

**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 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 # \_\_\_\_\_



## 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	I POL	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 5<sup>th</sup> 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 Hep B		
5 months		2 Polio			2 Hep B		
7 months	3 DTaP	2 Polio		2-3 Hib**	2 Hep B	3 PCV	
12 months	3 DTaP	2 Polio		2-3 Hib**	2 Hep B	3 PCV	
16 months	3 DTaP	2 Polio	1 MMR	3-4 Hib**	2 Hep B	4 PCV	
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

**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.					
Coronavirus disease 2019	COVID-19	Comirnaty, Spikevax, Nuvaxovid, Jcovden	Annually after age 6 months.					





## Discipline and Behavior Management Policy

Name of Facility: Teena's Family Child Care, LLC Date Adopted: 12-6-2023

No child shall be subjected to any form of corporal 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***

## Transportation Permission

Please only complete (1) per child. 😊

### A. Parent and Child Information

Name of Parent	Telephone Number - Primary
Name of Child <input type="checkbox"/> Picture attached	Telephone Number - Secondary

### B. Emergency Contact Information (non-parent)

Name	Telephone Number
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### C. Departure and Return Times

Departure Time Varies	Arrival Time Varies	Return Time Varies
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### D. Authorized Destinations

Child transported from Varies	Child transported to Varies
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### E. Parent Signature and Other

Person receiving child, if applicable <input type="checkbox"/> On application	Method of Travel TFCC Vehicle
Permission to transport is valid from [give date] to [give date]. From 01-01-25 To 12-31-2025 (up to 12 months)	Transportation Provider TFCC Staff
Signature of Parent or Guardian	Date

## Transportation Permission

### A. Parent and Child Information

Name of Parent	Telephone Number - Primary
Name of Child <input type="checkbox"/> Picture attached	Telephone Number - Secondary

### B. Emergency Contact Information (non-parent)

Name	Telephone Number
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### C. Departure and Return Times

Departure Time	Arrival Time	Return Time
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### D. Authorized Destinations

Child transported from	Child transported to
------------------------	----------------------

### E. Parent Signature and Other

Person receiving child, if applicable <input type="checkbox"/> 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



## Off-Premise Activity

### Permission

Please complete (1) per child.

#### A. Parent and Child Information

Name of Parent	<input type="checkbox"/> Emergency Contact	Telephone Number - Primary
Name of Child	<input type="checkbox"/> Picture attached	Telephone Number - Secondary

#### B. Emergency Contact Information (non-parent)

Name	Telephone Number
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#### C. Authorized Destination and Departure and Return Times

Location of off-premise activity Varies	Departure Time Varies	Return Time Varies
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#### D. Parent Signature and Date

Permission to participate is valid from [give date] to [give date]. From 01-01-25 To 12-31-25 (up to 12 months)	
Signature of Parent or Guardian	Date

## Off-Premise Activity

### Permission

#### A. Parent and Child Information

Name of Parent	<input type="checkbox"/> Emergency Contact	Telephone Number - Primary
Name of Child	<input type="checkbox"/> Picture attached	Telephone Number - Secondary

#### B. Emergency Contact Information (non-parent)

Name	Telephone Number
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#### C. Authorized Destination and Departure and Return Times

Location of off-premise activity	Departure Time	Return Time
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#### 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

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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: \_\_\_\_\_

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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***



### 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.

"Smoke-Free Environment" Teena's Family Childcare maintains a smoke-free environment. When dropping off or picking up your child, please do not smoke in view of children.

### 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)

# ANIMAL ACKNOWLEDGMENT FORM

## Child Care Requirement .1719(b)(3)

Prior to enrollment of children in a family child care home, and before new animals that will be in the home come into the family child care home, a parent of each child must sign a form acknowledging the type of animal and where the animal will be during operating hours. This documentation shall be maintained in each child's file.

I \_\_\_\_\_ understand that this Family Child Care Home  
Name of Parent (Print)

has the following animal(s) on the premises:

One english bulldog. Sura is a kid-friendly animal.

During operating hours, the animal(s) will be located:

\_\_\_\_\_ She will remain inside her crate unless she is let out to  
eat or relieve herself. She will be let out by another member of the family on the opposite side of the  
daycare alongside the fence and or on the back porch to eat three times a day.

Parent's Signature

Date

## Written Plan of Care

Hours of Operation: 12:00 AM to 11:59 PM

Date adopted: 12-6-2023

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
<i>Example</i> → Bank/BB&T – HWY 70	T	Tuesday	10:30 a.m.	11:30 a.m.
ALA Johnston Charter School	T	Weekly	7:20 A.M. - 8:45 A.M.	2:20 P.M. - 4:25 P.M.
Cleveland Elementary	T	Weekly	7:20 A.M. - 8:45 A.M.	2:20 P.M. - 4:25 P.M.
Cooper Elementary	T	Weekly	7:20 A.M. - 8:45 A.M.	2:20 P.M. - 4:25 P.M.

