

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.

Date Application Completed: _____ Date of Enrollment: _____

CHILD INFORMATION

Full Name: _____

(Last, First, Middle, Nickname)

Date of Birth: _____

Child's Physical Address: _____

FAMILY INFORMATION

Child lives with: _____

Father/Guardian's Name: _____

Address (if different from child's): _____

Zip Code: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Mother/Guardian's Name: _____

Address (if different from child's): _____

Zip Code: _____

Home Phone: _____ Work Phone: _____

Cell Phone: _____

Emergency Contact Persons(other than parents)

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. 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

Hours services Needed

Days of the week	Arrival Time	Pick-up Time	
Monday			
Tuesday			
Wednesday			
Thursday			
Friday			

HEALTH CARE INFO

A copy of your child's immunization records and physical examination will be needed

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

Allergies (list symptoms and type of response required):

Other health care needs/concerns (list symptoms and type of response required):

Particular fears or unique behavior characteristics:

List any types of medication taken for health care needs:

Other information regarding safe medical treatment:

Name of health care professional: _____ **Office Phone:**

Address: _____

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

Signature of Parent/Guardian: _____

Date: _____

Administrator Agreement: 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, guardian, or full-time custodian.

Signature of Administrator: _____

Date: _____

ABOUT YOUR CHILD

- **Has child been in care before?** _____ **When?** _____ **Long?** _____
 - Type? (center, in-home, grandma, etc.): _____
 - **Was it a positive experience?:** _____
- **Why are you looking for child care?:** _____
- **How does child feel about daycare/being left by parents?:** _____
- **Recent traumatic situations (death, divorce, move, etc.):** _____
- **Language spoken at home:** _____
- **Normal method of discipline:** _____
- **Normal temperament (easy going, demanding, aggressive, etc.):** _____
- **Experience playing with other children?:** _____

Habits Eating:

(Because parents provide food from home, please be sure to provide food, snacks, and drinks that your child prefers to eat)

Toilet Habits

- What terms does your child use for:
Bowel Movements: _____ Urination: _____
 - **Can child indicate bathroom wishes?:** _____

Sleeping Habits

What time does your child:

- Awaken in the morning: _____

- Go to sleep at night? _____
- Does your child sleep through the night? _____
- Does your child sleep in the bed or other?: _____
- Special problems or fears?: _____

Other info to share:

PERMISSIONS & AGREEMENTS

I give permission for Healthy Environments Staff to:

- Call a doctor/dentist in an emergency? _____
- Sign hospital release forms and transfer records requested by the hospital in the event of an emergency? _____
- Authorize any emergency care at local hospitals? _____
- Provide any minor First Aid? _____
- Walks in the neighborhood? _____
- Transport to designated relocation facility in the event of evacuation? _____
- Participate in water day (summer)? _____

I, the parent/guardian:

- Agree to update emergency/parental consent info whenever changes occur or every 6 months.
- Agree to keep medical info current and provide new health reports (every 6 months for toddlers; every 12 months for children 2 and up).

Mother/Guardian Signature: _____ **Date:** _____

Father/Guardian Signature: _____ **Date:** _____

Director Signature: _____ **Date:** _____

MEDICAL ACTION PLAN

Healthy Environments Child Development Center

Child's Name: _____ Date of Birth: _____

Condition: * EpiPen, Diazepam (for seizures), and Inhaler ONLY*

CONTACT INFORMATION

- Parent/Guardian Name: _____
- Phone: _____
- Primary Physician: _____
- Phone: _____
- Specialist (if applicable): _____
- Phone: _____

SYMPTOMS & RESPONSE

Please describe the specific symptoms the child may exhibit and the exact response required from staff.

Severity	Symptoms to Watch For	Action/Response Required
MILD		
MODERATE		
SEVERE		

MEDICATION INSTRUCTIONS

List any medications to be administered at the center for this condition.

- Medication Name:

- Dosage:

- Method of Administration:

- Storage Requirements:

EMERGENCY AUTHORIZATION

In the event of a medical emergency related to the condition listed above:

1. The center will follow the "Action/Response" steps listed above.
2. The center will contact the parent/guardian and/or emergency services (911).
3. The center is authorized to transport the child to Hospital Preference:

Parent/Guardian Consent: I authorize Healthy Environments staff to follow this Medical Action Plan and provide minor First Aid or emergency care as deemed necessary.

Parent/Guardian Signature: _____

Date: _____

Healthcare Professional Signature: _____

Date: _____

Director Signature: _____

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 the child allergic to anything? No ___ Yes ___ If yes, what?

2. Is the 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 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 #: _____

PERMISSION TO PHOTOGRAPH

I, _____, give permission for Healthy Environments Child Development Center, LLC to photograph my child, _____, for the following purposes:

Type of Use:	Grant Permission	Decline Permission
Still Photographs:		
Give to me for display in my personal scrapbook		
Give photographs possibly containing my child to current clients		
Display in facility's scrapbook or bulletin boards		
Display still photos on child care website*		
Post photos on our Facebook page		
Use still photos on center's flyer		
Videos:		
Give video to current parents		

Promotional video		
Security purposes		
Other (please list):		
Use still photo on digital media board advertisement		

**Only first names and possibly last initials will be displayed on the facility website.*

I understand that it is my responsibility to update this form. I agree that this form will remain in effect during the term of my child's enrollment.

Signed: _____

(Parent or Guardian signature)

Date: _____

NC Department of Health and Human Services (Updated 05 19)

Child Care Rules .0901(d) and .1706(c) state that parents may opt out of supplemental food provided by the operator.

When children bring their own food for meals and snacks to this program, if the food does not meet the nutritional requirements specified in paragraph (a) of this rule, the operator must provide the additional food necessary to meet those requirements unless the child's parents or Guardian opt out of the supplemental food Provided by the operator as set forth in G.S. 110-91 (2) h.1. A statement acknowledging the parental decision to opt out of the supplemental food provided by the operator signed by the child's parent or Guardian shall be on file at the facility. Opting out means that the operator will not provide any food or drink so long as the child's parent or Guardian provides all the meals, snacks, and drinks scheduled to be served at the program's designated times. If the child's parent or Guardian has opted out but does not provide all the food and drinks provided for the child the program shall provide supplemental food and drinks as if the child's parent or Guardian has not opted out of the supplemental food program.

I, _____ (Parent/Guardian Print Name), plan to provide all meals, snacks, and drinks for my child and do not want his/her meals, snacks, or drinks supplemented to meet the Meal Patterns for Children in Child Care Programs from the USDA, Which are based on the recommended nutrition intake judged by the National Research Council to be adequate for maintaining good nutrition.

Since I opted out, if I do not provide all the meals, snacks, or drinks for my child, I understand that the program will provide supplemental food and drink.

Parent/Guardian Signature: _____ **Date:**

WELCOME TO HEALTHY ENVIRONMENTS

Welcome to Healthy Environments, we are so excited to have you! Listed below are required items your child will need at all times:

- **Diapers and wipes for toddlers**
- **Pull ups and wipes for 2's and up who are not completely potty trained** (*If a child is not able to tell us that he/she needs to go potty at all times, the child is not fully potty trained*)
- **Change of clothing (all children)**
- **Lunch box packed with lunch of choice**
- **Afternoon snack**
- **Water bottle or thermos**

Please note that everything must be labeled with your child's name! The lunch box sent to school with your child must have your child's name and date daily on it. This includes all items inside of the lunch box as well (tape at the center and sharpie are provided if needed in morning) Water bottle or thermos must also include child's name and date on it