Neighbors Grove
CHILD DEVELOPMENT CENTER
NURTURING FAITH,
KNOWLEDGE AND CHARACTER

Date of application_____ Date of enrollment_____

Summer camp registration

Child's name_____

Parent's name _____

Contact Number _____

Fulltime ____ Part-time____

Registration Paid ____

Physical ____

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Date Application Completed_____ Date of Enrollment_____

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. 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

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 _____

FINANCIAL AGREEMENT

By signing this agreement, I understand that upon enrolling my child in Neighbors Grove Child Development Center, I am responsible for paying the registration fee of $30.00 and the first tuition payment for my child to start his/her first day. Registration fees are non-refundable.

ALL tuition fees are scheduled and due one week in advance. Payments are to be made on Fridays for the following week. A $5.00 late charge will be added to your bill if payment is made later than Monday. If you wish to make bi-weekly or monthly payments, you may make arrangements with the front office.

Red Notices- there will be a $10 fee added to the account when a Red Notice is issued. After 2 Red Notices within a 6 month period, the fee will increase to $20. If an account becomes more than 2 weeks delinquent, your child will not be able to return until the account balance is paid in full.

The expenses (e.g. salaries, utilities, maintenance) of the CDC continue whether your child is in attendance or not; therefore, tuition credits or refunds cannot be given for the day(s) that your child is absent.

If a child is picked up after 6:00 pm, a $1.00 per minute late fee will be added to the next tuition payment. On the second occurrence and thereafter, there will be a fee of $5.00 plus the $1.00 per minute.

Payments made by check should be deposited in the drop box at the daycare entrance. Checks can be made out to NGCDC. Please print your child's name at the bottom of your check. Cash payments should be given directly to office personnel so it can be receipted immediately.

There will be a $20.00 charge for all returned checks.

There is an annual curriculum fee beginning with the two year old classrooms. Parents are also responsible for the expense of most field trips, if they wish their child to participate.

If parents receive financial assistance from the Department of Social Services, be sure to note that the weekly rate owed may be different from the figure given to you by DSS. There is usually an additional parent "co-pay" since the CDC does not participate in all state programs.

A written two week notice is required before withdrawing a child from the center. This notice is to be given to the Director. If a child is removed for any reason other than an illness, payment is required for these two weeks, even if the child does not attend for the duration of the notice.

If a child is withdrawn and the account is left with an unpaid balance, NGCDC reserves the right to pursue collection of the unpaid balance, including the use of a lawyer. Collection expenses, including court costs and attorney fees are then added to the previous unpaid balance.

I/We understand these financial policies and agree to accept full responsibility accordingly for my/our child(ren)'s expenses.

Father's Signature: _____ Driver's License #_____ Date: _____

Mother's Signature: _____ Driver's License #_____ 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_____

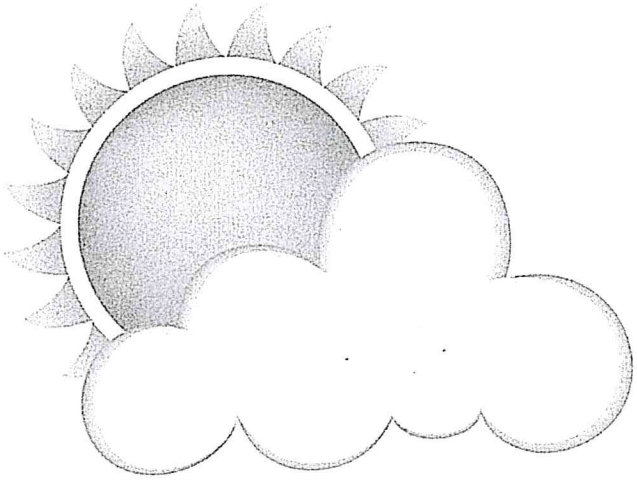
Developmental Evaluation: delayed_____ age appropriate_____
If delay, note significance and special care needed;_____

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

Date of Examination_____

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

DCD-0108
12/99



Dear parents,

It is that time of year again. Beautiful weather, longer days, brighter sun and longer days outside.... Which leads to sunburn. We provide sunscreen. The center provides Equate brand, broad spectrum, SPF 50 sunscreen. If you would like us to apply this sunscreen on your child while at our center please fill out the area below and return to your child's teacher.

Thank you,

Tami Thomas, Director

I, _____the parent/guardian of _____
give my child's teacher permission to apply Equate brand sunscreen on my child when going outside each day.

