Date Application Completed_____ ____ Date of Enrollment_____

CHILD'S APPLICATION FOR ENROLLMENT

To be completed, signed, and placed on file in the facility on the first day and updated as changes occur and at least annually

CHILD INFORMATION: Date of Birth: _____

Full Name:_____

Last First Middle Nickname

Child's Physical Address:_____

FAMILY INFORMATION: Child lives with: _____

Father/Guardian's Name _____ Home Phone_____

Address (if different from child's)_____ Zip Code _____

Work Phone_____ Cell Phone_____

Mother/Guardian's Name _____ Home Phone_____

Address (if different from child's)_____ Zip Code _____

Work Phone_____ Cell Phone_____

CONTACTS:

Child will be released only to the parents/guardians listed above. The child can also be released to the following individuals, as authorized by the person who signs this application. In the event of an emergency, if the parents/guardians cannot be reached, the facility has permission to contact the following individuals.

Name	Relationship	Address	Phone Number
Name	Relationship	Address	Phone Number
Name	Relationship	Address	Phone Number

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 parent or health care professional. Is there a medical action plan attached? Yes__ No__

List any allergies and the symptoms and type of response required for allergic reactions. _____

List any health care needs or concerns, symptoms of and type of response for these health care needs or concerns _____

List any particular fears or unique behavior characteristics the child has_____

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 health care professional _____ Office Phone _____

Hospital preference _____ Phone _____

I, as the parent/guardian, authorize the center to obtain medical attention for my child in an emergency.

Signature of Parent/Guardian_____Date_____

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

Signature of Administrator_____Date_____

Child Medical Action Plan

10A NCAC 09 .0801(b) [Centers] and .1721(a)(4) [Family Child Care Homes]

If a child has health care needs that require specialized health services, the child's parent or a health care professional should complete a medical action plan and attach it to the child's application. The plan must be updated annually and stored in the child's file and facility's Ready to Go File. A copy should be kept in the classroom.

Children with asthma, diabetes, seizures, or allergies should have medical action plans specific to those conditions.

Name of person completing form:		Today's date:
Child's full name:		Date of birth:
Parent/guardian's name:		Phone:
Primary health care professional:		Phone:
Specialist/therapist:	Type:	Phone:
Specialist/therapist:	Type:	Phone:
Diagnosis(es):		
Allergies (food, medication, environmental, insects, or other):		

Medication(s)

Complete a **Medication Administration Permission Form** if medications listed below are to be provided by the child care. Complete page three if child has more than two medications.

Medication name:	☐ Daily medication taken at child care	☐ Daily medication taken at home	☐ Emergency medication
Dosage:	Time/frequency:	Route:	
Special instructions:	Side effects:	Reason prescribed:	

Medication name:	☐ Daily medication taken at child care	☐ Daily medication taken at home	☐ Emergency medication
Dosage:	Time/frequency:	Route:	
Special instructions:	Side effects:	Reason prescribed:	

Accommodation(s)

Describe any accommodation(s) the child needs in daily activities and why.

Diet or Feeding:
Classroom Activities:
Naptime/Sleeping:
Toileting:
Outdoors or Field Trips:
Transportation:
Other/Comments:

Child Medical Action Plan

Equipment/Medical Supplies

1.
2.
3.
4.

Emergency Care

Call parents/guardians if the following symptoms are present:
Call 911 (emergency medical services) if the following symptoms are present, and contact the parents/guardians:
Take these measures while waiting for parents or medical help to arrive:

Suggested Special Training for Staff

If completed by a health care professional:

Health Care Professional Signature:	Date:

Parent notes

Parent/Guardian Signature:	Date:

Children's Medical Report

Name of Child _____ Birthdate _____

Name of Parent or Guardian _____

Address of Parent of 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 #** _____

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:

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***	Prevnar 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 Prevnar 13 and may be seen in high risk children over age 2. These children would also have received Prevnar 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.

