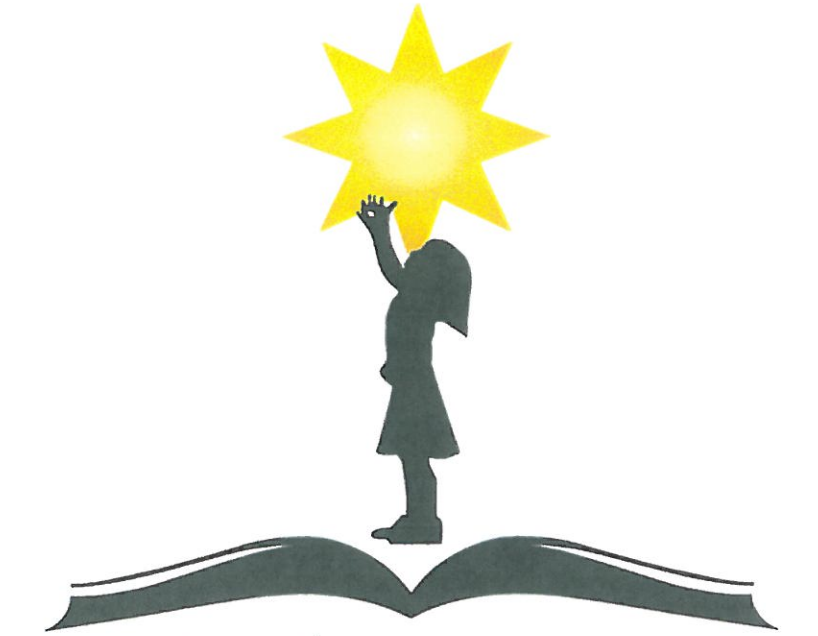

Bright Starz

Learning Center

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_____

DCD - A/N
Form 9A-r

(Facility's Name)

Child's Care and Emergency Information

Date of Enrollment	Date of Withdrawal

Name of Child (Last, First Middle Initial)		Name of Parents		
Child's Date of Birth	Home Phone Number ( )	Address (Number and Street)		
Allergies, if any		City	State	Zip Code
Special Health Conditions, if any				
1. Parent's Location When Child's in Care (Employer, School, etc.)		Hours of Employment	Phone Number ( )	
Address (Number and Street)		City	State	Zip Code
2. Parent's Location When Child's in Care (Employer, School, etc.)		Hours of Employment	Phone Number ( )	
Address (Number and Street)		City	State	Zip Code

PERSON OTHER THAN PARENT TO BE NOTIFIED IN EMERGENCY SITUATION WHEN PARENT IS NOT AVAILABLE

Name	Phone Number ( )		
Address (Number and Street)	City	State	Zip Code

NAMES OF PERSONS OTHER THAN PARENT TO WHOM CHILD MAY BE RELEASED

1.	3.
2.	4.

SEE REVERSE FOR ADDITIONAL INFORMATION

REVISED SAMPLE 8/99

Emergency treatment and transportation:

I hereby give permission to _____
(Child Care Provider)

licensed by the Division of Child Development to secure emergency medical, dental, and/or emergency surgical treatment and to provide emergency transportation for the above named minor child while in care.

Non-emergency medical treatment or elective surgery is not included in this authorization.

Signature of Parent or Guardian	Date Signed

Name of Child's Physician or Health Clinic	Office Hours	Phone Number ( )	
Address (Number and Street)	City	State	Zip Code
Hospital Preferred for Emergency Treatment	Health Insurance Policy Name and Number		
Name of Child's Dentist	Office Hours	Phone Number ( )	
Address (Number and Street)	City	State	Zip Code

Field Trips and Activities Outside the Fenced Playground

I hereby give permission to _____ for my child to participate
(Child Care Provider)

in a walking trip or to be transported in a vehicle for a field trip. I further give permission to the facility for my child to participate in developmentally appropriate supervised activities outside of the fenced playground.

Signature of Parent or Guardian	Date Signed

(Can be duplicated on the front/back of a 5 x 8 inch card)

REVISED SAMPLE 8/99

DCD 0108
12/99

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.					