Parent signature_____ Date _____

Neighbors Grove
CHILD DEVELOPMENT CENTER
NURTURING FAITH, KNOWLEDGE AND CHARACTER

Hello parents,

We are involved in a texting service where we can send you a text if we are going to close or have a delay due to bad weather. We are also going to use this if we ever have to evacuate the building for any reason and have relocated to a safe location. We want to make sure we have all parents registered in our texting service because this will be our first attempt to contact all parents.

If you are not registered or are not sure if you are all you have to do is text the,

Keyword: EZJJN77315 to 313131

And please fill out the bottom of this page so we can personalize your numbers with your name.

Child's name(s) _____ _____

Parent name_____ Number _____

Parent name_____Number_____

If you have any question you can see me or Mrs. Krystal in the office.

Thank you,

Ms. Tami Thomas, Director

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North Carolina Department of Health and Human Services
Division of Public Health Nutrition Services Branch
Child and Adult Care Food Program (CACFP)

Medical Statement for Meal Modifications

Please find additional guidance below when completing the medical statement and complying with 7 CFR § 15b, 7 CFR § 225.16(f)(4) and § 226.20(g).

General Information

- For CACFP, a medical statement is required for individuals with **any physical or mental impairment** (i.e. disability or medical condition) which substantially limits one or more "major bodily functions" and may also include conditions affecting "major life activities." *Examples: food allergy or intolerance, any condition that affects the digestive tract (e.g., lactose intolerance), diabetes, developmental delay, autism, celiac disease, renal disease, and failure to thrive.*
    - A participant's impairment should be accommodated even if medication or other mitigating measures reduce the impact of the impairment.
- Requirements of the medical statement:
    - A description of the participant's impairment that allows the Program operator to understand how it restricts the participant's diet. (*Example: Due to Johnny's medical condition he cannot consume eggs*)
    - Explanation of what must be done to accommodate the impairment. In the case of food allergies, this means identifying the food(s) that need to be omitted and recommending alternatives. (*Example: Omit peanut butter and substitute sunflower butter*)
    - It is highly recommended that the food(s) to be substituted be listed on the medical statement. If the substitution is absent, the medical statement remains valid and the Program operator may speak with the parent, guardian or participating adult to learn the food(s) to be substituted. (*Example: almond milk substituted for cow's milk*)
- Meal modifications following the meal patterns do not require a medical statement (*Example: soy milk that is nutritionally equivalent to cow's milk substituted for cow's milk*). Parents or guardians or participating adults may request these non-dairy beverages in writing.
- Program operators may choose to accommodate requests related to impairments without medical statements if the requested modifications can be met within the CACFP meal patterns.

CACFP Program Operators

- Program operators should not engage in weighing medical evidence against the legal standard to determine whether a physical or mental impairment is severe enough to qualify as a disability. The primary objective is providing appropriate accommodations. (*Example: The Program operator may not ask about medical history, request medical documentation nor for the medical diagnoses; operators may not ask how long a participant has had a physical or mental impairment.*)
- Meals that do not meet the Program meal pattern requirements are not eligible for reimbursement unless supported by a medical statement.
- Program operators must make reasonable modifications to the meal(s), including providing special meals at no extra charge, to accommodate impairments which restrict a participant's diet. Program operators are not required to make modifications that would result in a fundamental alteration in the nature of the Program (e.g., the financial burden of making the accommodation would cause continued operation to be unfeasible).
- Program operators are not required to provide the exact substitution or other modification requested but must work with the parent or guardian or participating adult to offer a reasonable modification that effectively accommodates the impairment and provides equal opportunity to participate or benefit from the Program (*Example: Program operators may not just say "no"; their duty is to negotiate a reasonable modification*).

North Carolina Department of Health and Human Services
Division of Public Health Nutrition Services Branch
Child and Adult Care Food Program (CACFP)

Medical Statement for Meal Modifications

Institution Name: Neighbors Grove CDC **Agreement Number:** 6417

This document does not apply to meal modifications made for dietary preferences or religious reasons.

