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_____ Email _____

Mother/Guardian's Name _____Home Phone_____

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

Work Phone_____ Cell Phone_____ Email _____

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.

_____

Name Relationship Address Phone Number

_____

Name Relationship Address Phone Number

_____

Name Relationship Address Phone Number

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

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/Mother_____Date_____

Signature of Parent/Father _____Date_____

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

Signature of Administrator _____Date_____

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CHILDREN'S MEDICAL REPORT

Name of Child: _____Birth Date: _____
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 child on any continuous medication? No ___ Yes___ If yes, for what reason? _____
_____
4.Any previous hospitalizations or operations No ___ Yes___ If yes, when and for what? _____
_____
5. Any history of significant previous diseases or recurrent illnesses? No ___ Yes___; diabetes No ___ Yes___; convulsions No ___ Yes___; heart trouble No ___ Yes___; asthma No ___ Yes___.
If others, what/when? _____Yes_____
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: _____

THIS SECION MUST BE COMPLETED BY A MEDICAL PROFESSIONAL AS DESCRIBED BELOW

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 _____ Follow-up _____
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: _____

Page left blank intentionally.

Health and Emergency Contact Information

Child's Name (Last, First, MI) _____ Birth Date: _____

Address: _____ ZIP Code: _____

Special Conditions, Disabilities, Allergies, or Medical Information for Emergency Situations:_____

Information about the Family

Legal Guardian (Father) Name: _____

Telephone Numbers: Home _____ Cell _____ Work _____

Email: _____

Address: _____ ZIP Code: _____

Employer: _____

Legal Guardian (Mother) Name: _____

Telephone Numbers: Home _____ Cell _____ Work _____

Email: _____

Address: _____ ZIP Code: _____

Employer: _____

Emergency Care Information

Contacts (to whom the child may be released if legal guardian is unavailable)

Name #1 _____ Relation to child: _____

Telephone Numbers: Home _____ Cell _____ Work _____

Name #2 _____ Relation to child: _____

Telephone Numbers: Home _____ Cell _____ Work _____

A Child's Usual Source of Medical Care (Doctor, Dentist, etc.)

Doctor or Practice Name: _____ Telephone: _____

Address: _____

Dentist or Dental Practice Name _____ Telephone: _____

Address: _____

Hospital Preference: _____ Telephone: _____

Child's Health Insurance:

Name of Insurance (BCBS, Medicaid, Health Choice, etc.) _____ ID # _____

Subscriber's Name (Name on the insurance card) _____

I agree that the operator may authorize the physician of his/her choice to provide emergency care in the event that neither the family physician nor I can be contacted immediately. I give consent for the emergency contact person listed above to act on my behalf until I am available. I agree to review and update this information whenever a change occurs and at least every 6 months.

Parent/Legal Guardian signature: _____

Date: _____

Review date: _____

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

Operator's signature: _____ Date _____

I, as the parent, do agree to allow administration to transport my child to an appropriate medical resource in the event of emergency.

Parent/Legal Guardian signature: _____ Date _____

Page left blank intentionally.

Infant Feeding Schedule

Please write small, but legible. You will need to update this same piece of paper every time your child's feeding schedule changes.

Name of Child _____ Date_____

Date of Birth_____

General Instructions

1. Food/Bottles Brought Daily: (quantity)
2. Instructions for Feeding:
    A. Bottles (breast milk, formula, milk, juice)
    B. Food (cereal, baby food, table food)
3. I plan to nurse: (approximate time) □ _____

_____
Parent Signature

Changes in Schedule (Must be recorded as eating habits change)

Food to Introduce:	Date	New Instructions	Parent Signature
Juice			
Cereal			
Baby Food			
Milk			
Table Food			

**Must be completed for all children less than 15 months old*

Page left blank intentionally.

Document of Receipt (Please Complete)

_____

Child's Name (Please print) Age Date of enrollment

This handbook contains discipline, attendance, and financial policies for children at Trinity Daycare Center. These policies can change without notice at the discretion of the Administration and will be strictly enforced. Parents should read them carefully. Parents will be notified in writing of any policy changes. Please contact the Daycare Director if clarifications are needed.

The statement below, when signed and dated by parents / guardian, serves as documentation and will become a part of the child's file. Any child whose parent/guardian fails to return this signed form within one week may be excluded from classes until the form is returned.

We have received, read and understand the following policies:

- Trinity Daycare Center Operational Policy/Parent Handbook
- Sick Policy
- Discipline and Behavior Management Policy
- Safe Sleep Policy
- Summary of Child Care Law and Rules provided by the North Carolina Department of Human Resources
- Prevention of Shaken Baby Syndrome and Abusive Head Trauma Policies
- Notification of Smoking and Tobacco Restriction

I have read and understand that the policies set forth can change without notice by the discretion of the Administration and will be strictly enforced.

_____

Parent/Guardian Signature Date

_____

Parent/Guardian Signature Date

_____

Facility Representative Signature Date

****

Trinity Daycare Center
Off Premise / Outside of Fence Activity Permission

I, _____ parent/guardian of _____

(Name of Parent/Guardian) (Name of Child)

DO DO NOT

(circle one)

Give my permission to Trinity Daycare Center to allow my child to play outside the fenced area during planned activities (nature walks, buggy rides, sidewalk chalk time, etc.). I understand my preference does not apply to safety drills and will be void in the event of an emergency that requires my child be removed from the fenced area for his/her safety.

_____

Parent/Guardian Signature Date

Page left blank intentionally.

Trinity Christian School and Daycare
Photo/Videotape Waiver

Throughout the school year, there may be times when Trinity Christian School and Daycare (TCS) staff, the media, or other organizations, with the approval of the school administrator and or daycare director may take photographs of students, audiotape/videotape students, or interview students for school or daycare-related stories in a way that would individually identify a specific student. Those photographs and/or audio/videotaped images or interviews may appear in publications; in video productions; on the school or church web site; in classroom blogs; in the news media; or in other nonprofit, education-related organizations' publications.

____ Yes, I give permission for my child to be videotaped or photographed.

____ No, I do not give permission for my child to be videotaped or photographed.

Student's Name: _____

Father/Guardian's Signature _____

Mother/Guardian's Signature _____