

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 # _____



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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/Guardian Signature _____ Date _____

Family 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. You can also scan the QR code below for quick access. After reviewing 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, please feel free to contact us at any time. Thank you for your continued support and cooperation.

Sincerely,
Brentwood Management

Caregiver Acknowledgment:

By my signature below, I acknowledge that I have received, read, and understand the Family Handbook, Online and agree to the terms and policies contained within. I understand that the Handbook forms part of a contract with the School and is a legally binding document.

I further understand that the Handbook, along with the state-specific Family Agreement and any addendum or policies issued by the School, governs:

- The terms of my child's enrollment and attendance
- My financial responsibilities
- The expectations shared between my family and the School

I also understand that my child, as well as each Caregiver, must comply with all policies outlined in the Family Handbook, Family Agreement, and any additional School-issued policies or updates.

Name of Enrolling Parent/Caregiver : _____ Date _____

Signature of Enrolling Parent/Caregiver : _____ Date _____

**Access Our
Handbook
Here:**



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)

M T W Th F Sat Sun

Normal/Typical
Hours of Care

_____ to _____

Meals Normally Eaten
(Circle all that apply)

B AM L PM S LPM