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_______________

Operational Policies
Welcome to Ms Carolyn's Child Care Center/Preschool

1. The center is open Monday through Friday from 5:00am to 7:00pm.
2. We serve age's newborn up to 12 years of age.
3. There is a nonrefundable $45.00 registration fee charged per child and renewed yearly. The enrollment packet contains all necessary documents for enrollment such as (medical, rules, application, etc.) that needs to be filled out and returned by the first day of attendance along with Procare registration.
4. All weekly fees are due Monday of each week. If payment has not been made by Wednesday, your child will not be able to return and there will be a $15.00 late fee applied. DSS parents have to have their parent fee paid by the 15th of each month or a $15.00 late fee will be applied.
5. The weekly child care fee includes two meals, one snack and no more than 10 hours a day.

6. Transportation is included in the fee charged for after school children at the public schools we transport to. Snacks will be served when they arrive.

7. Children are not allowed to be dropped off after 11:00am. If a child has an appointment during this time frame, they cannot return before 2:00pm due to the interruption of nap time.

8. Children MUST be escorted to their class by the parent/guardian.

9. We welcome and encourage parent involvement at the center. This plays a very important part in your child's young life.

10. Parents are required to provide all necessities for their children i.e. (diapers, change of clothes and blanket) per state laws.

11. In the event of bad weather, we will post information on WRAL TV channel 5.

12. We participate in the CACFP program which is located in Raleigh, N C. and their phone number is 919)733-2973. This program allows us to provide nutritious meals and snacks. There is a food application

you will need to fill out and need to be update yearly for this program.

13. You will be notified in writing of any changes to the operational policy.

14. Ms Carolyn's Child Care is a tobacco and smoke-free facility.

15. Smart Start provides vision screening once a year at no cost to the parents.

Child name: ______________________________

Parents Signature: __________________________

Date ____________________________________

Ms Carolyn's Child Care Center

Rules and Procedures

Welcome to Ms Carolyns's Child Care located at 2590 Cumberland Creek Drive, Fayetteville, NC 28306, 910-425-6266. Registration fee is $45.00 per child per year. The registration fee is NON REFUNDABLE. The childcare fee that you are charged is for five (5) days per week and up to ten (10) hours per day. Please see rules and procedures below.

- **HOURS:** 5:00 am until 7:00 pm Monday through Friday
    - Children are not allowed to be dropped off between 11:00am and 2:00pm.
    - Hours cannot be carried over. If not used, they will be lost.
    - If you run over ten (10) hours, you will be charged an hourly rate.
    - If you arrive AFTER 7:00 PM you **WILL BE CHARGED** $5.00 PER MINUTE PER CHILD.
- **MEALS:** Your fee includes breakfast (8:00am – 9:00am), lunch (11:00am – 12:00pm) and afternoon snack (2:00pm – 3:00pm) NO MEALS WILL BE SERVED AFTER THESE TIMES.
- **NAPTIME:** Naptime is from 12:00pm – 2:00pm.
- **CHANGE OF CLOTHES:** Children **MUST** have a change of clothes **AT ALL TIMES** per State Law.
- **WEEKLY PAYMENT:** Payments are due on Monday of each week. If your child misses any days during the week, you are still charged full price. Payments not made by Wednesday will be charged a $15.00 late fee and the child/children WILL BE DENIED ENTRY.
- **NO CHECK POLICY:** Payments can be made by debit/credit card via Procare's Tuition Express at home, in the center OR you can pay cash and avoid the processing fee.
- **OPEN DOOR POLICY:** Ms. Carolyn's childcare center has an open door policy. Parents that wish to come may do so at ANY TIME with the exception of nap time.
- **VACATION:** You are entitled to a two week vacation per year at no charge AFTER your child has been enrolled for a period of six (6) months. If you take more than 2 weeks and/or you take vacation before your six month period, you will be charged FULL price to hold your child's place.
- **WITHDRAWEL:** You MUST give a two (2) week notice for withdrawing children or you will be OBLIGATED to pay the two weeks.
- **PERSONAL ITEMS:** We ARE NOT responsible for any personal items brought to the center by your child/children.
- **SMOKE FREE FACILITY:** Ms. Carolyn's Child Care Center is a tobacco and smoke free facility.

