Application Date _____
Date of Enrollment _____

The CHILDREN'S CAMPUS
PRESCHOOL APPLICATION

(Please Print)
Name of Child _____ Birthdate _____
(Last) (First) (MI) (Nickname)
Address _____ Zip Code _____

FAMILY INFORMATION:
Father/Guardian's Name _____ Home Phone _____
Address _____ Cell Phone _____
Where Employed _____ Business Phone _____
Email: _____ NC Driver's License # _____

Mother/Guardian's Name _____ Home Phone _____
Address _____ Cell Phone: _____
Where Employed _____ Business Phone _____
Email: _____ NC Driver's License # _____

CHILD INFORMATION:
Does your child have any known allergies? No ____ Yes _____
Explain: _____
Please give any information concerning your child, which will be helpful in his/her experience in group setting (such as play, eating and sleeping habits, special fears, special likes or dislikes).

_____

EMERGENCY CARE INFORMATION:
Name of child's doctor _____ Office Phone _____
Address _____
Name of child's dentist _____ Office Phone _____
Address _____
Hospital Preference _____ Phone _____
Insurance Carrier _____ Policy # _____

If a parent cannot be contacted, the following person(s) may be contacted in the event of an emergency. The following person(s) also have permission to pick up.
Name _____ Relationship _____ Phone _____
Name _____ Relationship _____ Phone _____
Name _____ Relationship _____ Phone _____
Name _____ Relationship _____ Phone _____
I agree that the director may authorize the physician of her choice to provide emergency care in the event that neither I, nor the family physician can be contacted immediately. I agree that the director or other authorized employee may provide transportation for my child to an appropriate medical resource in the event of an emergency.

_____
(Signature of Parent) (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. Provisions will be made for adequate and appropriate rest and outdoor play:

_____
(Signature of Director) (Date)

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 #**_____

Child Immunization History

Child's Name _____ **Date of Birth** _____

Instructions: *Enter each date of each dose received (Month/Day/Year)* ***or*** *attach a copy of the immunization record. G.S. 130A-155(b) requires child care facilities to file this information. Please refer to page 2 for the Minimum State Vaccine Requirements for Child Care Entry and the additional Vaccines Recommended by the Advisory Committee on Immunization Practices.*

Vaccine Type	Vaccine Abbreviation	Trade Name	Combination Vaccines	1	2	3	4	5
Diphtheria, Tetanus, Pertussis	DTaP, DT, DTP	Infanrix, Daptacel	Pediarix, Pentacel, Kinrix					
Polio	IPV, OPV	IPOL	Pediarix, Pentacel, Kinrix					
Haemophilus influenza type B	Hib	Act HIB, Pedvax HIB **	Pentacel					
Hepatitis B	HepB, HBV	Engerix-B, Recombivax HB	Pediarix					
Measles, Mumps, Rubella	MMR	MMR II	Proquad					
Varicella/Chicken Pox	Var	Varivax	Proquad					
Pneumococcal Conjugate*	PCV, PCV-13, PPV-23	Prevnar, Pneumovax***						

Legend:
*Required by state law for children born on or after 7/1/2015.
** 3 shots of Pedvax HIB are equivalent to 4 Hib doses. 4 doses are required if a child receives more than one brand of Hib shots.
***Pneumovax is a different vaccine than Prevnar and may be seen in high risk children.
Note: Children beyond their 5th birthday are not required to receive Hib or PCV vaccines.

Gray shaded boxes above indicate that the child should not have received any more doses of that vaccine.

Record updated by:	Date		Record updated by:	Date

THE CHILDREN'S CAMPUS
DISCIPLINE AND BEHAVIOR MANAGEMENT POLICY

Date Adopted: May 2010

Praise and positive reinforcement are effective methods of the behavior management of children. When children receive positive, non-violent, 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 misbehavior.
10. DO explain things to the 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 as stated in the *The* Children's Campus' *Policies and Procedures Handbook* on pages 10 and 11, and that the facility's director (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 or Guardian _____ Date _____

TRAVEL AND ACTIVITY AUTHORIZATION

According to the Law 1322 the Travel and Activity Authorization must be signed annually.

If the facility has planned activities outside the fenced area of the facility,

_____ *I will allow my child to play outside the fenced area, as follows:
*For fire drill purposes
*Once a year for fire safety week, the children get to sit on the fire truck
*Once a year for Community Helpers' awareness, the children get to step outside to see the patrol car

_____ I will not allow my child to play outside the fenced area.

_____ _____
Parent/Guardian Signature Date Signed

This authorization is valid from ___/___/___ to 09/15/___

PERMISSION TO PHOTOGRAPH CHILD

The Children's Campus has my permission to photograph my child for the purposes of, but not limited to, display in teacher made books, bulletin boards, art projects, child portfolios, and prospective parent viewing. I understand that these photographs are the property of Children's Campus and may be displayed at any Children's Campus location at any time.

___ I agree.

___ I do not agree.

Child's name_____

Parent signature_____

This authorization is valid from ____/____/____ to end of enrollment.

