

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 _____

Mother/Guardian's Name _____ Home Phone _____

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

Work Phone _____ Cell Phone _____

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.

Name	Relationship	Address	Phone Number
Name	Relationship	Address	Phone Number
Name	Relationship	Address	Phone Number

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

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__*

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 _____

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 # _____

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 care facilities to have this information on file.

Enter date of each dose - Month/Day/Year

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

*Required by state law.

****Required by state law, however the requirement for the booster dose, #4, is temporarily suspended.**

***Required by State law for children born on or after 4/1/01.

[illegible]

Travel and Activity Authorization

Pint-Sized Morning School

Travel and Activity Authorization

Child's Name _____
(First) (Last)

I give permission for my child to participate in nature walks and walks to community playgrounds.

I understand that the Pint-Sized Morning School will notify me each time that my child is to participate in an activity that would involve leaving 119 Carver Ave.

I can be reached at (____)_____ during the hours of the trip/activity.

Signature of Parent/Guardian

Date

Permission to Photograph

Child's Name _____

☐ **Yes**, I give Pint-Sized Morning School/Michelle Galloway permission to take pictures of my child. I understand that these pictures could be used for bulletin boards, advertising, art projects, memory books, websites, etc.

☐ **No**, I do not wish for my child's picture to be taken while attending Pint-Sized Morning School.

Parent/Guardian Signature _____
Date _____



Child Care Requirement .1719

(b) Prior to enrollment of children in a family child care home, and before new animals that will be in the home come into the family child care home, a parent of each child must sign a form acknowledging the type of animal and where the animal will be during operating hours. This documentation shall be maintained in each child's file.

(Effective May 1, 2012)

I _____ understand that this Family Child Care Home
Name of Parent (Print)

has the following animal(s) on the premises:

We have two young cats. _____

During operating hours, the animal(s) will be located:

Our cats roams our home freely. _____

_____ .

Signature

Date

Provider/Parent Contract

I, _____, have fully read all policies and procedures in the 2023-24 Pint-Sized Morning School Family Handbook and understand its contents. I wish to enroll/continue enrollment my child _____ at the Pint-Sized Morning School. I understand that by signing this contract I agree to the tuition/fees listed in the 2023-24 Pint-Sized Morning School Family Handbook and understand that these rates can change with a 30 day written notice. I also understand that in order to terminate my child's care and end this contract I must give a written 30 day notice to Michelle Galloway. If I fail to give a written 30 day notice then I will be held responsible for one full month of tuition from my child's last day attended plus any past due tuition or fees.

_____ I am enrolling my child for Sept-May 2023-2024 nine month option.

_____ My child will be returning for the 2024-25 school year.

_____ I am enrolling my child for the year-round option.

_____ I am enrolling for 2023 Summer program option (June, July, Aug).

Parent/Guardian Signature _____ Date _____

Provider Signature _____ Date _____