Date Application Completed_____

Brentwood Child Care The Foundation Of Knowledge
(919) 872-6004
4001 Green Rd. Raleigh, NC 27604
www.brentwoodchildcare.org

CHILD'S APPLICATION FOR ENROLLMENT

CHILD INFORMATION:

Child's Full Name:_____

Birthday:_____ **Child's Age:**_____ **Sex: M or F**

Address:_____

City:_____ **State:**_____ **Zip:**_____

FAMILY INFORMATION:

Father/Guardian's Name _____
Address (if different from child's) _____ **Zip** _____
Employer_____ **Work#**_____ **Cell #**_____

Mother/Guardian's Name _____
Address (if different from child's) _____ **Zip** _____
Employer_____ **Work#**_____ **Cell #**_____

CONTACTS: Your 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:**_____ **Phone #**_____
Name:_____ **Relationship:**_____ **Phone #**_____
Name:_____ **Relationship:**_____ **Phone #**_____

EMERGENCY CONTACTS: In the event of an emergency, if the parents/guardians cannot be reached, the facility has permission to contact the following individuals.

Name:_____ **Relationship:**_____ **Phone #**_____
Name:_____ **Relationship:**_____ **Phone #**_____
Name:_____ **Relationship:**_____ **Phone #**_____

Primary Parent/Guardian's Email_____

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 may have.

_____

_____

List any types of medication taken for health care needs.

_____

_____

Share any other information on assuring safe medical treatment for your child.

_____

_____

EMERGENCY MEDICAL CARE INFORMATION:

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

Hospital preference _____ **Phone**_____

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

Signature of Parent/Guardian_____**Date**_____

I, 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**_____

For Office Use Only:

Start Date:_____ **Voucher Start Date:**_____ **Registration Fee:**_____

Tuition Rate : $_____ **Parent Fee (Vouchers Only) : $**_____

School/Track (5yrs. & up): _____

Children File Checklist:

☐ Application ☐ Parent Handbook Agreement ☐ CACFP Application ☐ Immunization Record

☐ Travel Authorization ☐ Medical Report (DCD 0108) ☐ Photo Permission ☐ Aquatic Policy

Infant File Checklist 15mo & Under:

☐ Feeding Schedule ☐ I Can Roll Over ☐ Safe Sleep Policy ☐ Prevention of Shaken Baby Syndrome

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_____

Doctor Stamp Here:

Signature of authorized examiner/title_____Phone #_____

Brentwood Child Care
The Foundation Of Knowledge

Travel and Activity Authorization

__Yes __No

I _____Parent/Guardian

Of_____ Give My Permission To

Brentwood Child Care TFK:
For my child to participate in the following activities:

- **Planned activities outside the fenced area of the facility**
- **Transportation to and from public school**
- **Field trips (details to be announced and posted in advance)**
- **Participation in regular fire and safety drills**
- **Occasional nature walks**

I understand that the facility will use the appropriate child restraint devices and abide by all safety regulations outlined in Rule when transporting my child. Additionally, the facility will notify me in advance each time my child is scheduled to participate in an activity involving transportation.

Photo Permission Form

Please fill out and sign the permission form below and return to the office. I give my consent that photos of my child involved in classroom activities can be taken for class/school use.

____ I Do give consent for photography of my child for the purpose of class/school use. (All school age students and rising Kindergarten must check giving consent for transporting on Brentwood Childcare vehicles.)

____ I Do Not give consent for photography of my child for the purpose of class/school use.

Parent Handbook
Acknowledgment & Agreement

Welcome!
We are delighted to provide you with our Parent Handbook, which contains essential information about our policies, procedures, and guidelines for the care and education of your child. The handbook is available on our website under the Parent Handbook tab.
By scanning the code below, you can easily access and review the handbook. Please be sure to click the acknowledgment link at the bottom of the page to confirm that you agree to abide by the policies and guidelines outlined within.

If you have any questions or need further clarification, feel free to contact us at any time.
Thank you for your support and cooperation.

Sincerely,
Brentwood Management

Access Our Handbook Here:

For Office Use Only:

Signature of Administrator_____**Date**_____

*Please Verify Parent/Guardian Signed Acknowledgment and Agreement Online

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Emergency Contact & Medical Information

Child's Full Name:_____ **Birthday:**_____ **Sex: M or F**

Father/Guardian's Name _____
Address (if different from child's) _____ **Zip** _____
Employer_____ **Work#**_____ **Cell #**_____

Mother/Guardian's Name _____
Address (if different from child's) _____ **Zip** _____
Employer_____ **Work#**_____ **Cell #**_____

EMERGENCY CONTACTS: In the event of an emergency, if the parents/guardians cannot be reached, the facility has permission to contact the following individuals.

Name:_____ **Relationship:**_____ **Phone #**_____

Name:_____ **Relationship:**_____ **Phone #**_____

Name:_____ **Relationship:**_____ **Phone #**_____

Medical Information

Doctor's Office _____ **Office Phone** _____
Hospital preference _____ **Phone**_____
Health Insurance Policy Name _____ **Policy #**_____

List any allergies :

_____

_____

Emergency Treatment

I hereby give permission to **Brentwood Child Care TFK**
licensed by the Division of Child Development to secure emergency medical, dental, and/or emergency surgical treatment and to provide emergency transportation for the above named minor child while in care. Non-emergency medical treatment or elective surgery is not included in this authorization.

Signature of Parent/Guardian_____**Date**_____

Field Trips and Outside Play

I hereby give permission to **Brentwood Child Care TFK.**
For my child to participate in a walking trip or to be transported in a vehicle for a field trip. I understand that provision will be made for daily rest and outside play.

Signature of Parent/Guardian_____**Date**_____

Signature of Witness_____**Date**_____

Brentwood Child Care TFK
Food Program Enrollment Form

Dear Parent/Guardian,

This center/program receives funding from the U.S. Department of Agriculture (USDA) Child and Adult Care Food Program (CACFP). CACFP needs proof of enrollment for all infants and children. Please complete the table below for each infant and/or child in your family enrolled at this center/program.

1.PARTICIPANT'S NAME(S) & DATE(S) OF BIRTH:

First Name_____ Last Name_____ Date of Birth_____

2. SNAP or WIC benefits number:

SNAP #_____WIC #_____

3. Is this application for a:

Foster Child? __Yes __No **Homeless Child?** __Yes __No **Child from a migrant family?** __Yes __No

4. HOUSEHOLD MEMBERS MONTHLY INCOME:

(Please Names of All Other Household Members)

Full Name_____ Monthly Wages or Salaries $_____ All Other Income $_____

Full Name_____ Monthly Wages or Salaries $_____ All Other Income $_____

Full Name_____ Monthly Wages or Salaries $_____ All Other Income $_____

Full Name_____ Monthly Wages or Salaries $_____ All Other Income $_____

ETHNIC IDENTITY: (Check one). __Hispanic or Latino __Not Hispanic or Latino

RACE (Check one or more): __White __Black or African American __American Indian or Alaskan Native __Asian __Native Hawaiian or Other Pacific Islander

Primary Parent/Guardian's Name _____

Address:_____

City:_____ State:_____ Zip:_____ Cell #_____

Normal/Typical Days of Care (Circle all that apply)	Normal/Typical Hours of Care	Meals Normally Eaten (Circle all that apply)
M T W Th F Sat Sun	_____ to _____	B AM L PM S LPM