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.					

Infant Feeding Plan

As your child's caregiver, an important part of my job is feeding your baby. The information you provide below will help me to do my very best to help your baby grow and thrive.

Child's name: _____ Birthday: _____
mm / dd / yyyy

Parent/Guardian's name(s): _____

Did you receive a copy of our "Infant Feeding Guide?" Yes No

If you are breastfeeding, did you receive a copy of:
"Breastfeeding: Making It Work?" Yes No
"Breastfeeding and Child Care: What Moms Can Do?" Yes No

TO BE COMPLETED BY PARENT

At home, my baby drinks (check all that apply):

- Mother's milk from (circle)
  Mother bottle cup other
- Formula from (circle)
  bottle cup other
- Cow's milk from (circle)
  bottle cup other
- Other: _____ from (circle)
  bottle cup other

How does your child show you that s/he is hungry?

How often does your child usually feed?

How much milk/formula does your child usually drink in one feeding?

Has your child started eating solid foods?

If so, what foods is s/he eating?

How often does s/he eat solid food, and how much?

TO BE COMPLETED BY TEACHER

Clarifications/Additional Details:

At home, is baby fed in response to the baby's cues that s/he is hungry, rather than on a schedule?
Yes No

If NO,

- I made sure that parents have a copy of the "Infant Feeding Guide" or "Breastfeeding: Making it Work"
- I showed parents the section on reading baby's cues

Is baby receiving solid food? Yes No

Is baby under 6 months of age? Yes No

If YES to both,

- I have asked: Did the child's health care provider recommend starting solids before six months?
  Yes No

If NO,

- I have shared the recommendation that solids are started at about six months.

Handouts shared with parents:

Child's name: _____ Birthday: _____
mm / dd / yyyy

Tell me about your baby's feedings at my Home.
I want my child to be fed the following foods while in your care:

	Frequency of feedings	Approximate amount per feeding	Will you bring from home? (must be labeled and dated)	Details about feeding
Mother's Milk				
Formula				
Cow's milk				
Cereal				
Baby Food				
Table Food				
Other (describe)				

I plan to come to your Home to nurse / feed my baby at the following time(s): _____

My usual pick-up time will be: _____

If my baby is crying or seems hungry shortly before I am going to arrive, you should do the following (choose as many as apply):
__ hold my baby __ use the teething toy I provided __ use the pacifier I provided
__ rock my baby __ give a bottle of milk __ other Specify: _____

I would like you to take this action _____ minutes before my arrival time.

At the end of the day, please do the following (choose one):
____ Return all thawed and frozen milk / formula to me. _____ Discard all thawed and frozen milk / formula.

We have discussed the above plan, and made any needed changes or clarifications.

Today's date: _____

Teacher Signature: _____ Parent Signature _____

Any changes must be noted below and initialed by both the teacher and the parent.

Date	Change to Feeding Plan (must be recorded as feeding habits change)	Parent Initials	Teacher Initials

CAROLINA GLOBAL BREASTFEEDING INSTITUTE
Breastfeeding-Friendly CHILD CARE

In Collaboration With:
NC Department of Health and Human Services
NC Child Care Health and Safety Resource Center
NC Infant Toddler Enhancement Project
Shape NC: Healthy Starts for Young Children
Wake County Human Services and
Wake County Smart Start

Alternative Sleep Position Waiver

Parent

Parents may only use this waiver for infants over the age of six months.

Parent/guardian completes this section.

Child's name _____ Date of birth _____ Age in months _____

Parent/guardian name _____

Address _____

City _____ State _____ Zip _____

Home phone _____ Work phone _____ Cell phone _____

Email _____

The child care facility named below places all infants on their backs to sleep to reduce the risk of Sudden Infant Death Syndrome (SIDS); Child Care Rule .0606 (a)(1). As the parent or guardian of the child named above, I request my child be placed to sleep in an alternative sleep position now that my child is 6 months or older; Child Care Rule .0606 (e). The facility shall retain the waiver in the child's record as long as the child is enrolled at the center.
This waiver is valid if I have checked the box(es) below:

☐ I request that my child not be placed on the back to sleep and instead placed to sleep in the alternative sleep position described below.

