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 address_____

Mother/Guardian's Name _____Home Phone_____

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

Work Phone_____ Cell Phone_____

Email address_____

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__ (Medical action plan must be updated on an annual basis and when changes to the plan occur)

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_____

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 #**_____

LOGAN COMMUNITY DAY CARE ASSOCIATION INC
DISCIPLINE AND BEHAVIOR MANAGEMENT POLICY

DATE ADOPTED -- 8/21

No child shall be subjected to any form of corporal punishment. Praise and positive reinforcement are effective methods of the behavior management for 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 center will practice the following discipline and behavior management policy:

WE

DO praise, reward, and encourage the children.

DO reason with and set limits for the children.

DO model appropriate behavior for the children.

DO modify the classroom environment in an attempt to prevent problems before they occur.

DO listen to the children.

DO provide alternatives for inappropriate behavior to tile children.

DO provide the children with natural and logical consequences of their behaviors.

DO treat the children as people and respect their needs, desires, and feelings.

DO ignore minor misbehaviors.

DO explain things to the children on their levels.

DO use short, supervised periods of time-away

DO stay consistent in our behavior management program.

DO use effective guidance and behavior management techniques that focus on a child's development.

WE

DO NOT handle children roughly in any way, including spanking, shaking, biting, pinching, pushing, shoving, slapping or otherwise physically punish the children.

DO NOT make fun of, yell at, threaten, make sarcastic remarks about, use profanity or otherwise verbally abuse the children.

DO NOT discipline, shame or punish the children as when bathroom accidents occur.

DO NOT deny food as punishment or give food as a means of reward.

DO NOT relate discipline to eating, resting, or sleeping.

DO NOT leave the children alone, unattended, or without supervision.

DO NOT place the children in lucked rooms, closets, or boxes as punishment.

DO NOT allow discipline of children by children.

DO NOT criticize, make fun *or,* or otherwise belittle children's parents, families, or ethnic groups.

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.

DO NOT withhold or require physical activity, such as running laps and doing push-ups, as punishment.

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 CENTER'S DISCIPLINE AND BEHAVIOR MANAGEMENT POLICY AND THAT THE CENTER'S DIRECTOR COORDINATOR (OR OTHER DESIGNATED STAFF MEMBER) HAS DISCUSSED THE CENTER'S DISCIPLINE AND BEHAVIOR MANAGEMENT POLICY WITH ME.

DATE OF CHILD'S ENROLLMENT: _____

SIGNATURE OF PARENT OF GUARDIAN: _____ DATE_____

SIGNATURE OF DIRECTOR: _____ DATE_____

Distribution: one copy child's parent/one copy child's folder

STANDARD PHOTOGRAPHY RELEASE FORM

I,

_____

Parent/guardian of _____

DO _____ DO NOT_____

hereby grant to the Logan Community Day Care the unlimited right to use and/or reproduce photographs, likenesses, or the voice of my child in any legal manner for the external promotional/informational activities of the Logan Community Day Care.

I also AGREE_____ DO NOT AGREE_____

to allow my child to be interviewed and/or photographed by representatives of the external news media in relation to any and all coverage of the Logan Community Day Care in which they are involved.

I further understand that by signing the release, I waive any and all present, or future, compensation rights to the use of the above stated material(s).

_____ _____

(SIGNATURE OF PARENT/GUARDIAN) (DATE)

AFFIDAVIT OF ACKNOWLEDGEMENT//RECEIPT

CHILD' NAME & DATE OF ENROLLMENT_____

Parent Handbook and NC Child Care Law & Rules Form

I have received a copy of the Logan Community Parent Handbook, information about developmental milestones/screenings, and the North Carolina Child Care Law & Rules form. I have read and discussed the parent handbook with the director/administration, including the Parent Participation Plan, Safe Sleep Policy (if applicable), Biting policy, and sanitation rule for bottled beverages brought from home.

_____ _____

Parent Signature Date

SHAKEN BABY SYNDROME & ABUSIVE HEAD TRAUMA POLICY

I acknowledge that I have received and read, understand, and been given a copy of the ***Shaken Baby Syndrome (Abusive Head Trauma, and Child Maltreatment) policy.***

_____ _____

Print name of parent/guardian Date

_____ _____

Signature of parent/guardian Date

SMOKING AND TOBACCO RESTRICTION

I am aware that Logan Community CDC is a smoke free environment and I may not smoke or use tobacco products within 50 feet of the entire premises.

_____ _____

Signature Date

COMMUNICABLE DISEASE POLICY

If a child or staff member has a Communicable Disease, they must be removed from the center's environment immediately.
Upon their return, the child or staff member must have a written excuse from the doctor.

_____ _____

(Parent or Guardian) **(Date)**

LOGAN COMMUNITY CDC
ESTABLISHED SINCE 1936
Helping Families Succeed

CHECK LIST FOR READINESS

CHILD'S NAME_____ DATE OF BIRTH_____

Check what applies to your child:

- ☐ Toilet trained
- ☐ Feeds self
- ☐ Needs help feeding self
- ☐ Eats almost all foods
- ☐ Eats very few foods
- ☐ Has temper tantrums
- ☐ Teases other children
- ☐ Overactive
- ☐ Highly excitable
- ☐ Timid and/or shy
- ☐ Plays well with others
- ☐ "Picked on" by others
- ☐ Overly aggressive
- ☐ Cries easily
- ☐ Has many fears
- ☐ Has few interests
- ☐ Has many interests
- ☐ Is attentive
- ☐ Cares for own property
- ☐ Follows requests
- ☐ Initiates owns actions
- ☐ Speech impediment*
- ☐ Does not speak
- ☐ Speaks in sentences
- ☐ Seldom speaks
- ☐ Speaks understandably

*Please explain in the comments section

My child needs to:

- ☐ Become self-reliant
- ☐ Get interested in something
- ☐ Become cooperative
- ☐ Adjust to other children
- ☐ Other:_____
  _____
- ☐ Acquire manual/motor skills
- ☐ Relax
- ☐ Become more active
- ☐ Become less active

Comments_____

_____

_____

Signature of Parent/Guardian:_____Date:_____

Special note: This form allows the teacher to know the concerns and expectations of the parent/guardian. It also allow parents to have a say in their child's education and appreciate the teacher's concerns.