Enclosed in your packet is a copy of the state of North Carolina childcare rules that govern the state of North Carolina centers. Please sign and return all necessary paperwork by the first day of enrollment.

I have read and understand this contract

Child's Name: ______________________________

Parent's Signature: __________________________

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 #**____________

North Carolina Department of Health and Human Services
Women's and Children's Health
CHILD AND ADULT CARE FOOD PROGRAM
CHILD ELIGIBILITY APPLICATION

1. PRINT PARTICIPANT'S NAME & DATE OF BIRTH:

First Name   Last Name   Date of Birth

First Name   Last Name   Date of Birth

INSTITUTION NAME: Ms Carolyns Child Care

AGREEMENT#: 7697

FACILITY NAME: Ms Carolyns Child Care

2. SNAP, TANF or FDPIR: If a child is a member of a SNAP or FDPIR household or TANF recipient, the child is automatically eligible to receive free Program meal benefits, subject to the completion of the application. If the household currently receives SNAP, TANF or FDPIR benefits give the case number.

Case number is: **SNAP #** ______________ **TANF#:** ______________ **FDPIR #** ______________
If you have provided the case number; **DO NOT complete #3 and #4. Complete #5 and #6.**

3. A foster child is automatically eligible to receive free Program meal benefits, and a Head Start participant is automatically eligible to receive free Program meal benefits, subject to submission by Head Start officials of a Head Start statement of income eligibility or income eligibility documentation.

Is this a Foster Child? ☐Yes ☐No

Households with foster and non-foster children may choose to include the foster child as a household member, as well as any personal income earned by the foster child, on the same household application that includes their non-foster children.

Is this a homeless child or a child evacuated from Japan or Bahrain? ☐Yes ☐No

Certification from the agency that assisted with the evacuation or is providing shelter is required.

4. HOUSEHOLD MEMBERS MONTHLY INCOME: List all others living in your household, **DO NOT** include participant listed above. List all gross income **(before deductions)** received last month. If you did not give a SNAP, TANF or FDPIR case number or if this is not a foster child, you must complete the income information.

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

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

Last Four Digits of Social Security Number   Check if no SSN ☐
((Required for households 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.

For Institution to be classified and completed by institution/sponsor

TOTAL HOUSEHOLD SIZE ______ TOTAL HOUSEHOLD MONTHLY INCOME $ ______

Approved: ☐Free ☐Reduced ☐Denied

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

Withdrew on (Date): ______

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

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

Child and Adult Care Food Program (CACFP)
Child Participant Enrollment Form

Institution Name: ______________________ Agreement Number: ________

Center Name: ______________________

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 Ea (Circle all that appl
			____ to ____	M T W Th F Sat Sun	B AM L PM S
			____ to ____	M T W Th F Sat Sun	B AM L PM S
			____ to ____	M T W Th F Sat Sun	B AM L PM S
			____ to ____	M T W Th F Sat Sun	B AM L PM S
			____ to ____	M T W Th F Sat Sun	B AM L PM S

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.

Space and Equipment
There are space requirements for indoor and outdoor environments that must be measured prior to licensure. Outdoor play space must be fenced. Indoor equipment must be clean, safe, well maintained, and developmentally appropriate. Indoor and outdoor equipment and furnishings must be child size, sturdy, and free of hazards that could injure children.

Licensed centers must also meet requirements in the following areas.

Staff Requirements
The administrator of a child care center must be at least 21 and have at least a North Carolina Early Childhood Administration Credential or its equivalent. Lead teachers in a child care center must be at least 18 and have at least a North Carolina Early Childhood Credential or its equivalent. If administrators and lead teachers do not meet this requirement, they must begin credential coursework within six months of being hired. Staff younger than 18 years of age must work under the direct supervision of staff 21 years of age or older. All staff must complete a minimum number of training hours, including ITS-SIDS training for any caregiver that works with infants 12 months of age or younger. All staff who work directly with children must have CPR and First Aid training, and at least one person who completed the training must be present at all times when children are in care. One staff must complete the Emergency Preparedness and Response (EPR) in Child Care training and create the EPR plan. All staff must also undergo a criminal background check initially, and every three years thereafter.

Staff/Child Ratios
Ratios are the number of staff required to supervise a certain number of children. Group size is the maximum number of children in one group. Ratios and group sizes for licensure are shown below and must be posted in each classroom.

