Upper Room Kids Academy
Early Childhood Learning Center

Enrollment Application

Name of Child _____ Start Date _____ Termination Date _____

The following items must be present in each child's file.

Items	Date Received/Completed
☐ Application	
☐ Initial Medical Report	
☐ Immunization Record	
☐ *Feeding Schedule (***Children 15 months and under***)	
☐ Discipline Policy	
☐ Permission to play outside of fence	
☐ Documentation of receipt of policies/Summary laws	
☐ Medication Policy	
☐ *Sleep policy Waiver (***Children 12months and under***)	
☐ Photo Waiver	
☐ Food Program Application	
☐ Emergency Pink Card / Emergency Pre. File	
☐ Health Consultant	
☐ Registration Fee	
☐ Parent Fee Contract	

Date Application Completed or Updated_____ 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.

Name	Relationship	Address	Phone Number
Name	Relationship	Address	Phone Number
Name	Relationship	Address	Phone Number

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
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_____

Email Address: _____

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:_____

_____

_____

Date of Examination_____

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

Discipline and Behavior Management Policy

Praise and positive reinforcement are effective methods of the behavior management of children. When children receive positive, nonviolent, and understanding interactions from adults and others, they develop good self-concepts, problem solving abilities, and self discipline. Based on this belief of how children learn and develop values, this facility will practice the following discipline and behavior management policy:

We:

1. DO praise, reward, and encourage the children.
2. DO reason with and set limits for the children.
3. DO model appropriate behavior for the children.
4. DO modify the classroom environment to attempt to prevent problems before they occur.
5. DO listen to the children.
6. DO provide alternatives for inappropriate behavior to the children.
7. DO provide the children with natural and logical consequences of their behaviors.
8. DO treat the children as people and respect their needs, desires, and feelings.
9. DO ignore minor misbehaviors.
10. DO explain things to children on their levels.
11. DO use short supervised periods of "time-out"
12. DO stay consistent in our behavior management program.

We:

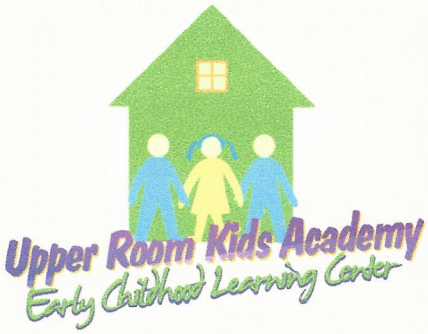
1. DO NOT spank, shake, bite, pinch, push, pull, slap, or otherwise physically punish the children.
2. DO NOT make fun of, yell at, threaten, make sarcastic remarks about, use profanity, or otherwise verbally abuse the children.
3. DO NOT shame or punish the children when bathroom accidents occur.
4. DO NOT deny food or rest as punishment.
5. DO NOT relate discipline to eating, resting, or sleeping.
6. DO NOT leave the children alone, unattended, or without supervision.
7. DO NOT place the children in locked rooms, closets, or boxes as punishment.
8. DO NOT allow discipline of children by children.
9. DO NOT criticize, make fun of, or otherwise belittle children's parents, families, or ethnic groups.

I, the undersigned parent or guardian of _____ (child's full name), 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/coordinator (or other designated staff member) has discussed the facility's Discipline and Behavior Management Policy with me.

Date of Child's Enrollment:_____

Signature of Parent/Guardian_____ Date_____

Distribution: one copy to parent(s) signed copy in child's facility record



Travel and Activity Authorization
One Time Permission For All Given Activities

I, _____, parent/guardian of _____
(Parent/Guardian full name) (Child's full name)

Give my child permission to participate in any field trips away from the facility (includes neighborhoods, and nature walks) and give permission for my child to be transported by vehicles owned by Upper Room Kids Academy. I understand Upper Room Kids will use appropriate child restraint devices and will abide by all the safety rules in Rule.1000 of the North Carolina Division of Child Development requirements when your child is transported in a vehicle. Upper Room Kids will notify parents each time prior to participating in any activities or field trips that involves transportation.

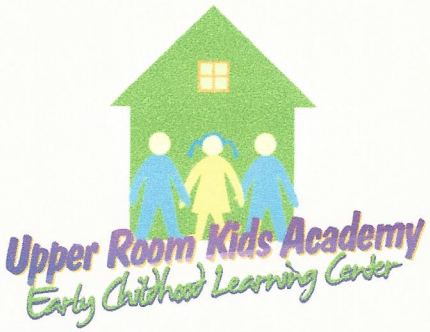
In addition, if the facility has planned activities outside the fence area of facility.

☐ I will allow my child to play outside the fence area

☐ I will not allow my child to play outside the fence area.

