A BRIGHT START CHILD CARE LEARNING CENTER APPLICATION FOR ENROLLMENT

Date Application Completed: _____Date of Child's Enrollment: _____

CHILD INFORMATION

Date of Birth: _____
Name: (First)_____(Middle)_____(Last)_____(Nickname)_____
Address: _____(City)_____(Zip Code)_____
Child lives with: Mother Father Grandparents Other If "Other", Explain Relationship: _____

PARENT/ GUARDIAN INFORMATION

Mother/Guardian Name: _____
Address: _____
_____
Home Phone: _____
Cell Phone: _____
Employer: _____
Work Phone: _____
E-Mail Address: _____

Father/Guardian Name: _____
Address: _____
_____
Home Phone: _____
Cell Phone: _____
Employer: _____
Work Phone: _____
E-Mail Address: _____

CHILD RELEASE CONTACTS

My child can be released to the following individuals and in the event of an emergency and the parent/guardian cannot be reached. A Bright Start Child Care Learning Center can contact the following individuals, as authorized by the person who signs this application.

NAME *(First & Last)*	**RELATIONSHIP** *(To Child)*	**ADDRESS**	**PHONE NUMBER**
1.			
2.			
3.			
4.			

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 health care professional.

My child has: Asthma Allergies Diabetes Food Allergies Seizures Other: _____
MY CHILD NEEDS A MEDICAL ACTION PLAN COMPLETED BY HIS/HER PHYSICIAN TO BEGIN CHILD CARE: Yes No
List any health care needs/concerns:_____
List any fears or unique behavior characteristics your child may have: _____
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 child's Health Care Professional (Doctor): _____Phone Number:_____
Hospital Preferred for Emergency Treatment: _____Phone Number: _____

FIRE DRILL AND FIELD TRIP ACTIVITIES OUTSIDE THE FENCED PLAYGROUND AREA

I give permission to A Bright Start Child Care Learning Center for my child to participate in a walking trip or fire drill. I further give my permission to the facility for my child to participate in developmentally appropriate supervised activities outside of the fenced playground area.

Parent/Guardian Signature: _____Date: _____

I, as the parent/guardian, authorize A Bright Start Child Care Learning Center to obtain medical attention for my child in an emergency.

Parent/Guardian Signature: _____Date: _____

I, as the operator, do agree to provide transportation to an appropriate medical resource in the event of emergency. in 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 or the child's parent/guardian.

Signature of Administrator: _____Date:_____

ADDITIONAL CONTACT RELEASE AUTHORIZATION

Please sign here acknowledging that all names listed below are provided and approved by you, the child's parent/guardian, to be contacted or released in an event we can not contact you or an emergency:

Parent/Guardian Signature: _____Date:_____

NAME	RELATIONSHIP TO CHILD	PHONE NUMBER	DATE ADDED	INITIAL TO REMOVE/ DATE

Discipline and Behavior Management Policy

Name of Facility:_____ Date Adopted _____

No child shall be subjected to any form of corporate punishment. Praise and positive reinforcement are effective methods of 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 age and developmentally appropriate 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 stay consistent in our behavior management program.
12. DO use effective guidance and behavior management techniques that focus on a child's development.
13. DO use short supervised periods of time-out sparingly.

We:

1. DO NOT handle children roughly in any way, including shaking, pushing, shoving, pinching, slapping, biting, kicking, or spanking.
2. DO NOT place children in a locked room, closet, or box or leave children alone in a room separated from staff.
3. DO NOT delegate discipline to another child.
4. DO NOT withhold food as punishment or give food as a means of reward.
5. DO NOT discipline for toileting accidents.
6. DO NOT discipline for not sleeping during rest period.
7. DO NOT discipline children by assigning chores that require contact with or use of hazardous materials, such as cleaning bathrooms, floors, or emptying diaper pails.
8. DO NOT withhold or require physical activity, such as running laps and doing push-ups, as punishment.
9. DO NOT yell at, shame, humiliate, frighten, threaten, or bully children.
10. DO NOT restrain children as a form of discipline unless the child's safety or the safety of others is at risk.

The program's goals for helping children develop self-control and learn acceptable forms of social behavior are:

_____

_____

_____

_____

Children are helped to resolve conflict and develop problem solving skills with peers by:

_____

_____

_____

_____

I ensure myself and the additional caregivers follow the programs discipline and behavior management policies and practices and use behavior management strategies appropriately by:

_____

_____

_____

_____

Local resources that can assist with services and support when persistent challenging behaviors continue to occur are:

_____

_____

_____

_____

Operator:

I, the undersigned facility director/operator (or other designated staff member) of

_____ Do hereby state that
(facility name)

I have given and discussed the facility's Discipline and Behavior Management Policy with the child's parent or guardian.

