Student Application

Child Information

Full Name:______________________________ Nickname________________________ Date of Birth_________________________

Physical Address:____

City:____ Zip Code:____________________________________

Child Lives With____

Parent/Guardian Information

Father/Guardians Name: ________________________Phone Number:________________Email Address:______________________

Address (if different from child's)___________________________City________________________ZIP________________________

Mother/Guardians Name: ________________________Phone Number:________________Email Address:______________________

Address (if different from child's)___________________________City________________________ZIP________________________

Emergency Contacts/Approved Pickup (Please list at least 2 emergency contacts other than parents)

Emergency Contact Name:__________________________ Relationship:________________ Phone:__________________________

Emergency Contact Name:__________________________ Relationship:________________ Phone:__________________________

Other Individuals Approved for Pickup:____

____

____

Health Care Needs:

For any child with health care needs (allergies, asthma, or other chronic conditions that may require specified health services), a medical action plan shall be attached to this application. The action play should be completed by the child's parent or health care professional. Is there an action plan attached? Yes______ No______

List any allergies and accompanying symptoms:____

List any health concerns:____

List any medications taken for health concerns:____

List any other pertinent information:____

Pediatrician Name:____ Office Phone Number:_________________________________

Hospital Preference (We cannot accept "closest"):___________________ Preferred Hospital Phone Number:___________________

I, as the parent/guardian, authorize the center to obtain medical attention for my child in an emergency.

Parent/Guardian Signature____ Date:______________________________

I, as the Operator, agree to provide transportation to an appropriate medical resource in the event of an emergency. In the event of an emergency, other children in the facility will be supervised by a responsible adult. I will not administer any drug or medication without specific instructions from the physician, parent, or guardian.

Administrator Signature____ Date:______________________________

Experience Record

All of the information you provide is used for the purpose of helping the appropriate staff members know the individual child better. Thank you!

1. Who are the members of your present household?

Name	Relation to child	Nickname

2. Who are the other persons close to the family? Please include siblings, grandparents, pets,

Name	Relation to child	Nickname

3. Do you have any a unique family arrangement that you believe would be important for our staff to understand?

4. Has your child previously been in a group experience or another child care center?

5. How was that experience for your family and your child? Please give us any details that may help us acclimate your child to CBCP better based on his/her prior experience.

Experience Record

6. How does your family value church attendance?

7. In which programs do you and your child participate within your church?

8. How would you describe your relationship with God?

—Mom

—Dad

9. What are your child's favorite play activities?

10. What do you notice most about your child's play with others?

11. What do you notice most about your child's play when he/she is alone?

12. What are your child's favorite screen time activities (i.e. TV, videos, technology)

13. How frequently does your child engage in screen time?

14. What are your child's favorite books and stories?

15. Do you have any concerns regarding your child's physical or cognitive development? If so, please let us know what they are so that we may best help address these concerns.

Experience Record

16. Please describe any serious illnesses or injuries your child has experienced in the past, including any requiring hospital stays.

17. Does your child take a nap? What time (s)?

(infants sleep schedule will be discussed with the classroom teachers as needed.)

18. What is your child's bedtime? What time does your child typically wake up?

19. Does your child fall asleep easily?

20. What do you do to help when needed?

21. Is your child accustomed to sleeping in a room alone? (This may affect how adjusting to naptime at preschool goes.)

22. What words does your family use for parts of the body and bodily functions as they relate to toileting?

23. If shy or not verbal, what are some signals your child gives to let you know it is time to go to the bathroom?

24. Please share any other information that would be helpful in best serving your child's needs.

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 the parent)

1. Is child allergic to anything? No____ Yes____ If yes, what?___________________
2. Is child currently under a doctors 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 what for?__________________
5. Any history of significant previous diseases or recurrent illnesses? 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____ follow up____

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 #**______________________

Authorizations / Agreements

These authorizations are valid for the duration of my child's enrollment

I, ____________________________ give CBC Preschool my permission:
parent/guardian (please print)

__________ I give CBC Preschool my permission to transport my child off campus in the event of an
Initial emergency evacuation only

__________ I also allow CBC Preschool permission to use the image of my child.
Initial Such use includes the display, distribution, publication, transmission, or otherwise use of photographs, images and/or video taken of my child for use in materials that include, but my not be limited to, printed materials such as brochures and newsletters, videos, and digital images such as those on our website.

__________ I allow CBC Preschool permission to use the image of my child for display within the facility.
Initial

__________ Central Baptist Church Preschool agrees with *NC Child Care Rule.0604 Children shall be in a*
Initial *smoke free and tobacco free environment. Smoking and the use of any product containing, made or derived from tobacco, including e-cigarettes, cigars, little cigars, smokeless tobacco, and hookah, shall not be permitted on the premises of the child care center, in vehicles used transport children, or during any off-premise activities. All smoking materials shall be kept in locked storage.* For child care centers in an occupied residence that are licensed for 3 to 12 children when any preschool-age children are in care, or for 3 to 15 children when only school-age children in care, the premises shall be smoke free and tobacco free during operating hours.

I also agree that I have received the Parent Handbook found on the website. This handbook includes the following policies:

Discipline and Behavior Management Policy
Infant Safe Sleep Policy
Summary of NC Child Care Law and Rules
Prevention of Shaken Baby Syndrome

____ enrolled__________________________
Name of child *Date*

____
Parent/Guardian Signature *Date*

Outside Fence Permission Form

2020-2021

__ I do

__ I do not

give CBC Preschool my permission to allow my child outside of the fence for planned activities.

This permission is intended for the 2020-2021 school year.

____ enrolled _______________________

Name of child Date

____

Parent/Guardian Signature Date