Children's Packet

Welcome to **First Presbyterian Child Development Center**. We are happy to have the opportunity to serve you and your family. Please take time to read and sure that you understand everything in this packet and in the Parent Handbook. If you have any questions, please feel free to call the center for clarification. The number to the center is **919-775-2822**. This is also a good time to add our number in your contacts, so you always have our number in case of an emergency. **Please do not leave any blank lines. If it does not apply to your child, please mark it N/A.**

Medical Treatment & Release Form

When filling out the information on hospital preference, know that choosing a hospital other than Central Carolina will result in us having to call an ambulance. If you choose Central Carolina Hospital, your child will be taken by a staff member, if it is not life-threatening. You will be notified immediately that your child is in route to CCH so that you can meet us there. You can then decide if you feel like your child should be transferred.

Please make sure that you include the name, number, and complete address of your child's pediatrician. This information is very important, especially if the pediatrician's office is out of town.

If your child needs an **action plan** for asthma, diabetes, or any other health condition, please let us know so that we can make sure we have everything we need to provide your child with the care they need.

Travel and Activity Authorization Form

All children are supervised if they are outside the fenced in area. This gives the teacher permission to take the children on the sidewalk to draw with chalk, sit in the grassy area, and play games in a larger group, when space is needed. Should you check no, your child will not be able to participate in those activities.

Emergency Contacts

Please list at least two contacts other than yourself or your spouse. This is to ensure that we can reach someone that your child feels comfortable with in the event of an emergency and parents cannot be reached.

REACH Alert

FPCDC uses REACH Alert to send out messages to inform you of important information such as center closings due to weather and other simple reminders. When you enroll your child at First Presbyterian, we will enroll you into the REACH Alert system (using your cell phone number) and send you a message to let you know you have been entered. Messages will be sent out by text. If you would rather receive a phone call instead of a text message, please let us know, we can enroll you so that you receive a phone call to deliver the message. We can also take you out of the system if you decide you no longer wish to participate.

Please visit our Facebook page www.facebook.com/FPCDC/

We also have a closed Facebook group for parents and family to give them a glimpse of some of the things that happen here at FPCDC. The group name is **FPCDC Staff and Parents**. Please go in and invite yourself. We would be happy to have you join.

First Presbyterian Child Development Center wants to do everything we can to ensure that our center is a safe place for children and staff. We would like to make sure that everyone enters and exits from the front door so that we can monitor who comes in and out. Please make sure you do not pick children up off the playground from the back-parking lot. Every family will be given ONE key fob free of charge to make entering our facility easier for you. Extra key fobs are available at an additional charge of $10.00 per fob. Please fill out the following information so that we can get key fobs activated. Thank you.

Child's Name: _____

Free Key Fob (Name): _____

Extra Key Fobs ($10.00 Each) Please list first and last name of person receiving key fobs.

1. _____
2. _____
3. _____

Extra key fobs will be activated after payment has been received.
Please do not include key fob payment with tuition payment.

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_____ Email- _____ Cell Phone_____

Mother/Guardian's Name _____ Home Phone_____

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

Work Phone_____ Email- _____ 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 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 #**_____

First Presbyterian Child Development Center
Travel and Activity Authorization

I, _____parent/guardian of _____

give my permission to First Presbyterian Child Development Center for my child to participate in age appropriate field trips away from the facility. (This includes, walking trips to the Library and/or Educational Nature Walks.) I also understand that the facility will use the appropriate child restraint devices and abide by all the safety rules when my child is transported in a vehicle. The facility will also notify me each time that my child will participate in an activity that would involve transportation.