I request that the child care facility place my child in the alternative sleep position described below.

_____

_____

☐ I request that a wedge is used for my child according to the direction and for the specified reason(s) I provided below :

_____

_____

Effective Dates of Waiver: **from** ____/____/____ **to** ____/____/____

I, as the parent or guardian of the above mentioned child, do hereby release and hold harmless the child care facility listed below, its officers, directors, and employees, from any and all liability whatsoever associated with harm to my child due to Sudden Infant Death Syndrome (SIDS). I affirm and acknowledge that the child care facility named above gave me information about SIDS. I authorize this child care facility and its employees to place my child in the alternative sleep position described above at my request.

Parent/guardian signature _____ **Date** _____

An authorized facility representative of the child care facility completes this section.

Name of Child Care Facility _____ ID # _____

Facility Representative's Signature _____ **Date** _____

Infant/Toddler Safe Sleep Policy

Child Care Facility: Teena's Family Childcare

A safe sleep environment for infants reduces the risk of sudden infant death syndrome (SIDS) and other sleep related infant deaths. According to N.C. Law, child care providers caring for infants 12 months of age or younger are required to implement a safe sleep policy and share the policy with parents/guardians and staff. We implement the following safe sleep policy.
References: N.C. Law G.S. 100-91 (15), N.C. Child Care Rules .0606 and .1724, Caring for Our Children

Safe Sleep Practices

1. We train all staff, substitutes, and volunteers caring for infants aged 12 months or younger on how to implement our Infant/Toddler Safe Sleep Policy.
2. We always place infants under 6 months of age on their **backs to sleep**, unless a signed *ITS-SIDS Alternate Sleep Position Health Care Professional Waiver* is in the infant's file and posted at the infant's crib. We retain the waiver in the child's record for as long as they are enrolled.
3. ☐ We do not accept *Parent Waivers* for infants older than six months.* **-OR-**
   ☑ We accept the *ITS-SIDS Alternate Sleep Position Parent Waiver.*
4. We place infants on their backs to sleep even after they can easily turn over from the back to the stomach. We then allow them to adopt their own position for sleep.
   ☑ We document when each infant can roll from back to stomach and tell the parents. We put a notice in the child's file and on or near the infant's crib.*
5. We visually check sleeping infants every 15 minutes and record what we see on a *Sleep Chart.*
   ☑ We check infants 2-4 month of age more frequently.*
6. We maintain the temperature in the room where infants sleep between 68-75°F and check it on the thermometer in the room.
   ☑ We further reduce the risk of overheating by not over-dressing infants*
7. We provide all infants supervised "tummy time" daily.
8. We follow N.C Child Care Rules .0901(k) and .1706(j) regarding breastfeeding.
   ☐ We further encourage breastfeeding in the following ways:* _____

Safe Sleep Environment

9. We use Consumer Product Safety Commission (CPSC) approved cribs or other approved sleep spaces for infants. Each infant has his or her own crib or sleep space.
10. ☐ We do not allow infants to use pacifiers. **-OR-**
    ☑ We allow pacifiers without any attachments. Pacifiers attached to clothing will be removed when placed to sleep.
    ☑ We do not reinsert the pacifier in the infant's mouth if it falls out.*
    ☐ We remove the pacifier from the crib once it has fallen from the infant's mouth.*
11. We do not allow infants to be swaddled.
12. We do not allow garments that restrict movement.*
13. We do not allow any objects, such as, pillows, blankets, or toys other than pacifiers in the crib or sleep space.
14. Infants are not placed in or left in car safety seats, strollers, swings, or infant carriers to sleep.
15. We give all parents/guardians of infants a written copy of the *Infant/Toddler Safe Sleep Policy* before enrollment. We review the policy with them, and ask them to sign a statement saying they received and reviewed the policy.
    ☐ We encourage families to follow the same safe sleep practices to ease infants' transition to child care.*
16. Family child care homes: We post a copy of this policy and a safe sleep practices poster in the infant sleep room where it can easily be read.
17. Centers: We post a copy of this policy in the infant sleep room where it can easily be read.