_____ _____
Signature of Parent Date

Date of Enrollment _____



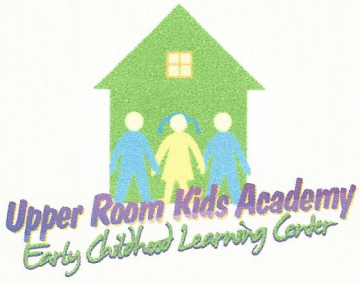
Receipt of Policies and Documents

Please initial next to those that apply

_____ I have received a copy of Upper Room Academy's parent handbook inclusive of their biting and Shaken Baby Syndrome policies.

_____ I have received a copy of the NC Child Care Laws and Rules

_____ I received a copy of the Upper Room Academy's Infant/Toddler Sleep Policy



Medication Policy

The state legislature passed a bill that allows childcare worker to be charged with a felony if they give the wrong medication to a child. As a result, the licensing consultants are advising all childcare centers to discontinue dispensing all medications. They have talked to the physicians who have assured them that there is no medication that cannot be given in the morning before arrival, in the afternoon when they are picked up and at bedtime if it is prescribed to be given three times a day.

Effectively April 30, 2008 we will no longer be able to give medication at the center. We will continue to do breathing treatments and diaper rash ointments if ordered by a physician. All other medications will have to be dispensed by the parent at home.

Signature _____ Date _____

Upper Room Kids
Child Development Center

Sudden Infant Death Syndrome is the unexpected death of a seemingly healthy baby for whom no cause of death can be determined based on an autopsy, an investigation of the place where the baby died and a review of the baby's medical history.

The Child Care Law requires that child care providers caring for children 12 months of age or younger implement a safe sleep policy, share this information with parents, and participate in training.

This facility believes all families have a right to safe and healthy child care and will practice the following safe sleep policy:

Mandatory Safe Sleep Practices

1. All child care staff working in the infant room, or child care staff with scheduled hours in the infant room, will receive training on our Infant Safe Sleep Policy and SIDS risk reduction.
2. Infants will always be placed on their backs to sleep, unless there is a signed sleep position waiver on file as allowed by law. A copy of the waiver will be posted for quick reference near the infant's crib.
3. Infants will be placed in a crib with a firm mattress.
4. Infants heads will not be covered with blankets or bedding. The tops of infants' cribs will not be covered with bedding.
5. Room temperature will not exceed 75 degrees F.
6. Only one infant is allowed in a crib at a time, unless we are evacuating infants in an emergency or practice drills.
7. No smoking is permitted nowhere in the building.
8. Awake babies will be given supervised "tummy time".
9. Caregivers will visually check on sleeping infants every 15 minutes. We will check them by going to the crib, and observing both their skin color and breathing. We will keep a record of this on a sleep chart.

Optional Safe Sleep Practices

10. No loose bedding, blankets, pillows, bumper pads, will be used in cribs.
11. Only 1 crib toy/pacifier will be allowed in the crib ex. Mobiles, etc. (Fastened crib toy)
12. If an infant changes position from back to side or stomach, child will be left to sleep in that position to sleep.

Note: All Parents/guardians of infants cared for in this facility's will receive a written copy of our Infant/Toddler Safe Sleep Policy and information about SIDS risk reduction before enrollment

I, the undersigned parent or guardian of _____(child's full name), do hereby 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.

Date of Child's Enrollment: _____

Signature of Parent or Guardian: _____ Date: _____

Signature of Child Care Provider: _____ Date: _____

Upper Room Kids Child Development Center
Standard Photographic Release

I, _____

Do hereby grant to Upper Room Kids Child Development Center the unlimited rights to use and/or reproduce photographs, likenesses or the voice of my child in any legal manner for the external promotional/informational activities (may include but not limited to, newsletters, fliers, brochures, etc.) of Upper Room Kids C.D.C.

I also agree to allow my child to be interviewed and/or photographed by representatives of the external news media in relation to any and all coverage of Upper Room Kids C.D.C in which they are involved.

I further understand that by signing this release, I waive any and all present, or future, compensation rights to use of the above stated material(s)

_____ _____

Signature of parent/guardian Date

I_____ (parent of)_____ agree to pay an annual registration fee of $60 to be admitted into the child care program.

Child Care Fee_____

Amount to be paid by Parent_____

Thereafter, I agree to pay $_____ Weekly **Start Date** _____

By signing below you agree to all that is stated in this contract. If you fail to abide by this contract, your child(ren) will immediately be dropped from the program.

- All payments are due ***before services are rendered***.
- All payments are due on Monday and late after Tuesday.
- Services will be suspended after 3 days of non-payment.
- Late fees will be assessed if fees are not paid on time based on that due date.
- Fees are to be paid whether your child is in attendance or not.

Tuition ID# _____ ***4 Digit Registration Code*** _____

x_____ _____
Parent Date

x_____ _____
Director Date