Children's Campus

First Steps to a Lifetime of Learning

Acknowledgement:

"I have received and read a copy of the **North Carolina Child Care Law and Rules**, a copy of the Children's Campus **operational policy/parent handbook,** and the center's **Shaken Baby Syndrome/Abusive Head Trauma policy** and each item has been discusses with me. I agree to abide by all policies stated herein."

_____ _____

Parent/Guardian signature Date

FARE Food Allergy Research & Education — FOOD ALLERGY & ANAPHYLAXIS EMERGENCY CARE PLAN

Name: _____ D.O.B.: _____

Allergy to: _____

Weight: _____ lbs. Asthma: ☐ **Yes (higher risk for a severe reaction)** ☐ **No**

PLACE PICTURE HERE

NOTE: Do not depend on antihistamines or inhalers (bronchodilators) to treat a severe reaction. USE EPINEPHRINE.

Extremely reactive to the following allergens: _____

THEREFORE:

☐ If checked, give epinephrine immediately if the allergen was LIKELY eaten, for ANY symptoms.

☐ If checked, give epinephrine immediately if the allergen was DEFINITELY eaten, even if no symptoms are apparent.

FOR **ANY** OF THE FOLLOWING:

SEVERE SYMPTOMS

LUNG
Short of breath, wheezing, repetitive cough

HEART
Pale, blue, faint, weak pulse, dizzy

THROAT
Tight, hoarse, trouble breathing/ swallowing

MOUTH
Significant swelling of the tongue and/or lips

SKIN
Many hives over body, widespread redness

GUT
Repetitive vomiting, severe diarrhea

OTHER
Feeling something bad is about to happen, anxiety, confusion

OR A COMBINATION of symptoms from different body areas.

1. **INJECT EPINEPHRINE IMMEDIATELY.**
2. **Call 911.** Tell emergency dispatcher the person is having anaphylaxis and may need epinephrine when emergency responders arrive.

- Consider giving additional medications following epinephrine:
  - » Antihistamine
  - » Inhaler (bronchodilator) if wheezing
- Lay the person flat, raise legs and keep warm. If breathing is difficult or they are vomiting, let them sit up or lie on their side.
- If symptoms do not improve, or symptoms return, more doses of epinephrine can be given about 5 minutes or more after the last dose.
- Alert emergency contacts.
- Transport patient to ER, even if symptoms resolve. Patient should remain in ER for at least 4 hours because symptoms may return.

MILD SYMPTOMS

NOSE
Itchy/runny nose, sneezing

MOUTH
Itchy mouth

SKIN
A few hives, mild itch

GUT
Mild nausea/ discomfort

FOR **MILD SYMPTOMS** FROM **MORE THAN ONE** SYSTEM AREA, GIVE EPINEPHRINE.

FOR **MILD SYMPTOMS** FROM **A SINGLE SYSTEM** AREA, FOLLOW THE DIRECTIONS BELOW:

1. Antihistamines may be given, if ordered by a healthcare provider.
2. Stay with the person; alert emergency contacts.
3. Watch closely for changes. If symptoms worsen, give epinephrine.

MEDICATIONS/DOSES

Epinephrine Brand or Generic: _____

Epinephrine Dose: ☐ 0.15 mg IM ☐ 0.3 mg IM

Antihistamine Brand or Generic: _____

Antihistamine Dose: _____

Other (e.g., inhaler-bronchodilator if wheezing): _____

_____

PATIENT OR PARENT/GUARDIAN AUTHORIZATION SIGNATURE DATE PHYSICIAN/HCP AUTHORIZATION SIGNATURE DATE

FORM PROVIDED COURTESY OF FOOD ALLERGY RESEARCH & EDUCATION (FARE) (FOODALLERGY.ORG) 7/2016

_____'s Asthma Action Plan DOB: _____

Child's Name

Avoid Triggers: (Check all that apply)

☐ Illness	☐ Cigarette/other smoke	☐ Food:
☐ Emotions	☐ Exercise	☐ Allergies:
☐ Weather Changes	☐ Chemical odors	☐ Other:

Green Zone:
Child breathing at best
Well

- sleeps through the night without coughing or wheezing
- has no early warning signs of an asthma flare-up
- plays actively

Take Long-Term Control medications:

- _____
- _____
- _____
- _____

Take quick-relief medicines 15 minutes before active playtime.

- _____
- _____

Parent: _____

Telephone:_____

Physician: _____

Telephone:_____

Adapted by the NC Child Care Health Consultants Association

Yellow Zone:
Child not breathing at best
Sick

- coughing or wheezing at night or at child care
- has early warning signs of a flare-up:

_____

_____

- has trouble doing usual activities/play,
- may self limit activities/ squat/hunch over
- decrease in appetite/difficulty drinking or taking a bottle.