**Indicates we follow this best practice recommendation.*

Effective date: 7/23/2019 **Review date(s):** _____ **Revision date(s):** _____

Distribution: We give parents/guardians a copy of the policy. We give all staff, substitutes and volunteers a copy to review. We inform them of changes 14 days before the effective date. We give parents/guardians a copy of the policy they signed and put a copy in child's file.

I, the undersigned parent/guardian of _____ (child's full name), have received a copy of the facility's *Infant/Toddler Safe Sleep Policy.* I have read the policy and discussed it the facility director/owner/operator, or other designated staff member.

Child's Enrollment Date: _____ Parent/Guardian Signature: _____ Date: _____

Facility Representative Signature: [signature] Date: 7/23/2019

NC Division of Child Development
and Early Education

Transportation Permission

A. Parent and Child Information

Name of Parent	Telephone Number - Primary
Name of Child ☐ Picture attached	Telephone Number - Secondary

B. Emergency Contact Information (non-parent)

Name	Telephone Number

C. Departure and Return Times

Departure Time	Arrival Time	Return Time

D. Authorized Destinations

Child transported from	Child transported to

E. Parent Signature and Other

Person receiving child, if applicable ☐ On application	Method of Travel
Permission to transport is valid from [give date] to [give date]. From To (up to 12 months)	Transportation Provider
Signature of Parent or Guardian	Date

NC Division of Child Development
and Early Education

Transportation Permission

A. Parent and Child Information

Name of Parent | Telephone Number - Primary

Name of Child ☐ Picture attached | Telephone Number - Secondary

B. Emergency Contact Information (non-parent)

Name | Telephone Number

C. Departure and Return Times

Departure Time | Arrival Time | Return Time

D. Authorized Destinations

Child transported from | Child transported to

E. Parent Signature and Other

Person receiving child, if applicable ☐ On application | Method of Travel

Permission to transport is valid from [give date] to [give date].
From To (up to 12 months) | Transportation Provider

Signature of Parent or Guardian | Date

Permission to Play Outside of the Fenced in Area

I understand that the facility may have planned activities outside of the fenced area of the facility. This may include but not limited to fire drills, nature walks, buggy rides, walk to the play area, etc. The children will not be off premises during these times only outside of the fenced play area.

I will allow my child to play outside the fenced area. **YES** ☐ **NO** ☐
This authorization is valid for the time the child is enrolled unless indicated by parent by updating form.

Aquatic Policy

All children who attend aquatic field trips must have a swim suit, proper shoes that are strapped to their feet, and a towel. Sun screen must be put on by the parent or guardian at the beginning of the day. Children are NOT allowed to administer sun screen to themselves or their peers. Teena's Family Childcare will only visit area pools with a life guard on duty and will require that 2 staff members accompany the children to the pool. Teena's Family Childcare always requires that 1 staff member be in the pool with children. All parents will need to sign stating that they have read this policy statement.

Prevention of Shaken Baby Syndrome and Abusive Head Trauma Policy

Parent or guardian acknowledgement form

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

_____ _____

Date policy given/explained to parent/guardian **Date of child's enrollment**

_____

Print name of parent/guardian

_____ _____

Signature of parent/guardian **Date**

Teena's Family Childcare reserves the right to make changes, or updates to the policy at any time without notice. Please note that parents will be notified of changes via email immediately thereafter.

