CHRIST LUTHERAN CHILDREN'S CENTER **4519 Providence Road** **Charlotte, NC 28226** **704-365-8687 / 704-366-6958 Fax** **www.christelca.org**	Enrollment Date_____________ Class______________________ Christ Lutheran Church member? Yes No

Child's Name____Birthdate_______________
LAST FIRST M.I. NICKNAME

Address____ Phone___________________________
____

FATHER/GUADRIAN

Name____ Home Phone________________________
Address____
Employer____ Business Phone_____________________
Car Phone____ Cell. Phone_________________________

MOTHER/GUARDIAN

Name____ Home Phone________________________
Address____
Employer____ Business Phone_____________________
Car Phone____ Cell. Phone_________________________

EMERGENCY INFORMATION

Child's Doctor____ Phone__________________________
Child's Dentist____ Phone__________________________
Hospital Preference_____________________________________
Insurance Carrier_______________________________________ Policy #________________________
Any Known Allergies____

In the event that neither parent/guardian can be contacted, call:
Name____ Relationship______________________
Home Phone____ Work Phone_______________________

Name____ Relationship______________________
Home Phone____ Work Phone_______________________

If you cannot pick up your child, list the names and relationship of persons to whom your child may be released: ____
____

I agree that the operator may authorize the physician of his/her choice to provide emergency care.

____
Parent's Signature Date

I, as the operator, do agree to provide transportation to an appropriate medical resource in the event of an emergency. In an emergency, other children in the facility will be supervised by a responsible adult. I will not administer any medication without specific instructions from the physician or the child's parent/ guardian. Provisions will be made for adequate and appropriate rest and outdoor play.

____
Operator's Signature Date

Personal & Family History

Family Information:

Siblings (Names and Ages)____
____
____
____

Other persons living in the home and relationship:_______________________________
____
____
____

Are there any medical problems of which we should be aware?______________________
____
____

Has this child had previous group or preschool experience? Explain.__________________
____
____

Please give any information concerning your child which will be helpful in his or her experience in a group setting:

Eating Habits-____
____

Sleeping Habits-____
____

Fears-____
____

Special Likes & Dislikes-____
____

Other-____
____

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, for 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 _____ Follow up _______

Developmental Evaluation: Delayed _______ Age Appropriate _______
If delayed, note significance and special care needed: ______________________________________
____

Should activities be limited? No ______ Yes ______ If yes, explain: ______________________________
____
____

Date of Examination ________________________________

Signature of Authorized Examiner/Title ______________________________ **Phone** ______________

Immunization History

Name: ____ Date of Birth: ____________________

Enter the date an immunization was received in the space below or attach a copy of the immunization record. G.S. 130A-155(b) requires all child facilities to have this information on file.

Enter date if each dose – Month/Day/Year

VACCINE	#1	#2	#3	#4	#5
***DTP/DT (circle which)**					
***Polio**					
****Hib**					
*****Hepatitis B**					
***MMR (combined doses)**					
Other ______________					
Other ______________					

* Required by State law.
** Required by State law for children born on or after 10/1/88.
*** Required by State law for children born on or after 7/1/94.

____

Records Updated by:	Date Updated:

New Rules for Administering Medication

Effective immediately, Christ Lutheran Children's Center (CLCC) will administer medication to children in the CLCC full-day program only and on the terms and conditions below. CLCC will no longer administer any medication to children in the half-day program. Notwithstanding the terms and conditions described below, CLCC reserves the right at any time to refuse to administer any medication for any reason to any child in the full-day program.

To administer any medication to a child in the full-day program, the following requirements most be satisfied:

1. all medications must be in the original container and, if a prescription, bear a legible pharmacist label;

2. prescription medication may be administered only to the child for whom the medication was prescribed and whose name appears on the pharmacist's label;

3. a medication that has been mixed will not be administered;

4. a medication will not be administered for non-medical reasons (such reasons to include but not limited to inducing sleep);

5. a medication will not be administered beyond the expiration date of the medication;

6. a medication will not be administered without a written authorization from the parent or legal guardian, which written authorization must include and satisfy the following:

    - the child's name, date of birth and weight, the specific name of the medication, the dosage instructions (including how much to administer and when), any special storage or administration instructions, and the length of time during which the medication is to be administered;

    - the parent or legal guardian must sign and date the written authorization;

    - medication may be administered in accordance with the written, dated and signed instructions from a medical doctor or other authorized healthcare professional provided such written instructions include the pertinent information and the child's name and such instructions are countersigned and dated by the parent or legal guardian;

    - written instructions that require over-the-counter medication to be administered in excess of the amount and/or frequency of dosage specified in the printed instructions on the medicine or label will not be accepted unless a doctor or other authorized healthcare professional provides written dosage instructions that include the child's name and are signed and dated by the medical doctor or other authorized healthcare professional and such written instructions are countersigned and dated by the parent or legal guardian;

    - if there are no dosage instructions on the label of a prescription medication, the written authorization must include written dosage instructions from the prescribing medical doctor or other authorized healthcare professional that include the child's name and are signed and dated by the medical doctor or other authorized healthcare professional and such instructions are countersigned and dated by the parent or legal guardian;

    - each medication to be administered will require a separate written authorization;

    - no medication will be administered contrary to the written authorization and written instructions;

- no written authorization will be accepted that states the medication is to be given "as needed", provided, however, (a) a blanket permission may be given for up to 6 months to authorize the administration of medication for asthma and allergic reactions provided the written authorization includes a detailed explanation of when the medication is to be administered (i.e., it must describes symptoms the child will exhibit if having an asthma attack or allergic reaction and how CLCC is to respond) and (b) a blanket permission for up to 1 year may be given to authorize the administration of sunscreen, insect repellant and over-the-counter diapering creams;

- all medications, written authorizations and written instructions are to be dropped off to the Director (or, in her absence, the assistant director) of CLCC is satisfied that all of the requirements regarding the administration of medication are satisfied;

- teachers will no longer be authorized to accept medications, written authorizations and/or written instructions;

- no medications will be administered beyond the time period stated in written authorization and written instructions;

- all medications will be returned to the parent or legal guardian after the course of treatment specified in the written authorization; a note will be placed in your child's box or folder and the medication will be thrown away if not picked up within 1 week; and

- for any medication that is to be administered longer than 1 month, the parent or legal guardian must update the written authorization on a monthly basis to include the current age and weight of the child and updates of any other pertinent information; and

7. medications that are to be administered 1 or 2 times per day will not be administered by CLCC (these are medications such as cough syrup, decongestant, etc. that may be administered by the parent or legal guardian without involving CLCC);

8. Tylenol and other similar medications will not be administered for children over the age of 2; for children under the age of 2, such medication may be administered for teething only;

9. if there are any questions or doubts about whether or how to administer medication, CLCC may at any time require (a) written instructions or supplemental written instructions from a medical doctor or other authorized healthcare professional that include the pertinent information and are signed and dated by the medical doctor or other authorized healthcare professional and such instructions or supplemental instructions are countersigned and dated by the parent or legal guardian or (b) any other documents, instructions or certifications it may deem necessary, appropriate or advisable;

10. CLCC assumes no duty or obligation to verify whether a person is a medical doctor or other authorized healthcare professional or whether written instructions provided by a parent or legal guardian are in fact from a medical doctor or authorized healthcare professional. This is the parent's or legal guardian's responsibility. A parent's or legal guardian's counter signature to any written instructions shall be deemed to be a certification from the parent or legal guardian that the person providing the instructions is a medical doctor or other authorized healthcare professional;

11. notwithstanding the fact that all requirements for administering medication are satisfied, CLCC may at any time refuse to administer the medication or at any time discontinue the administration of the medication for any reason; and

12. these rules remain subject to change at any time in the sole discretion of CLCC.

Medication Policy

I have received a copy and reviewed the New Rules for Administering Medication Policy. I understand that as a parent of Christ Lutheran Children's Center I shall acknowledge and respect all the rules and standards noted in the policy. I also understand that in the event any changes are made to the existing policy, I will be notified at least 30 days prior the official adoption of rules and standards by the facility.