Parents Signature_____

Date Signed _____

This Authorization is valid from ____/____/____to ____/____/____ (One year)

In addition, if the facility has planned activities outside the fenced area of the facility,

_____I will allow my child to play outside the fenced area; or

_____I will not allow my child to play outside the fenced area.

Parents Signature_____Date_____

This authorization is valid from ____/____/____ to ____/____/____(one year)

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: _____

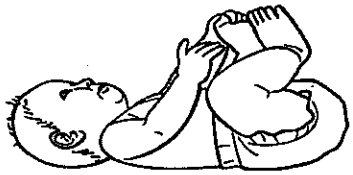
Signature of Parent or Guardian_____Date _____

"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 Schedule

Name of child:

_____ Date:_____

Date of Birth: _____

General Instructions

1. Food/ Bottles Brought Daily: (Quantity)

2. Instructions for Feeding:

A. Bottles (Formula, milk, juice)

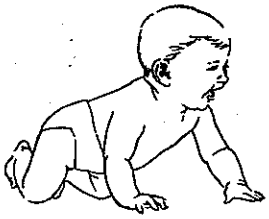
B. Food (cereal, baby food, table food)

Parent Signature: _____

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

Introduce:	**Date:**	**New Instructions**
Juice		
Cereal		
Baby Food		
Milk		
Table Food		**Parent or Staff Signature**

Must be completed for all children less than 15 months old



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) and .1724 (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) and .1724 (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**____/____/____

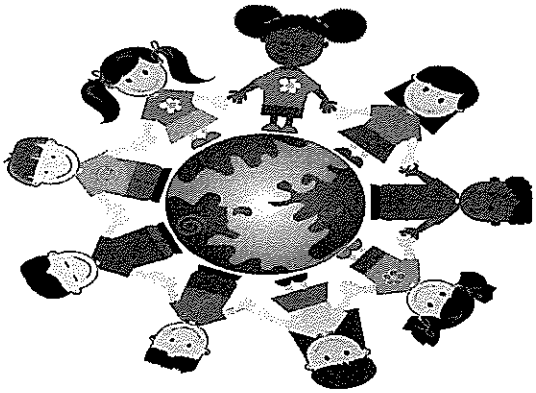
I, as the parent or guardian of the above mentioned child, do hereby release and hold harmless the child care facility listed below, its officers, directors, and employees, from any and all liability whatsoever associated with harm to my child due to Sudden Infant Death Syndrome (SIDS). I affirm and 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**_____



Multimedia Release

I give my consent for FPCDC to photograph or video my child or use photograph(s) or videos that already exist of my child that were taken during childcare hours, field trips or activities. I understand that the photographs, digital images, or video segments may be used in print or electronic media and that the photographs may be displayed on websites owned by FPCDC. Names will not be included in any photographic marketing materials. I understand that I have the right to request, in writing, to have a photo or video removed from the website or Facebook within 30 workdays.

Child's Name(s) _____

_____

_____

_____

_____

Parents Printed Name _____

Signature _____

Date:_____

1. I received and read the FPCDC parent handbook. I understand and agree to the Center Operation Policies and Procedures prescribed therein.

   Parent Signature: _____

2. I understand the payment policy of FPDC. I understand that the payment is due by Monday for the week service is provided and payment is due regardless of attendance. I also understand that the Enrollment Fee is nonrefundable. I have also received a copy of My Procare Portal paper in the FPCDC Handbook.

   Parent Signature: _____

3. I have received the **North Carolina Child Care Law and Rules**

   Parent Signature: _____

4. I agree to allow FPCDC to provide transportation to an appropriate Medical Response in the event of an Emergency.

   Parent Signature: _____

5. I have received a copy of the **Facility's Shaken Baby Syndrome/Abusive Head Trauma, Sudden Infant Death Syndrome, Infant/Toddler Safe Sleep Policy** in the FPCDC Handbook.

   Parent Signature: _____

6. I have received and read the Centers **No Smoking Policy** in the handbook.

   Parent Signature: _____

7. I have received and read **Discipline and Behavior Management Policy, Safe Procedures for Pick-Up & Delivery** in the FPCDC Handbook.

   Parent Signature: _____

8. I Understand that FPCDC Hours of Operation are **6:45am-5:45pm** and FPCDC **Cut Off Time is 9:30 unless you have a Doctor's Note** as also stated in FPCDC Handbook.

   Parent Signature: _____

   Administrator's Signature- _____

   Date- _____