

**CHRIST LUTHERAN CHILDREN'S CENTER**

**4519 Providence Road  
Charlotte, NC 28226  
704-365-8687 / 704-366-6958 Fax**

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) \_\_\_\_\_

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Other persons living in the home and relationship: \_\_\_\_\_

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Are there any medical problems of which we should be aware? \_\_\_\_\_

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Has this child had previous group or preschool experience? Explain. \_\_\_\_\_

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

Eating Habits- \_\_\_\_\_

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Sleeping Habits- \_\_\_\_\_

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Fears- \_\_\_\_\_

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Special Likes & Dislikes- \_\_\_\_\_

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Other- \_\_\_\_\_

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# 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 \_\_\_\_\_



# 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.



## 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

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Charlotte, NC 28226

704-365-8687 / 704-366-6958 Fax

Website: [www.christelca.org](http://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.

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**Child's Name**

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**Mother's Signature**

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**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.

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### 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 your pediatrician with a diagnoses 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.

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Parent's Signature

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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.

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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.

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Parent's Signature/Date