**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.

N/A

- ☒ 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 manner, 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:

Parent(s) are notified of any unscheduled task resulting in the transport of their child via phone call, and/or preferred method of contact

- ☒ 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 parent(s) 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: Teena Leach Date: 12-6-2023

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



North Carolina Department of Health and Human Services  
Division of Child and Family Well-Being, Community Nutrition Services Section  
Child and Adult Care Food Program  
**Infant and Child Enrollment Form**



INSTITUTION NAME: Chatham County Partnership for Children FACILITY NAME: TEENA'S FAMILY CHILDCARE AGREEMENT#: 9422

**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 infants and children. Please complete the table below for each infant and/or child in your family enrolled at this center/program. Be sure to sign and date in the space below.

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

Infant/Child's First Name	Infant/Child'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:** Write in each infant/child's usual arrival and departure time. Indicate a.m. or p.m.

**Normal Days of Care:** Circle the days of the week each infant/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** – Circle the meals each infant/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 infant/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. Adult participant or Parent/Guardian self-identification is the preferred method of data collection. Information is for report use only. (Identification by observation is no longer an allowable means of collecting ethnic and racial data.)

**ETHNIC AND RACIAL DATA FORM**

Enrolled Participant's Name: _____	
Site Name: _____	
Address: _____	
Sponsor Name: Chatham County Partnership for Children      Agreement # 9422	
<b>Ethnic Categories</b>	<b>Number of Participating Children or Adults</b>
<b>Hispanic or Latino.</b> (A person of Mexican, Puerto Rican, Cuban, Central or South American, or other Spanish culture or origin, regardless of race).	
<b>Not Hispanic or Latino.</b> (All persons not fitting in one of the above describes categories)	
<b>Race Categories</b>	<b>Number of Participating Children or Adults</b>
<b>American Indian or Alaska Native.</b> (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).	
<b>Asian.</b> (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).	
<b>Black or African American.</b> (A person having origins in black racial groups of Africa).	
<b>Native Hawaiian or Other Pacific Islander.</b> (A person having origins in any of the original people of Hawaii, Guam, Samoa, or other Pacific Islands).	
<b>White.</b> (A person having origins in any of the original peoples of Europe, North Africa, or the Middle East).	
Signature: _____	Date: _____

Please review the entire *Enrollment Registration Information Packet* and *Family Handbook* with each family. Be sure that all forms are filled out completely with appropriate signatures. Review the child's health record and immunizations for state compliance to ensure the physician has stamped/signed it and has filled in all the necessary dates.

**Obtain Signed Forms from Family**

- ☐ Completed *Enrollment Registration Information Packet* (Staple the carbon copy of the *Enrollment Agreement* to the back pages of the *Family Handbook*)
- ☐ *Family Handbook Acknowledgement*
- ☐ *Child Information Card* (if applicable)
- ☐ Other state or federal required forms: \_\_\_\_\_

**Review with Family**

- |  |   |
|--|---|
| <input type="checkbox"/> The child's first day   | <input type="checkbox"/> Immunization/health information                    |
| <input type="checkbox"/> Child guidance and classroom management (discipline policy)                     | <input type="checkbox"/> Annual registration fee                            |
| <input type="checkbox"/> Tuition payment schedule, amounts, and due dates                                | <input type="checkbox"/> Late fees  |
| <input type="checkbox"/> Parent conferences and other communications, what to expect daily and/or weekly | <input type="checkbox"/> Vacation policy                                    |
| <input type="checkbox"/> Process and procedures of security access                                       | <input type="checkbox"/> Special needs                                      |
| <input type="checkbox"/> Authorized pick-up, late pick-up policy and emergency controls                  | <input type="checkbox"/> Absenteeism policy                                 |
| <input type="checkbox"/> Child custody documents (if applicable)   | <input type="checkbox"/> Sick policy  |
| <input type="checkbox"/> Clothing and other items to bring (labeled)                                     | <input type="checkbox"/> Meals  |
| <input type="checkbox"/> Any pick-up restrictions  | <input type="checkbox"/> Allergies  |
| <input type="checkbox"/> Any field trip restrictions   | <input type="checkbox"/> Security deposit (if applicable)                   |
| <input type="checkbox"/> Any photo restrictions  | <input type="checkbox"/> Medication policy                                  |
|  | <input type="checkbox"/> Relevant curriculum features for child's age group |
|  | <input type="checkbox"/> Infant/Toddler Needs Services Plan (if applicable) |
|  | <input type="checkbox"/> Review Emergency and Disaster Plans                |

The information above was reviewed with me and all of my questions have been answered to my satisfaction. I have a clear understanding of \_\_\_\_\_

Name of Parent/Guardian: \_\_\_\_\_ Relationship: \_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Name of Director: \_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Name of Child: \_\_\_\_\_

Date: \_\_\_\_\_

Parent/Guardian Initial \_\_\_\_\_