Age	Teacher: Child Ratio	Max Group Size
0-12 months	1:5	10
12-24 months	1:6	12
2 to 3 years old	1:10	20
3 to 4 years old	1:15	25
4 to 5 years old	1:20	25
5 years and older	1:25	25

Additional Staff/Child Ratio Information:
Centers located in a residence that are licensed for six to twelve children may keep up to three additional school-age children, depending on the ages of the other children in care. When the group has children of different ages, staff-child ratios and group size must be met for the youngest child in the group.

Reviewing Facility Information

From the Division's Child care Facility Search Site, the facility and visit documentation can be viewed.
A public file is maintained in the Division's main office in Raleigh for every licensed center or family child care home. These files can be viewed during business hours (8 a.m. -5 p.m.) by contacting the Division at 919-814-6300 or 1-800-859-0829 or requested via the Division's web site at www.ncchildcare.ncdhhs.gov.

How to Report a Problem
North Carolina law requires staff from the Division of Child Development and Early Education to investigate a licensed family child care home or child care center when there has been a complaint. Child care providers who violate the law or rules may be issued an administrative action, fined and/or may have their licenses suspended or revoked.

Administrative actions must be posted in the facility. If you believe that a child care provider fails to meet the requirements described in this pamphlet, or if you have questions, please call the Division of Child Development and Early Education at 919-814-6300 or 1-800-859-0829.

NC DEPARTMENT OF
HEALTH AND HUMAN SERVICES
Division of Child Development and Early Education

Summary of the North Carolina Child Care Law and Rules
(Center and FCCH)

Division of Child Development and Early Education

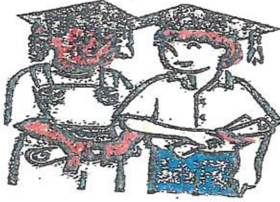
North Carolina Department of Health and Human Services
333 Six Forks Road
Raleigh, NC 27609

Child Care Commission
https://ncchildcare.ncdhhs.gov/Home/Child-Care-Commission

Revised June 2019

The North Carolina Department of Health and Human Services does not discriminate on the basis of race, color, national origin, sex, religion, age or disability in employment or provision of services.

Ms Carolyn's Child Care & Preschool



2590 Cumberland Creek Drive

Fayetteville, N.C. 28306

Mscarolyns6266@gmail.com

I have received a copy of the North Carolina Child Care Laws and Rules attached to my child care application.

Parent Signature ________________

Date ________________

TRAVEL AND ACTIVITY AUTHORIZATION

☐ Blanket permission for this activity
☐ Special 1-time permission only
☐ Blanket permission for all given activities

I, ______________________________________ parent/guardian of
name of parent/guardian

______________________________________ give my permission to
name of child

______________________________________ for my child to participate in the
following activities name of

Trips in the van/automobile (facility or parent-owned)

To and From all public school's / Emergency purposes to Hospital
Explain planned activity – where and when

Field trips away from the facility

Will be posted at the office and classroom for parents to approve
Explain planned activity – where and when

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.

____
Parent/Guardian Signature

____
Date Signed

This authorization is valid from ____/____/____ to ____/____/____ OR until.

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

______ I will allow my child to play outside the fenced area; or

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

____
Parent/Guardian Signature

____
Date Signed

This authorization is valid from ____/____/____ to ____/____/____ OR until

Ms Carolyn's Child Care

2590 Cumberland Creek Drive
Fayetteville, N.C. 28306
910-425-6266
License # 26001078

As the parent/guardian of ______________________________

I hereby,

DO give my permission for my child's photo to be used in the following (check all that apply) :

- Within the center
- Materials sent home with parents (newsletters, etc.)
- Outside sources (advertising, website, etc.)

DO NOT give my permission for my child's photo to be used for any purpose.

Signature of Parent/Guardian ___________________________

Date _____________

Vacation Dates

Childs Name_______________ Start Date__________

____ Year Wk1_____________ Wk2____________

____ Year Wk1_____________ Wk2____________

____ Year Wk1_____________ Wk2____________

____ Year Wk1_____________ Wk2____________

____ Year Wk1_____________ Wk2____________

____ Year Wk1_____________ Wk2____________

____ Year Wk1_____________ Wk2____________

____ Year Wk1_____________ Wk2____________

____ Year Wk1_____________ Wk2____________