Take quick–relief medicines:

- _____
- _____

Adjust Long-Term Control medicines as follows until back in Green Zone:

- _____
- _____

Activity Restrictions:

- _____

Ozone Restrictions:

- _____

Call child's parent if:

- child's symptoms do not improve or worsen 15 to 20 minutes after treatment

Call the physician if:

- parent not available

Red Zone:

- breathing is hard and fast
- coughing, short of breath, wheezing
- neck and chest "suck in" skin between ribs, above the breastbone and collarbone when breathing
- has trouble walking or talking
- stops activities
- unable to drink or take bottle

Emergency Medicine Plan:

- _____
- _____
- _____
- _____

Call 911 if

no improvement 15 minutes after quick relief medication given and

- nails or lips are blue
- is having trouble walking or talking
- cannot stop coughing

_____

Physician Signature

Date:_____

Children's Campus
First Steps to a Lifetime of Learning

Infant/Toddler Safe Sleep Policy

Revised: Dec 12 2014

Sudden Infant Death Syndrome (SIDS) 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 infant died, and a review of the infant's medical history.

We believe that a safe sleep environment for infants helps lower the chances of an infant dying from SIDS, and that parents and child care providers can work together to provide a safe sleep environment. According to N.C. Law G.S. 100-91 (15), child care providers caring for infants 12 months of age or younger, are required to implement a safe sleep policy, share the safe sleep policy with parents/guardians, and participate in Infant-Toddler Safe Sleep and SIDS Risk Reduction in Child Care training. The Children's Campus will implement the following safe sleep practices.

Safe Sleep Practices

1. All child care staff caring for infants and child care staff that may potentially care for infants will receive training on how to implement our infant Safe Sleep Policy.
2. Infants will always be placed on their **backs to sleep**, unless there is a signed *Alternate Sleep Position Waiver*- Health Care Professional Recommendation (Medical Waiver) or an *Alternate Sleep Position Waiver* – Parent Request (for infants older than 6 months) in the infant's file. A waiver notice will be posted at the infant's crib. Waivers will be retained in the children's record as long as they are enrolled. Parents of infants over the age of 6 months who request a waiver will be advised by the director about best safe sleep practices prior to filling out the waiver form.
3. When babies can easily turn over from the back to the stomach, they will be placed to sleep on their backs and then allowed to adopt the sleep position they prefer. This is in accordance with the American Academy of Pediatrics (AAP) recommendations. Child care staff can further discuss with parents how to address circumstances when the baby turns onto their stomach or side.
4. Sleeping infants will be visually checked daily, every 15-20 minutes, by assigned staff. The sleep information will be recorded on a Sleep Chart. The Sleep Chart will be kept on file for one month after the reporting month. We will be especially alert to monitoring a sleeping infant during the first weeks the infant is in child care. We will check the infant for:
   - Normal skin color
   - Normal breathing by watching the rise and fall of the chest
   - His or her level of sleep
   - Signs of overheating: flushed skin color, increase in body temperature (touch the skin), and restlessness
5. Staff will reduce the risk of overheating by not over-dressing or over-wrapping the infants.
6. All parents/guardians of infants cared for in the facility will receive a written copy of our Infant/Toddler Safe Sleep Policy before enrollment, will review the policy with staff, and sign a statement saying they received and reviewed the policy.
7. The temperature in the room where the infant(s) sleep will be kept between 68-75°F and monitored by the thermometer kept in the infant sleeping room.
8. To promote healthy development, awake infants will be given supervised "tummy time" for exercise and for play.

Safe Sleep Environment

9. Infants' heads will not be covered with blankets or bedding. Infants' cribs will not be covered with blankets or bedding. We may use a sleep sack instead of a blanket. This facility does not allow swaddling practices.
10. No loose bedding, blankets, pillows, bumper pads, etc. will be used in cribs.
11. Toys and stuffed animals will be removed from the crib when the infant is sleeping.
12. Pacifiers will be allowed in infants' mouths while they sleep. When the pacifier falls out of the sleeping infant's mouth, it will not be reinserted into the infant's mouth and will be removed from the crib.
13. A safety-approved crib with a firm mattress and tight fitting sheet will be used or from 6 months old or when developmentally we may transition to a 2 inch mat.
14. Each infant will be assigned to and sleep in his or her own crib or mat. Only one infant will be in a crib/mat at a time, unless we are evacuating infants in an emergency or drill.
15. Infants who fall asleep in a bouncer seat or on the floor will be immediately placed in their crib or mat to continue their rest time.
16. No smoking is permitted in the infant room or on the premises.

Distribution: Parents and staff will review the policy and be informed of changes 14 days before the effective date. One copy signed by parent(s)/guardian(s) will be given to parent(s)/guardian(s) and one copy will be kept in child's facility record.

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: _____

SAMPLE
FORM

Infant Feeding Schedule

Name of Child _____ Date_____

Date of Birth_____

General Instructions

1. Food/Bottles Brought Daily: (quantity)

2. Instructions for Feeding:

A. Bottles (formula, milk, juice)

B. Food (cereal, baby food, table food)

_____
Parent Signature

Changes in Schedule (Must be recorded as eating habits change)

Introduce:	**Date**	**New Instructions**	**Parent or Staff Signature**
Juice			
Cereal			
Baby Food			
Milk			
Table Food			

*Must be completed for all children less than 15 months old