Brentwood Child Care The Foundation of Knowledge
4001 Green Rd., Raleigh, NC 27604
(919)872-6004/(919)874-6336 fax

CHILD'S APPLICATION FOR ENROLLMENT

Date of Application _____ Name of Child: _____

Address: _____ City: _____ State: _____ Zip: _____

Birthday: _____ Age: _____ Sex: _____

FAMILY INFORMATION:

Father/Guardian's Name _____ Home# _____
Address (if different from child's) _____ Zip Code _____
Employer _____ Work# _____ Cell# _____
Mother/Guardian's Name _____ Home# _____
Address (if different from child's) _____ Zip Code _____
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. 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 #: _____

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

Name: _____ Relationship: _____ Phone #: _____

Name: _____ Relationship: _____ 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 health care professional. Is there a medical action plan attached? Yes _____ No _____

(OVER)

Praimary Parent email address: _____

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 # _____

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_____

//

For office use ONLY:

Starting date: _____ Registration Fee: _____

Voucher start date: _____ Private Pay: $_____ School/Track: _____

Children's File Checklist:

□ *Application* □ *Shot Record* □ *Medical Form* □ *Physical (has to be completed on DCD form)*

□ *Travel & Activity Authorization* □ *Photo Permission Form* □ *School Age Vehicle form* □ *Aquatic Policy*

□ *CACFP (Child Eligibility Application/Participant Enrollment Form)*

□ *Enrollment Policy form (√ off SIDS policy if enrolling an infant 6weeks – 12 months)*

□ *Infants (only) ages 0-15 months* □ *Feeding Schedule mm*□ *Safe Sleep Policy Received*

□ *I can roll over on my back (posted over crib)* □ *CACFP (formula offered center form)*

Notes:_____

_____

DCD 0108
12/99

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_____

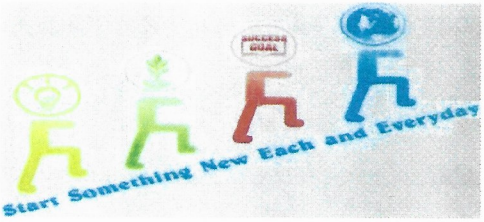
Developmental Evaluation: delayed_____ age appropriate_____
If delay, note significance and special care needed; _____

Should activities be limited? No___ Yes___ If yes, explain: _____
Any other recommendations: _____

Place Doctor Stamp Here

Date of Examination _____

Signature of authorized examiner/title _____ **Phone #** _____



Brentwood Child Care Center -
The Foundation of Knowledge
4001 Green Road
Raleigh, NC 27604
(919) 872-6004 (919) 874-6336 (FAX)

Child's Name: _____

Date of child's Enrollment: _____

I 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/owner/operator (or other designated staff member) has discussed the facility's Discipline and Behavior Management Policy with me.* ***Parent initial*** _____

I do herby state that I have read and received a copy of the facility's ***Infant/Toddler Safe Sleep Policy*** *and that the Facility's director/owner/operator (or other designated staff member) has discussed the facility's Infant/Toddler Safe Sleep Policy with me.*
□ ***Please check if applies*** ***Parent initial*** _____

I do herby state that I have read and received a copy of the facility's ***Guidelines/Policies*** *and the summary of the NC Child Daycare Laws and Rules, the Facility's director/owner/operator (or other designated staff member) has discussed the facility's* ***Guidelines/Policies*** *and the summary of the NC Child Daycare Laws and Rules with me.* ***Parent initial*** _____

I do herby state that I have read and received a copy of the facility's ***Prevention of Shaken Baby Syndrome and Abusive Head Trauma Policy****, the Facility's director/owner/operator (or other designated staff member) has discussed the facility's* ***Prevention of Shaken Baby Syndrome and Abusive Head Trauma Policy*** *with me.* ***Parent initial*** _____