Parent Handbook Receipt & NC Childcare Rules & Guidelines

I have received a copy of the *Parents* Handbook on _____.
Date
I have reviewed and understand all the policies and procedures.

_____ _____
Parent/Guardian Signature Date

_____
Name (printed)

NC Division of Child Development
and Early Education

Off Premise Activity Permission

A. Parent and Child Information

Name of Parent	☐ Emergency Contact	Telephone Number - Primary
Name of Child	☐ Picture attached	Telephone Number - Secondary

B. Emergency Contact Information (non-parent)

Name	Telephone Number

C. Authorized Destination and Departure and Return Times

Location of off premise activity	Departure Time	Return Time

D. Parent Signature and Date

Permission to participate is valid from [give date] to [give date]. From To (up to 12 months)	
Signature of Parent or Guardian	Date

NC Division of Child Development
and Early Education

Off Premise Activity Permission

A. Parent and Child Information

Name of Parent	☐ Emergency Contact	Telephone Number - Primary
Name of Child	☐ Picture attached	Telephone Number - Secondary

B. Emergency Contact Information (non-parent)

Name	Telephone Number

C. Authorized Destination and Departure and Return Times

Location of off premise activity	Departure Time	Return Time

D. Parent Signature and Date

Permission to participate is valid from [give date] to [give date]. From To (up to 12 months)	
Signature of Parent or Guardian	Date

Facility ID# & Name 51000854 - Teena's Family Childcare
Operator: Ms. Teena Leach

Written Plan of Care

Hours of Operation: 6 am to 6:30 pm Date adopted: 7/23/2019

All family child care home operators are required to develop and adopt a written plan of care for completing routine tasks; such as running errands, meeting family and personal demands, and attending classes. This ensures that routine tasks do not interfere with the care of children during hours of operation. This is required by Child Care Rule 10A NCAC 09 .1712(a)

NOTE: This plan of care must be given and explained to parents of children in care on or before the first day the child attends. Parents must sign a statement acknowledging the receipt and explanation of the plan. If the operator amends the plan, the operator must give written notice of the amendment to parents at least 30 days before the amended plan is implemented.

Part 1 Check the option that applies to your FCCH:

☐ I do not complete routine tasks while children are in care. If this changes, I will develop a plan of care and give parents at least 30-day notice prior to implementation. *If you check this option, only complete part 3.*

☑ I will complete routine tasks while children are in care. Below is a schedule of routine tasks and typical times they are completed while children are in care. *If you check this option, complete part 2 and 3.*

Part 2 Complete Routine Tasks Schedule:

Fill in this information to reflect the most accurate days/times routines tasks typically occur.

	Task/Destination	Plan of Care for children T = Transport S = Substitute caregiver	Frequency Weekly/Monthly	Departure Time	Return Time
Example	*Bank/BB&T – HWY 70*	*T*	*Tuesday*	*10:30 a.m.*	*11:30 a.m.*
	Neighborhood Bus Stop	T	Weekly	4:10 pm	4:30pm
	Wilson Mills Elementary	T	Weekly	3:45 pm	4:30 pm

Note: Routine tasks listed above must also be included on the written schedule.

☐ List any additional caregiver(s) and/or substitute caregiver(s) that will care for children while you, the operator, complete routine tasks. These individuals must meet requirements for staff qualifications stated in Rule .1729.
NONE

☐ Specify how you will maintain compliance with transportation requirements specified in Rule.1723 when children are transported off premises to accompany you while completing routine tasks:
All children ages 8 + under will secured in their individual seats; buckled while vehicle is in motion

☐ Indicate how parents will be notified when children accompany you off premises for routine tasks not specified on the written schedule:
Parents will be notified of any unexpected tasks via email.

☐ Indicate any other steps that will be taken to ensure routine tasks do not interfere with the care of children during hours of operation:
NONE

Part 3 Signatures:

I, the undersigned parent or guardian of _____(child's full name), do hereby state that I have read and received a copy of this family child care home's Written Plan of Care and that the operator has discussed the plan of care with me.