_____ _____

Signature of Director, Operator, (or other designated staff member) Date

Parent or Guardian:

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/operator (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_____

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

Child Immunization History

G.S. 130A-155. Submission of certificate to child care facility/G.S.130A-154. Certificate of immunization.

The parent/guardian must submit a certificate of immunization on child's first day of attendance or within 30 calendar days from the first day of attendance.

Child's full name:	Date of birth:

Enter the date of each dose received (Month/Day/Year) or attach a copy of the immunization record.

Vaccine Type	Abbreviation	Trade Name	Combination Vaccines	1 date	2 date	3 date	4 date	5 date
Diphtheria, Tetanus, Pertussis	DTaP, DT, DTP	Infanrix, Daptacel	Pediarix, Pentacel, Kinrix					
Polio	IPV	IPOL	Pediarix, Pentacel, Kinrix					
Haemophilus influenza type B	Hib (PRP-T) Hib (PRP-OMP)	ActHIB, PedvaxHIB **, Hiberix	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, PCV13, PPSV23***	Prevnar 13, Pneumovax***						

*Required by state law for children born on or after 7/1/2015.
**3 shots of PedvaxHIB are equivalent to 4 Hib doses. 4 doses are required if a child receives more than one brand of Hib shots.
***PPSV23 or Pneumovax is a different vaccine than Prevnar 13 and may be seen in high risk children over age 2. These children would also have received Prevnar 13.
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

Minimum State Vaccine Requirements for Child Care Entry

By This Age:	Children Need These Shots:						
3 months	1 DTaP	1 Polio		1 Hib	1 Hep B	1 PCV	
5 months	2 DTaP	2 Polio		2 Hib	2 Hep B	2 PCV	
7 months	3 DTaP	2 Polio		2-3 Hib**	2 Hep B	3 PCV	
12-16 months	3 DTaP	2 Polio	1 MMR	3-4 Hib**	3 Hep B	4 PCV	1 Var
19 months	4 DTaP	3 Polio	1 MMR	3-4 Hib**	3 Hep B	4 PCV	1 Var
4 years or older (in child care only)	4 DTaP	3 Polio	1 MMR	3-4 Hib**	3 Hep B	4 PCV	1 Var
4 years and older (in kindergarten)	5 DTaP	4 Polio	2 MMR	3-4 Hib**	3 Hep B	4 PCV	2 Var

Note: For children behind on immunizations, a catch-up schedule must meet minimal interval requirements for vaccines within a series. Consult with child's health care provider for questions.

Child Immunization History

G.S. 130A-155. Submission of certificate to child care facility/G.S.130A-154. Certificate of immunization.

Vaccines Recommended (not required) by the Advisory Committee on Immunization Practices (ACIP)

Vaccine Type	Abbreviation	Trade Name	Recommended Schedule	1 date	2 date	3 date	4 date	5 date
Rotavirus	RV1, RV5	Rotateq, Rotarix	Age 2 months, 4 months, 6 months.					
Hepatitis A	Hep A	Havrix, Vaqta	First dose, age 12-23 months. Second dose, within 6-18 months.					
Influenza	Flu, IIV, LAIV	Fluzone, Fluarix, FluLaval, Flucelvax, FluMist, Afluria	Annually after age 6 months.					

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 #** _____

Infant Feeding Plan

As your child's caregivers, an important part of our job is feeding your baby. The information you provide below will help us to do our very best to help your baby grow and thrive. **Page two of this form must be completed and posted for quick reference for all children under 15 months of age.**

Child's name: _____ Birthday: _____
mm / dd / yyyy

Parent/Guardian's name(s): _____

Did you receive a copy of our "Infant Feeding Guide?" Yes No

If you are breastfeeding, did you receive a copy of:
"Breastfeeding: Making It Work?" Yes No
"Breastfeeding and Child Care: What Moms Can Do?" Yes No

TO BE COMPLETED BY PARENT

At home, my baby drinks (check all that apply):

- Mother's milk from (circle)
  Mother bottle cup other
- Formula from (circle)
  bottle cup other
- Cow's milk from (circle)
  bottle cup other
- Other: _____ from (circle)
  bottle cup other

How does your child show you that s/he is hungry?

How often does your child usually feed?

How much milk/formula does your child usually drink in one feeding?

Has your child started eating solid foods?

If so, what foods is s/he eating?

How often does s/he eat solid food, and how much?