I do herby state that I have read and received a copy of the facility's ***Aquatic Policy*** *and that the Facility's director/owner/operator (or other designated staff member) has discussed the facility's Aquatic Policy with me. (ONLY Applies to Pe-K and ages 5 – 12 years old.* □ ***Please check if applies*** ***Parent initial*** _____

I do herby state that I have read and received a copy of the facility's ***Tobacco Free Policy*** *and that the Facility's director/owner/operator (or other designated staff member) has discussed the facility's Tobacco Free Policy with me.* ***Parent initial*** _____

(OVER)

I do herby state that I have read and received a copy of the facility's ***Remote Learning Policy*** *and that the Facility's director/owner/operator (or other designated staff member) has discussed the facility's Photo Policy with me.* ***Parent initial*** _____

I have read & understand the policies of Brentwood Childcare Center as set forth in all the documents I have received in my enrollment packet.

Brentwood Childcare Center's Director will be delighted to discuss any questions or suggestions which you may have. Please retain the documents in your enrollment package for future reference.

Signature of the Parent or Guardian: _____

Signature of Child Care Provider: _____

Date: _____

Brentwood Childcare Center

4001 Green Rd.
Raleigh, NC 27604
(919)872-6004

Elise Smalls/Director
Shante' Loftin/Assistant Director

Travel and Activity Authorization

( ) Yes ( ) No

I _____ *parent/guardian*
(name of parent/guardian)

of _____ *give my permission to*
(name of child)

Brentwood Child Care Center for my child to participate in the following activities: planned activities outside the fenced area of the facility, to & from public school, field trips (to be announced & will be posted)

I understand that the facility will use the appropriate child restraint devises and abide by all the safety rules in Rule.1000 when my child is transported in a vehicle. The facility will also notify me each time that my child is to participate in an activity that would involve transportation.

Do to the covid-19 pandemic Brentwood Child Care is not transporting students for public school and or fieldtrips until further notice.

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 Signed)*

Brentwood Child Care Center -
The Foundation of Knowledge
4001 Green Road
Raleigh, NC 27604
919) 872-6004 919) 874-6336 (FAX)

Emergency Contact and Medical Information for a Child

Child's Name

Date of Birth M F
Sex

Parent's/Guardian's Name

( ) ( )
Home Phone Work Phone

Address

City, ST ZIP Code

Parent's/Guardian's Name

( ) ( )
Home Phone Work Phone

Address

City, ST ZIP Code

Alternative Emergency Contacts

Primary Emergency Contact

( ) ( )
Home Phone Work Phone

Address

City, ST ZIP Code

Secondary Emergency Contact

( ) ( )
Home Phone Work Phone

Address

City, ST ZIP Code

Medical Information

Hospital/Clinic Preference

Physician's Name Phone Number

Insurance Company Policy Number

Allergies/Special Health Considerations

I authorize all medical and surgical treatment, X-ray, laboratory, anesthesia, and other medical and/or hospital procedures as may be performed or prescribed by the attending physician and/or paramedics for my child and waive my right to informed consent of treatment. This waiver applies only in the event that neither parent/guardian can be reached in the case of an emergency.

Parent's/Guardian's Signature Date

I give permission for my child to go on field trips. I release [Organization] and individuals from liability in case of accident during activities related to [Organization], as long as normal safety procedures have been taken.

Parent's/Guardian's Signature Date

Witness Signature Date

North Carolina Department of Health and Human Services
Division of Public Health
Child and Adult Care Food Program

CHILD INCOME ELIGIBILITY APPLICATION

INSTITUTION NAME:_____ FACILITY NAME:_____ AGREEMENT#: _____

1. PARTICIPANT'S NAME & DATE OF BIRTH:

First Name Last Name Date of Birth First Name Last Name Date of Birth

2. SNAP, TANF or FDPIR case number:

SNAP # _____ **TANF#:** _____ **FDPIR #** _____

If you have provided the case number; DO NOT complete #3 and #4. **Skip to complete #5 and #6.**

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:

Names of All Other Household Members	Monthly Wages / Salaries	Monthly Social Security	Monthly Public Assistance / Child Support	Monthly Retirement Pensions	Other Monthly Income
	$	$	$	$	$
	$	$	$	$	$
	$	$	$	$	$
	$	$	$	$	$

5. 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

6. **SIGNATURE AND LAST FOUR DIGITS OF SOCIAL SECURITY NUMBER:** I certify that all of the above information is true and correct; that the application is being made in connection with the receipt of federal funds, that Program officials may verify the information on the application; and that deliberate misrepresentation of any of the information on the application may subject me to prosecution under applicable State and Federal criminal statutes.