____

Parent's Signature Date

Christ Lutheran Children's Center
Discipline and Behavior Management Policy

Praise and positive reinforcement are effective methods of the behavior management of children. When children receive positive, non-violent, and understanding inactions 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 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 misbehavior.
10. DO explain things to children on their levels.
11. DO use short supervised periods of "time-out".
12. DO stay consistent in our behavior management program.

We:

1. DO NOT spank, shake, bite, pinch, push, pull, slap or otherwise physically punish the children.
2. DO NOT make fun of, yell at, threaten, make sarcastic remarks about, use profanity or otherwise verbally abuse the children.
3. DO NOT shame or punish the children when bathroom accidents occur.
4. DO NOT deny food or rest as punishment.
5. DO NOT relate discipline to eating, resting or sleeping.
6. DO NOT leave the children alone, unattended or without supervision.
7. DO NOT place the children in locked rooms, closets or boxes as punishment.
8. DO NOT allow discipline of children by children.
9. DO NOT criticize, make fun of, or otherwise belittle children's parents, families or ethnic groups.

I, the undersigned parent or guardian of _______________________________, do hereby state that I have read and
(Child's Full Name)
received a copy of the facility's Discipline and Behavior Management Policy and that the facility's director/coordinator (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

Institution Name: ____ **Agreement Number:** _____________

Facility/ Provider Name: ____

Child and Adult Care Food Program (CACFP)
Participant Enrollment Form

Dear Parent/Guardian,
Your day care facility participates in the U.S. Department of Agriculture (USDA) Child and Adult Care Food Program (CACFP). The enrolled participant will receive nutritious meals and snacks at no cost to you. CACFP needs verification of enrollment for each participant in this facility. Please fill out the parent/guardian section of this form, sign it and return it to the above facility/provider. Provide information for one participant per section. **(In order for the institution to receive reimbursement for meals served/claimed, this form must be completed for each enrolled participant annually.)**

Parent/Guardian:
Participant's Name: _________________________________ Date of Birth: ________________________ Age: ____________
Sex: Male ___ Female ___ Date participant enrolled in facility: ___________________________
Food Allergies: Yes __ No __ If yes, specify: ____
(If the participant cannot be served the CACFP Meal Pattern, a statement from participant's health Care Provider must be provided.)

Check Days of Normal Care at facility: _ Sunday _ Monday _Tuesday _ Wednesday _ Thursday _ Friday _ Saturday

Check meals normally eaten at facility: _ Breakfast _ AM Snack _ Lunch _PM Snack _ Supper _Evening Snack

Please list the normal times of arrival and departure **(check am or pm): Arrive:** _____ _ am _ pm Depart**:** ____ _am _pm

<u>If participant an infant (0-11 months), please complete this box. Check all applicable choice(s) below:</u>

This institution/facility offers ______________________________ **formula for infants through the CACFP. It your choice**
(To be completed by facility/provider)
whether or not to use this formula based on your infant's needs. Baby foods provided by the institution/facility must be in compliance with the infant meal pattern as required by 7CFR 226.20.

_ I will use formula offered by this facility. I give permission for the formula to be mixed and/ or bottles to be prepared for my infant by this facility's staff.
_ I will <u>not</u> use the formula offered by this facility.
If not, which formula will you send for your infant? _____________________________________
If the formula you provide is a special formula, a medical statement must be submitted.

_ I will provide breastmilk for my infant.

_ My infant is (4) months old or older and is developmentally ready for baby foods. I want the institution/facility to provide the following baby food(s) for my infant, which is/are allowed under 7CFR 226.20 (b)(2)(3)(4). ____
____

Note to parents who are getting formula through the WIC Program: Your baby is eligible to get formula from this child care institution /facility as well as from the WIC Program. It is your decision which formula you want your baby to use when she/he is at child care. If you find you are getting more formula than your baby needs, you may wish to talk with your WIC nutritionist or your child care provider

Parent/Guardian Signature: ____ **Date:** ______________________________

Print Name: ____

Address: ____________________________________ **City:** ______________________________ **State:** ______ **Zip Code:** __________

Home Telephone Number: __________________________

Work Telephone Number: __________________________ **Check Work Shift:** ___ **1st** ___ **2nd** ___ **3rd** ___ **Other (Specify)** _________

For Facility/Provider Use Only:

Signature of Facility Representative/Provider: ____________________________________ Date __________________________

Date the participant withdrew: ____

In accordance with Federal Law and U.S. Department of Agriculture policy, this institution is prohibited from discriminating on the basis of race, color, national origin, sex, age or disability. To file a complaint of complaint of discrimination, write USDA, Director, Office of Civil Rights. Room 326-W. Whitten Building, 1400 Independence Avenue, SW, Washington, DC 20250-9410 or call (202) 720-5964 (voice and TD). USDA is and equal opportunity provider and employer.

