

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. 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 or 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

Infant/Toddler Safe Sleep Policy

A safe sleep environment for infants reduces the risk of sudden infant death syndrome (SIDS) and other sleep related infant deaths. According to N.C. Law, child care providers caring for infants 12 months of age or younger are required to implement a safe sleep policy and share the policy with parents/guardians and staff.

Jump Start University Early Learning Center (facility name) implements the following safe sleep policy:

Safe Sleep Practices

1. We train all staff, substitutes, and volunteers caring for infants aged 12 months or younger on how to implement our Infant/Toddler Safe Sleep Policy.
2. We always place infants under 12 months of age on their backs to sleep, unless:
 - **the infant is 6 months or younger** and a signed ITS-SIDS Alternate Sleep Position Health Care Professional Waiver is in the infant's file and a notice of the waiver is posted at the infant's crib.
 - **the infant is 6 months or older** (choose one)
 - ☒ We do not accept the ITS-SIDS Alternate Sleep Position Parent Waiver.*
 - ☐ We accept the ITS-SIDS Alternate Sleep Position Parent Waiver.

We retain the waiver in the child's record for as long as they are enrolled.
3. We place infants on their back to sleep even after they are able to independently roll back and forth from their back to their front and back again. We then allow the infant to sleep in their preferred position.
 - ☒ We document when each infant is able to roll both ways independently and communicate with parents. We put a notice in the child's file and on or near the infant's crib.*
4. We visually check sleeping infants every 15 minutes and record what we see on a Sleep Chart. The chart is retained for at least one month.
 - ☒ We check infants 2-4 month of age more frequently.*
5. We maintain the temperature between 68-75°F in the room where infants sleep.
 - ☒ We further reduce the risk of overheating by not over-dressing infants*
6. We provide infants supervised tummy time daily. We stay within arm's reach of infants during tummy time.
7. We follow N.C Child Care Rules .0901(j) and .1706(g) regarding breastfeeding.
 - ☐ We further encourage breastfeeding in the following ways:*

Safe Sleep Environment

8. We use Consumer Product Safety Commission (CPSC) approved cribs or other approved sleep spaces for infants. Each infant has his or her own crib or sleep space.
9. We do not allow pacifiers to be used with attachments.
10. Safe pacifier practices:
 - ☒ We do not reinsert the pacifier in the infant's mouth if it falls out.*
 - ☒ We remove the pacifier from the crib once it has fallen from the infant's mouth.*
11. We do not allow infants to be swaddled.
 - ☒ We do not allow garments that restrict movement.*
12. We do not cover infants' heads with blankets or bedding.
13. We do not allow any objects other than pacifiers such as, pillows, blankets, or toys in the crib or sleep space.
 - ☒ We do not allow any weighted blankets or clothing in the crib.*
14. Infants are not placed in or left in car safety seats, strollers, swings, or infant carriers to sleep.
15. We give all parents/guardians of infants a written copy of this policy before enrollment. We review the policy with them and ask them to sign the policy.
 - ☒ We encourage families to follow the same safe sleep practices to ease infants' transition to child care.*
16. Posters and policies:
 - **Family child care homes:** We post a copy of this policy and a safe sleep practices poster in the infant sleep room where it can easily be read.
 - **Centers:** We post a copy of this policy in the infant sleep room where it can easily be read.
 - ☐ We also post a safe sleep practices poster in the infant sleep room where it can easily be read.*

Communication

17. We inform everyone if changes are made to this policy 14 days before the effective date.
 - ☒ We review the policy annually and make changes as necessary.*

*Best practice recommendation

Effective date: Jan 2007 Review date(s): 7/2026 Revision date(s): _____

I, the parent/guardian of _____ (child's name), received a copy of the facility's Infant/Toddler Safe Sleep Policy. I have read the policy and discussed it with the facility director/operator or other designated staff member.

Child's Enrollment Date: _____ Parent/Guardian Signature: _____ Date: _____

Facility Representative Signature: Angela Crosby Date: 7/2026

Reference: N.C. Law G.S. 100-91 (15), N.C. Child Care Rules .0606 and .1724, Caring for Our Children

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