan shall be attached to the application. The medical action plan must be completed by the child's health care professional.

My child has: Asthma Allergies Diabetes Food Allergies Seizures Other: _____

MY CHILD NEEDS A MEDICAL ACTION PLAN COMPLETED BY HIS/HER PHYSICIAN TO BEGIN CHILD CARE: Yes No

List any health care needs/concerns: _____

List any fears or unique behavior characteristics your child may have: _____

List any types of medication taken for health care needs: _____

Share any other information that has a direct bearing on assuring safe medical treatment for your child: _____

EMERGENCY MEDICAL CARE INFORMATION

Name of child's Health Care Professional (Doctor): _____ Phone Number: _____

Hospital Preferred for Emergency Treatment: _____ Phone Number: _____

FIRE DRILL AND FIELD TRIP ACTIVITIES OUTSIDE THE FENCED PLAYGROUND AREA

I give permission to A Bright Start Child Care Learning Center for my child to participate in a walking trip or fire drill. I further give my permission to the facility for my child to participate in developmentally appropriate supervised activities outside of the fenced playground area.

Parent/Guardian Signature: _____ Date: _____

I, as the parent/guardian, authorize A Bright Start Child Care Learning Center to obtain medical attention for my child in an emergency.

Parent/Guardian Signature: _____ Date: _____

I, as the operator, do agree to provide transportation to an appropriate medical resource in the event of emergency. In an emergency, other children in the facility will be supervised by a responsible adult. I will not administer any drug or medication without specific instructions from the physician or the child's parent/guardian.

Signature of Administrator: _____ Date: _____

ADDITIONAL CONTACT RELEASE AUTHORIZATION

Please sign here acknowledging that all names listed below are provided and approved by you, the child's parent/guardian, to be contacted or released in an event we can not contact you or an emergency:

Parent/Guardian Signature: _____ Date: _____

[illegible]

Discipline and Behavior Management Policy

Name of Facility: _____ Date Adopted _____

No child shall be subjected to any form of corporate punishment. Praise and positive reinforcement are effective methods of behavior management of children. When children receive positive, non-violent, and understanding interactions from adults and others, they develop good self-concepts, problem solving abilities, and self-discipline. Based on this belief of how children learn and develop values, this facility will practice the following age and developmentally appropriate discipline and behavior management policy:

We:

1. DO praise, reward, and encourage the children.
2. DO reason with and set limits for the children.
3. DO model appropriate behavior for the children.
4. DO modify the classroom environment to attempt to prevent problems before they occur.
5. DO listen to the children.
6. DO provide alternatives for inappropriate behavior to the children.
7. DO provide the children with natural and logical consequences of their behaviors.
8. DO treat the children as people and respect their needs, desires, and feelings.
9. DO ignore minor misbehaviors.
10. DO explain things to children on their levels.
11. DO stay consistent in our behavior management program.
12. DO use effective guidance and behavior management techniques that focus on a child's development.
13. DO use short supervised periods of time-out sparingly.

We:

1. DO NOT handle children roughly in any way, including shaking, pushing, shoving, pinching, slapping, biting, kicking, or spanking.
2. DO NOT place children in a locked room, closet, or box or leave children alone in a room separated from staff.
3. DO NOT delegate discipline to another child.
4. DO NOT withhold food as punishment or give food as a means of reward.
5. DO NOT discipline for toileting accidents.
6. DO NOT discipline for not sleeping during rest period.
7. DO NOT discipline children by assigning chores that require contact with or use of hazardous materials, such as cleaning bathrooms, floors, or emptying diaper pails.
8. DO NOT withhold or require physical activity, such as running laps and doing push-ups, as punishment.
9. DO NOT yell at, shame, humiliate, frighten, threaten, or bully children.
10. DO NOT restrain children as a form of discipline unless the child's safety or the safety of others is at risk.

The program's goals for helping children develop self-control and learn acceptable forms of social behavior are:

Children are helped to resolve conflict and develop problem solving skills with peers by:

I ensure myself and the additional caregivers follow the programs discipline and behavior management policies and practices and use behavior management strategies appropriately by:

Local resources that can assist with services and support when persistent challenging behaviors continue to occur are:

Operator:

I, the undersigned facility director/operator (or other designated staff member) of _____ Do hereby state that
(facility name)
I have given and discussed the facility's Discipline and Behavior Management Policy with the child's parent or guardian.

Signature of Director, Operator, (or other designated staff member)

Date

Parent or Guardian:

I, the undersigned parent or guardian of _____ (child's full name), do hereby state that I have read and received a copy of the facility's Discipline and Behavior Management Policy and that the facility's director/operator (or other designated staff member) has discussed the facility's Discipline and Behavior Management Policy with me.

Date of Child's Enrollment: _____

Signature of Parent or Guardian

Date

Distribution: one copy to parent(s) and a signed copy in child's facility record

Child Immunization History

G.S. 130A-155. Submission of certificate to child care facility/G.S.130A-154. Certificate of immunization.

The parent/guardian must submit a certificate of immunization on child's first day of attendance or within 30 calendar days from the first day of attendance.