AUTHORIZATION FOR AUTOMATIC DRAFT

Account Holder: **Christ Lutheran Children's Center**
4519 Providence Road
Charlotte, NC 28226

Financial Institution: **Park Sterling Bank**
Charlotte, NC

Transfer From

Account Type: ____

Account Number: ____

Type of Transfer: **Specific Amount Between Deposit Accounts**

Transfer: **Specific Amount**

Amount: _________________________

Transfer To

Account Type: **Checking**

Account Number: ____

Instructions

Beginning Date: ____

Frequency Half Day: **Monthly**

Frequency Full Day (Circle one): **Weekly** **Monthly**

Limitations: _____________________________________

Special Instructions or Provisions: ____

Authorization

Account Holder hereby authorizes you to make the transfer (s) indicated above until further notice from Account Holder. If this agreement changes any prior authorization between you and Account Holder, the prior authorization is hereby cancelled, and Account Holder instructs you to follow this authorization. Account older further acknowledges that you have no responsibility to contact Account Holder when the above transfer (s) occur (s). Account Holder understands that Account Holder can call you to find out whether or not the transfer has been made. Account Holder understands that it is Account Holder's responsibility to have sufficient funds available in Account Holder's account on the transfer date (s) in order for you to make the automatic payment (s). Account Holder acknowledges that if sufficient funds are available in Account Holder's account to cover the amount of the transfer (s), the automatic payment (s) may not be made. Account Holder further acknowledges that the Financial Institution will not be liable for any charges, including but not limited to, any charges related to items returned because of insufficient funds, or for any late charges or additional interest if this authorization is for automatic loan payment (s).

ACCOUNT HOLDER:

X ____ ________________________ ______________________________

Authorized Signer Date Phone Number

EMERGENCY FORM

PLEASE PRINT INFORMATION

CHILD'S NAME ______________________________

CHILD'S CLASS ______________________________

DAD'S NAME ______________________________

DAD'S WORK ADDRESS (BUILDING) ______________________________

DAD'S HOME # ________________ **DAD'S WORK #** ______________________________

DAD'S E-MAIL __________________ **DAD'S CELL #** ______________________________

MOM'S NAME ______________________________

MOM'S WORK ADDRESS (BUILDING) ______________________________

MOM'S HOME # ___________________ **MOM'S WORK #** ______________________________

MOM'S E-MAIL ______________________ **MOM'S CELL #** ______________________________

PLEASE LIST 4 PEOPLE AND THEIR PHONE NUMBERS WITH WHOM YOUR CHILD MAY BE RELEASED TO DURING THIS TIME. (THESE PEOPLE NEED TO BE CLOSE TO CLCC SO WE ARE ABLE TO REACH THEM QUICKLY.)

1. ______________________________
2. ______________________________
3. ______________________________
4. ______________________________

WHAT ALLERGIES OR MEDICAL CONDITIONS DOES YOUR CHILD HAVE?

____

CHRIST LUTHERAN CHILDREN'S CENTER HAS MY PERMISSION TO USE ANY MEANS NECESSARY TO PROTECT, HELP OR AID MY CHILD IN ANY EMERGENCY SITUATION THAT MIGHT OCCUR.

____

PARENT'S SIGNATURE **DATE**

Christ Lutheran Childrens Center
4519 Providence Road
Charlotte, NC 28226
704-365-8687 / 704-366-6958 Fax
Website: www.christelca.org

INTERNET PICTURE RELEASE FORM

______ I give CLCC permission to take pictures of my child and place them on their website.

______ I do not give CLCC permission to take pictures of my child and place them on their website.

____
Child's Name

____
Mother's Signature

____
Father's Signature

KEYFOB ORDERS

The Children's Center has a security system at each entrance to the Center (except for the playground door). Each family will need a "keyfob" to get in each of the Center's doors. Your keyfob can go on your keychain for easy access. You simply hold the keyfob in front of the security system panel located at each door.