Signature of Adult Household Member (Required) Date

Check if no SSN ☐
Last Four Digits of Social Security Number (Required if qualifying by income)

Printed Name Home Telephone # Work Telephone #

Address City Zip Code

The Richard B. Russell National School Lunch Act requires the information on this application. You do not have to give the information, but if you do not, we cannot approve your child for free or reduced-price meals. You must include the last four digits of the social security number of the adult household member who signs the application. The last four digits of the social security number is not required when you apply on behalf of a foster child or you list a Supplemental Nutrition Assistance Program (SNAP), Temporary Assistance for Needy Families (TANF) Program or Food Distribution Program on Indian Reservations (FDPIR) case number for your child or other FDPIR identifier or when you indicate that the adult household member signing the application does not have a social security number. We will use your information to determine if your child is eligible for free or reduced-price meals and for administration and enforcement of the Program.

To be completed by Institution/Sponsor

TOTAL HOUSEHOLD SIZE _____ TOTAL HOUSEHOLD MONTHLY INCOME $ _____

Approved: ☐ Free ☐ Reduced-Price ☐ Denied

Reason for denial: ☐ Income too high ☐ Incomplete application ☐ Other: _____

Withdrew on (Date): _____

For state use only:
Verified by: _____ Date: _____
Verified classification:
☐Free ☐Reduced-Price ☐Denied
Reason for classification change: _____

Signature of Eligibility Official (Individual at the Institution Level) – Required **Date – Required**

North Carolina Department of Health and Human Services
Division of Public Health
Child and Adult Care Food Program

Child Participant Enrollment Form

INSTITUTION NAME:_____ FACILITY NAME:_____ AGREEMENT#: _____

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 children. Please complete the table below for each child in your family that is enrolled at this center/program. Be sure to sign and date in the space below. Thank you.

The information below should be completed by the parent or guardian.

Child's First Name	Child's Last Name	Date of Birth	Normal/Typical Hours of Care	Normal/Typical Days of Care (Circle all that apply)	Meals Normally Eaten (Circle all that apply)
			____ to ____	M T W Th F Sat Sun	B AM L PM S LPM
			____ to ____	M T W Th F Sat Sun	B AM L PM S LPM
			____ to ____	M T W Th F Sat Sun	B AM L PM S LPM
			____ to ____	M T W Th F Sat Sun	B AM L PM S LPM
			____ to ____	M T W Th F Sat Sun	B AM L PM S LPM

Normal/Typical Hours of Care: Please write in each child's usual arrival and departure time. Indicate a.m. or p.m.

Normal Days of Care: Please circle the days of the week each child is usually in attendance at the facility.
(M-Monday; T-Tuesday; W-Wednesday; Th- Thursday; F-Friday; Sat-Saturday; Sun-Sunday)

Meals Normally Eaten – Please circle the meals each child usually eats at the facility.
(B-Breakfast; AM-AM Snack; L-Lunch; PM-PM Snack; S-Supper; LPM-Late PM/Evening Snack)

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

Print Name: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Home Telephone Number: ( ) _____ Work Telephone Number: ( ) _____

For Facility/Provider Use Only:
Signature of Facility Representative/Provider: _____ Date: _____

Date each child withdrew: _____

For State Use Only: Complete: _____ Incomplete _____ Reason: _____ Verified by: _____ Date: _____

This institution is an equal opportunity provider.