Date of Child's Enrollment: _____

Signature of Parent/Guardian: _____ Date: _____
Signature of Operator: _____ Date: 7/23/2019

Distribution: One signed copy to parent/guardian; signed copy in child's file.

Child and Adult Care Food Program (CACFP)
Child Participant Enrollment Form

Institution Name: Chatham County Partnership for Children Agreement Number: 9422

Center Name: Teena's Family Childcare, LLC

Dear Parent/Guardian,

This center/program receives funding from the U.S. Department of Agriculture (USDA) Child and Adult Care Food Program (CACFP). CACFP needs proof of enrollment for all children. Please complete the table below for each child in your family that is enrolled at this center/program. Be sure to sign and date in the space below. Thank you.

The information below should be completed by the parent or guardian.

Participant's First Name	Participant's Last Name	Date of Birth	Normal/Typical Hours of Care	Normal/Typical Days of Care (Circle all that apply)	Meals Normally Eaten (Circle all that apply)
			____ to ____	M T W Th F Sat Sun	B AM L PM S LPM
			____ to ____	M T W Th F Sat Sun	B AM L PM S LPM
			____ to ____	M T W Th F Sat Sun	B AM L PM S LPM
			____ to ____	M T W Th F Sat Sun	B AM L PM S LPM
			____ to ____	M T W Th F Sat Sun	B AM L PM S LPM

Normal/Typical Hours of Care: Please write in each child's usual arrival and departure time. Indicate a.m. or p.m.

Normal Days of Care: Please circle the days of the week each child is usually in attendance at the facility.
(M-Monday; T-Tuesday; W-Wednesday; Th- Thursday; F-Friday; Sat-Saturday; Sun-Sunday)

Meals Normally Eaten - Please circle the meals each child usually eats at the facility.
(B-Breakfast; AM-AM Snack; L-Lunch; PM-PM Snack; S-Supper; LPM-Late PM/Evening Snack)

Parent/Guardian Signature: _____ **Date:** _____

Print Name: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Home Telephone Number: _____ Work Telephone Number: _____

For Facility/Provider Use Only:

Signature of Facility Representative/Provider: _____ Date: _____

Date each child withdrew: _____

For State Use Only: Complete: _____ Incomplete _____ Reason: _____ Verified by: _____ Date: _____

This institution is an equal opportunity provider.

Instructions:
Parent: Please provide the Ethnic and Racial Data that applies to your child. If you choose not to complete the form the provider will complete the form by observation. Information is for report use only.

ETHNIC AND RACIAL DATA FORM

Enrolled Participant's Name: _____

Site Name: Teena's Family Childcare, LLC

Address: _____

Sponsor Name: Chatham County Partnership for Children Agreement # 9422

Ethnic Categories	Number of Participating Children or Adults
Hispanic or Latino. (A person of Mexican, Puerto Rican, Cuban, Central or South American, or other Spanish culture or origin, regardless of race).	
Not Hispanic or Latino. (All persons not fitting in one of the above describes categories)	

Race Categories	Number of Participating Children or Adults
American Indian or Alaska Native. (A person having origins in any of the original peoples of North and South America, (including Central America), and who maintains cultural identification through tribal affiliation or community recognition (includes Aleuts and Eskimos).	
Asian. (A person having origins in any of the original peoples of the Far East, Southeast Asia, or the Indian Subcontinent, including, for example, Cambodia, China, Japan, Korea, Malaysia, Pakistan, the Philippine Islands, Thailand, and Vietnam).	
Black or African American. (A person having origins in black racial groups of Africa).	
Native Hawaiian or Other Pacific Islander. (A person having origins in any of the original people of Hawaii, Guam, Samoa, or other Pacific Islands).	
White. (A person having origins in any of the original peoples of Europe, North Africa, or the Middle East).	

Parent or Provider Authorization:	Date