SAMPLE #1
Updated 6/19

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 the 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 level.
11. DO use short supervised periods of time-out sparingly.
12. DO stay consistent in our behavior management program.
13. DO use effective guidance and behavior management techniques that focus on a child's development.

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.

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

Infant Feeding Plan

As your child's caregivers, an important part of our job is feeding your baby. The information you provide below will help us to do our very best to help your baby grow and thrive. **Page two of this form must be completed and posted for quick reference for all children under 15 months of age.**

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 us about your baby's feedings at our center.
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 the center 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

In Collaboration With:
NC Department of Health and Human Services
NC Child Care Health and Safety Resource Center
NC Infant Toddler Enhancement Project

Infant/Toddler Safe Sleep Policy

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.

_____(facility name) implements the following safe sleep policy:

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 12 months of age on their backs to sleep, unless:
   - **the infant is 6 months or younger** and a signed ITS-SIDS Alternate Sleep Position Health Care Professional Waiver is in the infant's file and a notice of the waiver is posted at the infant's crib.
   - **the infant is 6 months or older** (choose one)
     - ❑ We do not accept the ITS-SIDS Alternate Sleep Position Parent Waiver.*
     - ❑ We accept the ITS-SIDS Alternate Sleep Position Parent Waiver.

   We retain the waiver in the child's record for as long as they are enrolled.
3. We place infants on their back to sleep even after they are able to independently roll back and forth from their back to their front and back again. We then allow the infant to sleep in their preferred position.
   - ❑ We document when each infant is able to roll both ways independently and communicate with parents. We put a notice in the child's file and on or near the infant's crib.*
4. We visually check sleeping infants every 15 minutes and record what we see on a Sleep Chart. The chart is retained for at least one month.
   - ❑ We check infants 2-4 month of age more frequently.*
5. We maintain the temperature between 68-75°F in the room where infants sleep.
   - ❑ We further reduce the risk of overheating by not over-dressing infants*
6. We provide infants supervised tummy time daily. We stay within arm's reach of infants during tummy time.
7. We follow N.C Child Care Rules .0901(j) and .1706(g) regarding breastfeeding.
   - ❑ We further encourage breastfeeding in the following ways:*_____
     _____

Safe Sleep Environment

8. 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.
9. We do not allow pacifiers to be used with attachments.
10. Safe pacifier practices:
    - ❑ 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.
    - ❑ We do not allow garments that restrict movement.*
12. We do not cover infants' heads with blankets or bedding.
13. We do not allow any objects other than pacifiers such as, pillows, blankets, or toys 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 this policy before enrollment. We review the policy with them and ask them to sign the policy.
    - ❑ We encourage families to follow the same safe sleep practices to ease infants' transition to child care.*
16. Posters and policies:
    - **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.
    - **Centers:** We post a copy of this policy in the infant sleep room where it can easily be read.
      - ❑ We also post a safe sleep practices poster in the infant sleep room where it can easily be read.*

Communication

17. We inform everyone if changes are made to this policy 14 days before the effective date.
    - ❑ We review the policy annually and make changes as necessary.*

***Best practice recommendation.**

Effective date:_____ Review date(s): _____ Revision date(s): _____

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

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

Facility Representative Signature: _____ 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

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

Bright Starz Learning Center

We hope that you have thoroughly read the Parent Handbook. If you have any questions or concerns about any of the items that are listed in the handbook, please feel free to speak with the Director, so that we may come to an agreement on any problems or concerns.

So that we know you have read the handbook and that you understand it, please sign the form below so that it can be placed in your child's folder.

Signature _____ Date_____

I have received the North Carolina child Care Law and Rule Handbook.

Signature_____ Date _____

Medical Authorization Form

In the event of an injury or medical emergency, trained staff will immediately administer first-aid and notify the director if further assistance is needed.

If we believe the situation may call for parent involvement or professional medical attention, the center will attempt to contact a parent or other authorized emergency contact. If the condition is serious, the Center will call 911 for EMT response or will transport the child to a hospital emergency room along with the Director or next in charge.

_____

Parent/ Guardian Signature

_____

Date