The information collected below is required for CACFP participants with medical conditions (i.e., physical or mental impairments) requiring meal modifications. Reasonable modifications *must* be made to accommodate children and adults with medical conditions (e.g., diabetes, lactose intolerance, food allergy, etc.) restricting their diet. **Meals that do not meet CACFP meal pattern requirements must be supported by this medical statement or comparable documentation signed by a North Carolina (NC) licensed healthcare professional authorized to write prescriptions under state law.**

Child/Adult Participant Information

Name: _____ DOB: _____

Parent/Guardian Name (if applicable): _____

CACFP Facility Information

Facility Name: _____ Facility Phone: _____

Facility Representative Name: _____ Facility Address: _____

To be completed by licensed healthcare professional

Describe the Physical or Mental Impairment Restricting the Diet:

Examples: Sara is allergic to cow's milk and soy milk; Ben does not tolerate strawberries and they cause hives, itchy skin, gastrointestinal distress and diarrhea; Julian has a food allergy and cannot drink cow's milk.

Beverages and/or Foods to Omit:	Beverages and/or Foods to be Substituted: (strongly recommended)

Other Special Dietary Needs or Modifications Needed

Textural modification, caloric modification, adaptive equipment or other modifications (describe, if applicable):

Authorized Signature

_____ Name of Licensed Healthcare Professional

_____ Title

_____ Signature

_____ Date

Reference: CACFP 17-09(a) Modifications to Accommodate Disabilities in the CACFP

This institution is an equal opportunity provider.
Medical statements are confidential and are securely maintained.

Prevention of Shaken Baby Syndrome and Abusive Head Trauma

Belief Statement

We, Neighbors Grove (name of facility), believe that preventing, recognizing, responding to, and reporting shaken baby syndrome and abusive head trauma (SBS/AHT) is an important function of keeping children safe, protecting their healthy development, providing quality child care, and educating families.

Background

SBS/AHT is the name given to a form of physical child abuse that occurs when an infant or small child is violently shaken and/or there is trauma to the head. Shaking may last only a few seconds but can result in severe injury or even death[1]. According to North Carolina Child Care Rule (child care centers, 10A NCAC 09 .0608, family child care homes, 10A NCAC 09 .1726), each child care facility licensed to care for children up to five years of age shall develop and adopt a policy to prevent SBS/AHT[2].

Procedure/Practice

Recognizing:

- Children are observed for signs of abusive head trauma including irritability and/or high pitched crying, difficulty staying awake/lethargy or loss of consciousness, difficulty breathing, inability to lift the head, seizures, lack of appetite, vomiting, bruises, poor feeding/sucking, no smiling or vocalization, inability of the eyes to track and/or decreased muscle tone. Bruises may be found on the upper arms, rib cage, or head resulting from gripping or from hitting the head.

Responding to:

- If SBS/ABT is suspected, staff will[3]:
  - Call 911 immediately upon suspecting SBS/AHT and inform the director.
  - Call the parents/guardians.
  - If the child has stopped breathing, trained staff will begin pediatric CPR[4].

Reporting:

- Instances of suspected child maltreatment in child care are reported to Division of Child Development and Early Education (DCDEE) by calling 1-800-859-0829 or by emailing webmasterdcd@dhhs.nc.gov.
- Instances of suspected child maltreatment in the home are reported to the county Department of Social Services. Phone number: 336-683-8010

Prevention strategies to assist staff* in coping with a crying, fussing, or distraught child

Staff first determine if the child has any physical needs such as being hungry, tired, sick, or in need of a diaper change. If no physical need is identified, staff will attempt one or more of the following strategies[5]:

- Rock the child, hold the child close, or walk with the child.
- Stand up, hold the child close, and repeatedly bend knees.
- Sing or talk to the child in a soothing voice.
- Gently rub or stroke the child's back, chest, or tummy.
- Offer a pacifier or try to distract the child with a rattle or toy.
- Take the child for a ride in a stroller.
- Turn on music or white noise.
- Other _____
- Other _____

In addition, the facility:

- Allows for staff who feel they may lose control to have a short, but relatively immediate break away from the children[6].
- Provides support when parents/guardians are trying to calm a crying child and encourage parents to take a calming break if needed.
- Other _____

Prevention of Shaken Baby Syndrome and Abusive Head Trauma

Prohibited behaviors
Behaviors that are prohibited include (but are not limited to):

- shaking or jerking a child
- tossing a child into the air or into a crib, chair, or car seat
- pushing a child into walls, doors, or furniture

Strategies to assist staff members understand how to care for infants
Staff reviews and discusses:

- The five goals and developmental indicators in the 2013 North Carolina Foundations for Early Learning and Development, ncchildcare.nc.gov/PDF_forms/NC_Foundations.pdf
- How to Care for Infants and Toddlers in Groups, the National Center for Infants, Toddlers and Families, www.zerotothree.org/resources/77-how-to-care-for-infants-and-toddlers-in-groups ,
- Including Relationship-Based Care Practices in Infant-Toddler Care: Implications for Practice and Policy, the Network of Infant/Toddler Researchers, pages 7-9, www.acf.hhs.gov/sites/default/files/opre/nitr_inquire_may_2016_070616_b508compliant.pdf

Strategies to ensure staff members understand the brain development of children up to five years of age
All staff take training on SBS/AHT within first two weeks of employment. Training includes recognizing, responding to, and reporting child abuse, neglect, or maltreatment as well as the brain development of children up to five years of age. Staff review and discuss:

- Brain Development from Birth video, the National Center for Infants, Toddlers and Families, www.zerotothree.org/resources/156-brain-wonders-nurturing-healthy-brain-development-from-birth
- The Science of Early Childhood Development, Center on the Developing Child, developingchild.harvard.edu/resources/inbrief-science-of-ecd/

Resources
List resources such as a staff person designated to provide support or a local county/community resource:

_____

_____

Parent web resources

- The American Academy of Pediatrics: www.healthychildren.org/English/safety-prevention/at-home/Pages/Abusive-Head-Trauma-Shaken-Baby-Syndrome.aspx
- The National Center on Shaken Baby Syndrome: http://dontshake.org/family-resources
- The Period of Purple Crying: http://purplecrying.info/
- Other _____

Facility web resources

- Caring for Our Children, Standard 3.4.4.3 Preventing and Identifying Shaken Baby Syndrome/Abusive Head Trauma, http://cfoc.nrckids.org/StandardView.cfm?StdNum=3.4.4.3&=+
- Preventing Shaken Baby Syndrome, the Centers for Disease Control and Prevention, http://centerforchildwelfare.fmhi.usf.edu/kb/trprev/Preventing_SBS_508-a.pdf
- Early Development & Well-Being, Zero to Three, www.zerotothree.org/early-development
- Other _____

Prevention of Shaken Baby Syndrome and Abusive Head Trauma

References

1. The National Center on Shaken Baby Syndrome, www.dontshake.org
2. NC DCDEE, ncchildcare.dhhs.state.nc.us/general/mb_ccrulespublic.asp
3. Shaken baby syndrome, the Mayo Clinic, www.mayoclinic.org/diseases-conditions/shaken-baby-syndrome/basics/symptoms/con-20034461
4. Pediatric First Aid/CPR/AED, American Red Cross, www.redcross.org/images/MEDIA_CustomProductCatalog/m4240175_Pediatric_ready_reference.pdf
5. Calming Techniques for a Crying Baby, Children's Hospital Colorado, www.childrenscolorado.org/conditions-and-advice/calm-a-crying-baby/calming-techniques
6. Caring for Our Children, Standard 1.7.0.5: Stress http://cfoc.nrckids.org/StandardView/1.7.0.5

Application

This policy applies to children up to five years of age and their families, operators, early educators, substitute providers, and uncompensated providers.

Communication

Staff*

- Within 30 days of adopting this policy, the child care facility shall review the policy with all staff who provide care for children up to five years of age.
- All current staff members and newly hired staff will be trained in SBS/AHT before providing care for children up to five years of age.
- Staff will sign an acknowledgement form that includes the individual's name, the date the center's policy was given and explained to the individual, the individual's signature, and the date the individual signed the acknowledgment
- The child care facility shall keep the **SBS/AHT staff acknowledgement form** in the staff member's file.

Parents/Guardians

- Within 30 days of adopting this policy, the child care facility shall review the policy with parents/guardians of currently enrolled children up to five years of age.
- A copy of the policy will be given and explained to the parents/guardians of newly enrolled children up to five years of age on or before the first day the child receives care at the facility.
- Parents/guardians will sign an acknowledgement form that includes the child's name, date the child first attended the facility, date the operator's policy was given and explained to the parent, parent's name, parent's signature, and the date the parent signed the acknowledgement
- The child care facility shall keep the **SBS/AHT parent acknowledgement form** in the child's file.

* For purposes of this policy, "staff" includes the operator and other administration staff who may be counted in ratio, additional caregivers, substitute providers, and uncompensated providers.