Child's full name:	Date of birth:
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Enter the date of each dose received (Month/Day/Year) or attach a copy of the immunization record.

Vaccine Type	Abbreviation	Trade Name	Combination Vaccines	1 date	2 date	3 date	4 date	5 date
Diphtheria, Tetanus, Pertussis	DTaP, DT, DTP	Infanrix, Daptacel	Pediarix, Pentacel, Kinrix					
Polio	IPV	IPOL	Pediarix, Pentacel, Kinrix					
Haemophilus influenza type B	Hib (PRP-T) Hib (PRP-OMP)	ActHIB, PedvaxHIB **, Hiberix	Pentacel					
Hepatitis B	HepB, HBV	Engerix-B, Recombivax HB	Pediarix					
Measles, Mumps, Rubella	MMR	MMR II	ProQuad					
Varicella/Chicken Pox	Var	Varivax	ProQuad					
Pneumococcal Conjugate*	PCV, PCV13, PPSV23***	Pneumovax 13, Pneumovax***						

*Required by state law for children born on or after 7/1/2015.
 **3 shots of PedvaxHIB are equivalent to 4 Hib doses. 4 doses are required if a child receives more than one brand of Hib shots.
 ***PPSV23 or Pneumovax is a different vaccine than Pnevmar 13 and may be seen in high risk children over age 2. These children would also have received Pnevmar 13.
Note: Children beyond their 5th birthday are not required to receive Hib or PCV vaccines.
Gray shaded boxes above indicate that the child should not have received any more doses of that vaccine.

Record updated by:	Date	Record updated by:	Date

Minimum State Vaccine Requirements for Child Care Entry

By This Age:	Children Need These Shots:						
3 months	1 DTaP	1 Polio		1 Hib	1 Hep B	1 PCV	
5 months	2 DTaP	2 Polio		2 Hib	2 Hep B	2 PCV	
7 months	3 DTaP	2 Polio		2-3 Hib**	2 Hep B	3 PCV	
12-16 months	3 DTaP	2 Polio	1 MMR	3-4 Hib**	3 Hep B	4 PCV	1 Var
19 months	4 DTaP	3 Polio	1 MMR	3-4 Hib**	3 Hep B	4 PCV	1 Var
4 years or older (in child care only)	4 DTaP	3 Polio	1 MMR	3-4 Hib**	3 Hep B	4 PCV	1 Var
4 years and older (in kindergarten)	5 DTaP	4 Polio	2 MMR	3-4 Hib**	3 Hep B	4 PCV	2 Var

Note: For children behind on immunizations, a catch-up schedule must meet minimal interval requirements for vaccines within a series. Consult with child's health care provider for questions.

Updated August 2019



Child Immunization History

G.S. 130A-155. Submission of certificate to child care facility/G.S.130A-154. Certificate of immunization.

Vaccines Recommended (not required) by the Advisory Committee on Immunization Practices (ACIP)

Vaccine Type	Abbreviation	Trade Name	Recommended Schedule	1 date	2 date	3 date	4 date	5 date
Rotavirus	RV1, RV5	Rotateq, Rotarix	Age 2 months, 4 months, 6 months.					
Hepatitis A	Hep A	Havrix, Vaqta	First dose, age 12-23 months. Second dose, within 6-18 months.					
Influenza	Flu, IIV, LAIV	Fluzone, Fluarix, FluLaval, Flucelvax, FluMist, Afluria	Annually after age 6 months.					

Updated August 2019



Children's Medical Report

Name of Child _____ Birthdate _____

Name of Parent or Guardian _____

Address of Parent or Guardian _____

A. Medical History (May be completed by parent)

1. Is child allergic to anything? No ☐ Yes ☐ If yes, what? _____

2. Is child currently under a doctor's care? No ☐ Yes ☐ If yes, for what reason? _____

3. Is the child on any continuous medication? No ☐ Yes ☐ If yes, what? _____

4. Any previous hospitalizations or operations? No ☐ Yes ☐ If yes, when and for what? _____

5. Any history of significant previous diseases or recurrent illness? No ☐ Yes ☐ ; diabetes No ☐ Yes ☐ ;
convulsions No ☐ Yes ☐ ; heart trouble No ☐ Yes ☐ ; asthma No ☐ Yes ☐ .
If others, what/when? _____

6. Does the child have any physical disabilities? No ☐ Yes ☐ If yes, please describe: _____

Any mental disabilities? No ☐ Yes ☐ If yes, please describe: _____

Signature of Parent or Guardian _____ Date _____

B. Physical Examination: This examination must be completed and signed by a licensed physician, his authorized agent currently approved by the N. C. Board of Medical Examiners (or a comparable board from bordering states), a certified nurse practitioner, or a public health nurse meeting DHHS standards for EPSDT program.

