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_____

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.					

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 _____

"Time-Out"

"Time-out" is the removal of a child for a short period of time (3 to 5 minutes) from a situation in which the child is misbehaving and has not responded to other discipline techniques. The "time-out" space, usually a chair, is located away from classroom activity but within the teacher's sight. During "time-out," the child has a chance to think about the misbehavior which led to his/her removal from the group. After a brief interval of no more than 5 minutes, the teacher discusses the incident and appropriate behavior with the child. When the child returns to the group, the incident is over and the child is treated with the same affection and respect shown the other children.

Adapted from original prepared by Elizabeth Wilson, Student, Catawba Valley Technical College

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

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

* Please only complete one *

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

Please only complete one.

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 51000895, Teena's Family Childcare
Operator:_____

Written Plan of Care

Hours of Operation: 12AM to 11:59PM Date adopted: 2-28-2021

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
Bank/BB&T – HWY 70	*T*	*Tuesday*	*10:30 a.m.*	*11:30 a.m.*

ample

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.

_____

☐ 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 will be transported in a secure, and safe manor, using age appropriate seating while bus 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 unscheduled task resulting in the transport of their child via phone call and/or 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:

A schedule will be made available to parents if daycare will be closed to conduct non business task in advance.

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: 2-28-21

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