01/10/18
Effective Date

This policy was reviewed and approved by: Jami Thomas — **Owner/Director (recommended)** — 01/29/18 **Date**

_____ **DCDEE Child Care Consultant (recommended)** _____ **Date** _____ **Child Care Health Consultant (recommended)** _____ **Date**

_____ _____ _____ _____

Annual Review Dates

Prevention of Shaken Baby Syndrome and Abusive Head Trauma

Parent or guardian acknowledgement form

I, the parent or guardian of _____
Child's name

acknowledges that I have read and received a copy of the facility's Shaken Baby Syndrome/Abusive Head Trauma Policy.

_____ _____
Date policy given/explained to parent/guardian **Date of child's enrollment**

_____
Print name of parent/guardian

_____ _____
Signature of parent/guardian **Date**

Neighbors Grove
CHILD DEVELOPMENT CENTER
NURTURING FAITH, KNOWLEDGE AND CHARACTER

For the health of its children, parents, and staff, the facilities and grounds of Neighbors Grove Child Development Center have been designated

Smoke Free

By the NC Division of Child Development and Early Education.

Thank you for your cooperation!

I _____ have read this policy and agree to abide by it.

Signature _____ Date _____

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Blanket Transportation Permission Slip

Neighbors Grove Child Development Center will schedule field trips from time to time in our three's and Pre-K departments. During these trips, your child will be transported by our preschool bus. Do to insurance reasons, parents are not allowed to ride on the bus. Parents are welcome and encouraged to participate in our field trips. I authorize Neighbors Grove Child Development Center to transport my child during scheduled field trips. I realize that Neighbors Grove CDC will schedule each trip in advance and send home a written permission slip that I must sign before my child will be permitted to participate in the off campus activity.

_____ _____

Parent Signature Date

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Photo Release

I, _____, hereby give permission to have my child included in any video or photos taken for promotional materials or for use on the Neighbors Grove Childe Development Centers website.

Parent's Name (print) _____

Parent's Signature _____

Child's Name _____

Date: _____

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www.neighborsgrove.com

Statement of NC Child Care Law Receipt

I, _____ the parent/guardian of

_____ do hereby acknowledge that I have

received a summary of the NC Child Care Law.

_____ _____

Parent/guardian signature Date

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www.neighborsgrove.com

I have carefully read and understand ALL policies and procedures laid out in this parent handbook. I also understand by signing below, I am responsible for abiding by ALL guidelines set forth.

Child's name: _____

Age: _____

Parents Signature: _____

Date: _____

BLANKET PERMISSION SLIP

I give permission for my child to take a "stroll" with his/her teacher outside the fenced area of the Neighbors Grove Child Development Center.

Child's Name _____

Parent's Signature _____

Date _____

HEAD LICE POLICY

According to the North Carolina State Health Board, the following applies:

If a child has head lice, they cannot return to school until they are completely nit free.

There are some products available on the market to help treat this problem. They are Nix, Clear, and Rid. These are over-the-counter products and can be found at any pharmacy or drug store.

You will be notified in writing if your child has been exposed to any case of head lice in the daycare and preschool.

By signing below, I agree to and understand the policy set forth by Neighbors Grove Child Development Center.

Father's Signature: _____ Date: _____

Mother's Signature: _____ Date: _____

NGCDC DISCIPLINE POLICY

All children enrolled in NGCDC will be treated fairly regarding any discipline procedure taken.

Should a child misbehave while in our care, he/she will be placed in an isolated area (time-out) for one minute per year of age. Every effort will be made to channel the child's interests in other directions before using any disciplinary action.

If time-out is not successful and the unacceptable behavior continues, a conference with the Director, teacher, and the parents may be called to discuss a more positive way of correcting any behavioral problem. Should these two methods fail and the Director cannot get control of the child, the child will be released from the Center immediately.

SPANKING IS NEVER ALLOWED UNDER ANY CIRCUMSTANCES!

If, at any time, a child does not respond favorably to the Center, or the Director feels that the Center is not meeting the child's/parent's needs, the child could be dismissed from the NGCDC at the discretion of the Director or the Christian Education Center Board Members.

STATEMENT OF DISCIPLINARY PRACTICES

I, _____, the parent/guardian of _____
(Parent/Guardian Signature) (Child's Name)
Do hereby acknowledge and agree to the disciplinary practices of Neighbor's Grove Child Development Center. These practices have been discussed with me, and I have received a copy of this Discipline Policy.

Parent/Guardian Signature: _____ Date: _____

Director's Signature: _____ Date: _____

Enrollment Date: _____