Height _____ % Weight _____ %

Head _____ Eyes _____ Ears _____ Nose _____ Teeth _____ Throat _____

Neck _____ Heart _____ Chest _____ Abd/GU _____ Ext _____

Neurological System _____ Skin _____ Vision _____ Hearing _____

Results of Tuberculin Test, if given: Type _____ date _____ Normal ☐ Abnormal ☐ followup _____

Developmental Evaluation: delayed _____ age appropriate _____

If delay, note significance and special care needed: _____

Should activities be limited? No ☐ Yes ☐ If yes, explain: _____

Any other recommendations: _____

Date of Examination _____

Signature of authorized examiner/title _____ Phone # _____

Acknowledgements

Documentation of Receipt: Summary of Child Care Law

By signing below, you are acknowledging you have received A Bright Start Child Care Learning Center Operational Policies

Signature: _____ Date: _____

Documentation or Receipt: Center Operational Policies

By signing below, you are acknowledging you have received the Summary of North Carolina Child Care Law for Child Care Centers

Signature: _____ Date: _____

Documentation or Receipt: Prevention of Shaken Baby Syndrome and Abusive Head Trauma Policies

I, the parent/guardian of _____, acknowledges that I have read and received a copy of the facility's Shaken Baby Syndrome/Abusive Head Trauma Policy.

Date policy given/explained to parent or guardian: _____

Date of child's enrollment: _____

Print name of parent/guardian: _____

Signature of Parent/ guardian: _____

Date: _____

Permission to Photograph

I give permission for A Bright Start Child Care Learning Center to photograph my child for the following purposes:

Type of Use	Grant Permission	Decline Permission
Display in my child's portfolio	<input type="checkbox"/>	<input type="checkbox"/>
Give photographs possibly containing your child to current clients (ex: Classroom photo)	<input type="checkbox"/>	<input type="checkbox"/>
Display in facility's bulletin boards, shown to current and prospective clients	<input type="checkbox"/>	<input type="checkbox"/>

I understand that it is my responsibility to update this form in the event that I no longer wish to authorize one or more of the above uses. I agree that this form will remain in effect during the term of my child's enrollment.

Parent Guardian Signature_____

Date_____

A Bright Start Child Care Learning Center Notification of Smoking and Tobacco Restriction

Objective:

To maintain a smoke free-environment and protect the health of all those who work, attend, or visit A Bright Start Child Care Learning Center.

A Bright Start Child Care is a smoke free- environment, in accordance with the North Carolina Division of Child Care children must be in a smoke free and tobacco free environment. [Rules. 0604]

Policy: Effective May 1, 2018

Smoking and the use of any product containing, made, or derived from tobacco, is not permitted on the premises, in vehicles used to transport children, or during off premise activities.

Responsibilities and Procedures:

1. "No Smoking" signs are posted at each entrance and in vehicles used to transport children.
2. Notice will be given to all parents in writing of the smoking and tobacco restriction before their child is enrolled.
3. Notice will be given to all employees and volunteer prior to providing care or guidance to the children.
4. The smoking and tobacco restriction policy will be reviewed with staff at commencement of employment.

Print

Name_____Signature_____Date_____

Check one that applies:

- ☐ Employer
- ☐ Employee
- ☐ Parent/ Guardian
- ☐ Volunteer

A Bright Start Child Care Learning Center
Children's File Checklist

Name of Child _____ Date of Enrollment _____

The following items must be present in each child's file

Item	Due Date	Date Received/Completed
<input type="checkbox"/> Application for enrollment	1 st Day	
<input type="checkbox"/> Emergency Medical Care Information/Medical Action Plan (If applicable)	1 st Day/updated as changes occur	
<input type="checkbox"/> Medical Report	Within 30 days of enrollment	
<input type="checkbox"/> Immunization Record	Within 30 days of enrollment	
<input type="checkbox"/> Documentation of Receipt: Discipline Policy	1 st Day	
<input type="checkbox"/> Infant feeding plan (children less than 15 months old)	1 st Day	
<input type="checkbox"/> Infant sleep position waivers (if applicable)	1 st Day	
<input type="checkbox"/> Infant safe sleep visual check chart (if applicable)	1 st Day	
<input type="checkbox"/> Documentation of Receipt: Center Operational Policies (if applicable)	1 st Day	
<input type="checkbox"/> Authorization for Transportation (if applicable)	1 st Day/ As occurs	
<input type="checkbox"/> Documentation of Receipt: Summary of Child Care Law	1 st Day	
<input type="checkbox"/> Copies of Incident Reports	As occurs	
<input type="checkbox"/> Emergency Medical Care Authorization	1 st Day	
<input type="checkbox"/> Medication authorization, Record of Medication Administration (if applicable), and Medication Error Report (if applicable)	As occurs	
<input type="checkbox"/> Off premise activities authorization	As occurs	
<input type="checkbox"/> Permission to transport/participate in off premise activities (if applicable)	1 st Day	
<input type="checkbox"/> Nutrition opt-out form (if applicable)	As occurs	
<input type="checkbox"/> Documentation of Receipt: Prevention of Shaken Baby Syndrome and Abusive Head Trauma Policies	1 st Day	
<input type="checkbox"/> Permission for aquatic activities (if applicable)	1 st Day	
<input type="checkbox"/> Notification of smoking and tobacco restriction	1 st Day	
<input type="checkbox"/> Photo Authorization Form	1 st Day	

ð IEP/IFSP	1 st Day/ As occurs	
ð Discipline Notices	As occurs	