CONSENT TO REFERRAL TO THE DAY CARE NURSE

The Day Care Nurse is provided by Cabarrus Health Alliance, Glaxco Welcome and The Cabarrus Partnership for Children. The Day Care Nurse is a Registered Nurse assigned to childcare centers and NC Pre K programs. Your child's teacher or other staff may refer your child to the nurse for a health evaluation (such as a vision or hearing screening, development or behavior, or health and safety issues). You will be informed of any identified concerns. In the event of suspected communicable diseases, (e.g. head lice, scabies, chicken pox, etc.) all identified students will be evaluated by the nurse at the request of the school staff.

PLEASE COMPLETE THIS CONSENT FORM. IT WILL REMAIN IN EFFECT WHILE YOU CHILD ATTENDS LOGAN COMMUNITY CDC OR UNTIL YOU DECLINE THIS SERVICE.

AUTHORIZATION

I give my consent for my child to be referred to the Daycare Nurse as deemed necessary by Logan CDC:

☐ YES ☐ NO

Child's Name_____

Parent/Guardian Signature_____

Phone: (Home)_____(Work)_____

(Please list at least one phone number in case we need to reach you regarding results of your child's screening.)

I give the Day Care Nurse permission to contact my child's doctor to request or give information, which might benefit my child's health.

☐ YES ☐ NO

Child's Physician _____ Office Phone_____

Date_____

TRAVEL AND ACTIVITY AUTHORIZATION

[X] BLANKET PERMISSION FOR THIS ACTIVITY

I, _____parent/guardian
of
(Name of Parent/Guardian)

_____give my permission to

Transportation to and from school (if applicable)

Logan Community CDC for my child to participate in the following activities:

Developmentally appropriate supervised activities:
Mr. Music, Sign Language, etc.

Supervised Aquatic Activties (4-12 years old only)
Camp Spencer, YMCA, Happy Lake, Etc.

Please note that this is only authorization to participate in an aquatic activity. You will will be required to sign a field trip permission form for any scheduled aquatic activity field trip.

Field trips away from the facility (Walking Only):

Caldwell Park, Logan Multi Purpose Center, Nature or leisure walks, etc.

In addition, I give permission to Logan Community Day Care for my child to participate in planned activities outside the fenced area of the facility, and to participate in developmentally appropriate supervised activities inside or outside the fenced area.

[ ] I will allow my child to play outside the fenced area; or

[ ] I will not allow my child to play outside the fenced area.

****Any field trip that requires transportation will need a field trip authorization form***

_____
Parent/Guardian Signature

_____
Date Signed

This authorization is valid for the duration of my child's enrollment

LOGAN COMMUNITY CDC
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P.O. Box 812
Concord, NC 28026
185 Rone Avenue
Concord, NC 28025

Phone: 704.786.8800
Fax: 704.786.3645

Arrival and Departure Schedule

Child's Name:

Name: _____

Name: _____

Arrival Time: _____ a.m.

Departure Time: _____ p.m.

Parent/Guardian/Person Drop off List

1. _____
2. _____
3. _____

Parent/Guardian Pick-up List (*Note: *if under 18 years old, must be over 12 years of age with an adult in the vehicle)*

1. _____
2. _____
3. _____

The center hours of operation are 6:00 a.m. – 5:00 p.m.

There is a late fee of $2.00 per minute if arrival time is after 5:00 p.m.

Please sign and date below. Thank You

Parent's Name (print) _____

Parent's Signature _____

Date: _____

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Contract of Agreement for Child Care

Parent or Guardian

Child's/Children's Name (s)

Fee……$_

Fee Supplemented by Department of Social Services……...$_____

Fee to be paid by parent……..$

I agree to pay the beginning fee of $_____(two weeks in advance) for

the care of my child/children_____.

Thereafter, I will pay ***IN ADVANCE***:

$_____per week

$_____per two weeks

$_____per month (by 10th of month)

I understand that if I fail to live up to this contract, my child will be TERMINATED automatically from the center.

**Please note that your fee may increase at any time. You will be given notice of the fee change as soon as possible.

_____ _____
Signature – Parent or Guardian Date

_____ _____
Signature & Title Date

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Fax: 704.786.3645

TO ALL PARENTS/GUARDIANS OF CHILDREN ATTENDING LOGAN COMMUNITY CDC:

Below details the LATE FEE POLICY for Logan Community CDC:

The Center's hours of operation are from 6a until 5p, Monday through Friday. If the pick up time is after 5p that is considered late, unless you are already in the car line. The late fee is $2 per minute. Note: If you have been issued a voucher you are expected to follow the hours of arrival and departure specified by Department of Human Services.

Late Fee Payment is expected the next day or by the next day that your child returns to school.

Please give your late fee payment to the person who is at the door at that time. They will provide you with an envelope to fill out. Please specify that you are paying the late fee and the amount.

****Habitual tardies may result in suspension or termination from the center. Please be mindful of the hours of operation and thank you in advance for your cooperation.**

Regards,
Logan Community CDC Administration

PLEASE SIGN AND DATE BELOW THAT YOU HAVE BEEN MADE AWARE OF THE LATE FEE POLICY.

Parent/Guardian Name _____

Parent/Guardian Signature _____

Date _____