JUMP START UNIVERSITY EARLY LEARNING CENTER
CHILD CARE APPLICATION FOR ENROLLMENT

To be completed, signed and placed on file in the facility on the first day of enrollment. Application to be updated as changes occur and annually.

STUDENT INFORMATION

Date of Birth: _____ Sex: _____

Date of Application: _____ Date of Enrollment: _____

Full Name: _____
Last First Middle Nickname

Child's Physical Address: _____

FAMILY INFORMATION

Child Lives With: _____

Mother's Name:		Father's Name:	
Address:		Address:	
Cell Phone:		Cell Phone:	
Work Phone:		Work Phone:	
DL: State/Number		DL: State/Number	
Email Address:		Email Address:	

HOW DID YOU HEAR ABOUT US?

Google: ☐ Facebook or Instagram: ☐ Community Event: ☐ Family/Friend: ☐ Other: _____

CONTACTS:

Child will be released only to the custodial parent/legal guardian and the persons listed below. The following people will also be contacted and are authorized to remove the child from the facility in case of illness, accident or emergency, if for some reason, the custodial parent or legal guardian cannot be reached:

Name	Relationship	Address	Contact Number

EMERGENCY MEDICAL CARE INFORMATION:

I hereby grant permission for the staff of this facility to contact the following medical personnel to obtain emergency medical care if warranted.

Doctor: _____ Address: _____ Phone: _____

Dentist: _____ Address: _____ Phone: _____

Hospital Preference: _____ Phone: _____

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 a health care professional.
Is there a Medical Action Plan attached? ☐ Yes ☐ No

List any allergies, the symptoms and type of response required for allergic reactions:

List any health care needs or concerns, symptoms and type of response for these health care needs or concerns:

List any particular fears or unique behavior characteristics the child has:

List any medication taken for health care needs:

List any other information that has a direct bearing on assuring safe medical treatment for your child:

I, as the parent/guardian, authorize the center to obtain medical attention for my child in an emergency.

I, as the operator, do agree to provide transportation to an appropriate medical resource in the event of an 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/legal guardian.

_____ _____

Signature of Parent/Guardian *Date* *Signature of Administrator* *Date*

JUMP START UNIVERSITY EARLY LEARNING 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 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 facility will practice the following discipline and behavior management policy: We:

DO	DO NOT
1. DO use effective guidance and behavior management techniques that focus on a child's development.	1. DO NOT make fun of, yell at, threaten, make sarcastic remarks about, use profanity, or verbally abuse the children.
2. DO treat the children as people and respect their needs, desires, and feelings.	2. DO NOT criticize, make fun of, or otherwise belittle children's parents, families or ethnic groups.
3. DO provide the children with natural and logical consequences of their behaviors.	3. DO NOT place the children in locked rooms, closets, or boxes as punishment.
4. DO modify the classroom environment to attempt to prevent problems before they occur.	4. DO NOT spank, bite, pinch, pull, slap or otherwise physically punish the children.
5. DO use short supervised periods of time-out sparingly.	5. DO NOT shame or punish the children when bathroom accidents occur.
6. DO provide alternatives for inappropriate behavior to the children	6. DO NOT leave the children alone, unattended, or without supervision.
7. DO stay consistent in our behavior management program.	7. 7. DO NOT allow discipline of children by children.
8. DO listen to the children	8. DO NOT relate discipline to eating, resting, or sleeping.
9. DO praise, reward and encourage the children	9. DO NOT deny food or rest as punishment.
10. DO explain things to children on their levels.	
11. DO ignore minor misbehaviors.	
12. DO reason with and set limits for the children.	
13. DO model appropriate for the children.	

Time-Out is the removal of a child for a short period of time (3-5 minutes) for a situation in which the child is misbehaving and has not responded to other discipline techniques. The "time-out space" is usually an area located away from the group 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 appropriated 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 to the children.

I, _____, the undersigned parent of _____(child's 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 Enrollment: _____

_____

Signature of Parent/Guardian Print Name Date

JUMP START UNIVERSITY EARLY LEARNING CENTER

ACKNOWLEDGEMENT OF RECEIPT OF POLICIES

I, _____, parent of _____acknowledge that I have read and received the following information and will consent to the information below:

Documentation of Receipt of Polices
issued to me upon enrollment. I understand as a parent that the Parent Handbook may change during the year and I will be informed as to any changes so to revise my existing Parent Handbook. I am aware that I have access to immediate revisions of the Parent Handbook on the website and that I can also review a revised copy at any time at the facility. I agree to abide by the guidelines set forth in the Parent Handbook. I understand that failure to do so may result in termination of care. Parent's Initial: _____
Travel and Activity Authorization
I give permission to Cozy Corner CDC for my child to participate in planned field trips away from the facility. I understand that the facility will use the appropriated child restraint device and abide by all safety rules in Rule 1100 when my child is transported in a vehicle. The facility will also notify me of each planned field trip that would involve transportation. In addition, I will also allow my child to participate in activities that take place outside the fenced area of the facility. Parent's Initial: _____
Media Consent Release and Waiver
I hereby give Cozy Corner CDC consent to take and use photo and video images of my child. Such use includes the display, distribution, publication, transmission or other use of photographs and images and/or videos take of my child for the use in materials that include but not limited to printed materials, such as brochures and newsletters, videos, and digital images. Parent's Initial: _____
Prevention of Shaken Baby Syndrome and Abusive Head Trauma
I acknowledge that I have received a copy of the facility's Shaken Baby Syndrome and Abusive Head Trauma policy. Parent's Initial: _____
Documentation of Childcare Summary Laws
I have received an electronic copy of the Childcare Summary Laws and understand its contents. I agree to abide by the guidelines set forth in this policy and the Parent Handbook. I understand that failure to do so may result in termination of care. Parent's Initial: _____
Smoke-Free Facility
I have been notified through the Parent Handbook that this is a smoke-free facility. This includes the building, grounds, and buses. This also includes vaping and all tobacco free products. Parent's Initial: _____
Free Books Registration
I would like to sign my child(ren) up to receive FREE books through Dolly Parton's Imagination Library. Yes ☐ No ☐
Orientation
I acknowledge that policies have been reviewed and orientation has been completed. Parent's Initial: _____ Director's Initial: _____

_____ _____ _____

Signature of Parent Print Name Date

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 #**_____

Prevention of Shaken Baby Syndrome and Abusive Head Trauma

Parent or Guardian Acknowledgement Form

I, the parent or guardian of _____, (child or children's name) acknowledge that I have read and received a copy of the facility's Shaken Baby Syndrome/Abusive Head Trauma Policy.

_____ _____

Date Policy Given/Explained to Parent/Guardian Date of Child's Enrollment

_____

Print Name of Parent/Guardian

_____ _____

Signature of Parent/Guardian Date