Any person who picks up your child on a regular basis (ex. nannies, grandparents, etc.) will need a keyfob. An uncle or neighbor that rarely picks up will not need one. You may request up to five keyfobs. Most families will only need 2 keyfobs (one for each parent). There is a $10.00 fee for each keyfob. This is a refundable fee upon withdrawing from the Center and return of keyfob. If your keyfob is lost, your fee will not be refunded. You will need to notify the office as soon as possible and request another keyfob for $10.00.

Please fill out the bottom of this form and return with your check. Your check needs to be separate from your tuition or registration check. If you have automatic draft you will need to write a check. You will need to list each person that getting a keyfob.

Name

Keyfob# 1: ____ $10.00 ______

Keyfob# 2: ____ $10.00 ______

Keyfob# 3: ____ $10.00 ______

Keyfob# 3: ____ $10.00 ______

Keyfob# 4: ____ $10.00 ______

Keyfob# 5: ____ $10.00 ______

Child's Name: ____________________________________ TOTAL: ______

OFFICE USE ONLY:

NOT PAID
PAID AMOUNT:
CHECK #
CASH $
DATE ISSUED:

Christ Lutheran Children's Center Health Care Policies

If your child has any of the following symptoms, we will contact you to pick up your child from the Center (children should be picked up immediately). CLCC understands that it is difficult for a parent to leave or miss work, therefore, it is suggested that a backup plan for childcare should be arranged in advance.

Children with the following symptoms must remain home the next full day and be symptom free for at least 24 hours.

- Temperature of 101 or higher
- Vomiting
- Diarrhea or very loose stools inconsistent with usual bowel movements
- Any contagious illness
- Any symptoms requiring one-on-one and/or causing severe discomfort
- Any open, oozing sores, bacterial infection and/ or bloody gums
- Surgery (tubes, shunts, etc.)-your child can not return to the center until 24 hours after the surgery.
- A child that has been given an enema must remain at home for 24 hours before returning to school.

If your child has a runny green nose for 10 consecutive school days the Center will require documentation from the pediatrician with a diagnosis before returning to school.

When the child has been out one full day and is returning to school after an illness, please remember the following:

- A child must be fever free (without medication), vomiting, diarrhea and other symptoms for 24 hours prior to returning to school.
- A child must be able to participate in all activities when returning to school (this includes outdoor and gym activities).
- Chicken Pox lesions must be completely dry and child must have no other symptoms
- Children on prescription medication for a contagious illness must take it for 24 hours before returning to school.
- If your child has a rash, they may not come to school without a physician's note.

The teachers will give a courtesy call for those children that are running a low grade fever (between 99 & 100.9). Parents may not come in and administer any kind of fever reducers, due to the fact that you may be masking a serious illness (ex. Strep Throat, Ear Infection, Virus, etc.).

We do not administer medications to children in the half day programs.

Any exceptions to this policy will be at the discretion of the Center's administrators.

I have read and will abide by this policy.

______________________________ ______________________________

Parent's Signature **Director's Signature**

Field Trip Permission

Date: ___________________________

My child _________________________________ has permission to participate in field trips by foot, both on and off the premises of Christ Lutheran Children's Center from the time of the signing of this form. These walks or buggy rides are planned as part of our curriculum.

NORTH CAROLINA CHILD CARE LAW & RULES

This is to acknowledge that I have read and understand the content of the North Carolina Child Care Law and Rules.

____

Parent's Name   Date

PARENT HANDBOOK

I have received a copy and reviewed the parent handbook. I also understand that as a parent of Christ Lutheran Children's Center I shall acknowledge and respect all the rules and standards noted in the handbook. I also understand that in the event any changes are made to the existing handbook, I will be notified in writing at least 30 days prior to the official adoption of the rules and standards by the facility.

____

Parent's Signature/Date