TO BE COMPLETED BY TEACHER

Clarifications/Additional Details:

At home, is baby fed in response to the baby's cues that s/he is hungry, rather than on a schedule?
Yes No

If NO,

- I made sure that parents have a copy of the "Infant Feeding Guide" or "Breastfeeding: Making it Work"
- I showed parents the section on reading baby's cues

Is baby receiving solid food? Yes No

Is baby under 6 months of age? Yes No

If YES to both,

- I have asked: Did the child's health care provider recommend starting solids before six months?
  Yes No

If NO,

- I have shared the recommendation that solids are started at about six months.

Handouts shared with parents:

Child's name: _____ Birthday: _____
mm / dd / yyyy

Tell us about your baby's feedings at our center.
I want my child to be fed the following foods while in your care:

	Frequency of feedings	Approximate amount per feeding	Will you bring from home? (must be labeled and dated)	Details about feeding
Mother's Milk				
Formula				
Cow's milk				
Cereal				
Baby Food				
Table Food				
Other (describe)				

I plan to come to the center to nurse / feed my baby at the following time(s): _____

My usual pick-up time will be: _____

If my baby is crying or seems hungry shortly before I am going to arrive, you should do the following (choose as many as apply):
__ hold my baby __ use the teething toy I provided __ use the pacifier I provided
__ rock my baby __ give a bottle of milk __ other Specify: _____

I would like you to take this action _____ minutes before my arrival time.

At the end of the day, please do the following (choose one):
____ Return all thawed and frozen milk / formula to me. _____ Discard all thawed and frozen milk / formula.

We have discussed the above plan, and made any needed changes or clarifications.

Today's date: _____

Teacher Signature: _____ Parent Signature _____

Any changes must be noted below and initialed by both the teacher and the parent.

Date	Change to Feeding Plan (must be recorded as feeding habits change)	Parent Initials	Teacher Initials

CAROLINA GLOBAL BREASTFEEDING INSTITUTE
Breastfeeding-Friendly CHILD CARE

In Collaboration With:
NC Department of Health and Human Services
NC Child Care Health and Safety Resource Center
NC Infant Toddler Enhancement Project

Infant/Toddler Safe Sleep Policy

Child Care Facility: _____

A safe sleep environment for infants reduces the risk of sudden infant death syndrome (SIDS) and other sleep related infant deaths. According to N.C. Law, child care providers caring for infants 12 months of age or younger are required to implement a safe sleep policy and share the policy with parents/guardians and staff. We implement the following safe sleep policy.
References: N.C. Law G.S. 100-91 (15), N.C. Child Care Rules .0606 and .1724, Caring for Our Children

Safe Sleep Practices

1. We train all staff, substitutes, and volunteers caring for infants aged 12 months or younger on how to implement our Infant/Toddler Safe Sleep Policy.
2. We always place infants under 6 months of age on their **backs to sleep**, unless a signed *ITS-SIDS Alternate Sleep Position Health Care Professional Waiver* is in the infant's file and posted at the infant's crib. We retain the waiver in the child's record for as long as they are enrolled.
3. ☐ We do not accept *Parent Waivers* for infants older than six months.* **-OR-**
   ☐ We accept the *ITS-SIDS Alternate Sleep Position Parent Waiver*.
4. We place infants on their backs to sleep even after they can easily turn over from the back to the stomach. We then allow them to adopt their own position for sleep.
   ☐ We document when each infant can roll from back to stomach and tell the parents. We put a notice in the child's file and on or near the infant's crib.*
5. We visually check sleeping infants every 15 minutes and record what we see on a *Sleep Chart*.
   ☐ We check infants 2-4 month of age more frequently.*
6. We maintain the temperature in the room where infants sleep between 68-75°F and check it on the thermometer in the room.
   ☐ We further reduce the risk of overheating by not over-dressing infants*
7. We provide all infants supervised "tummy time" daily.
8. We follow N.C Child Care Rules .0901(k) and .1706(j) regarding breastfeeding.
   ☐ We further encourage breastfeeding in the following ways:* _____

Safe Sleep Environment

9. We use Consumer Product Safety Commission (CPSC) approved cribs or other approved sleep spaces for infants. Each infant has his or her own crib or sleep space.
10. ☐ We do not allow infants to use pacifiers. **-OR-**
    ☐ We allow pacifiers without any attachments. Pacifiers attached to clothing will be removed when placed to sleep.
    ☐ We do not reinsert the pacifier in the infant's mouth if it falls out.*
    ☐ We remove the pacifier from the crib once it has fallen from the infant's mouth.*
11. We do not allow infants to be swaddled.
12. We do not allow garments that restrict movement.*
13. We do not allow any objects, such as, pillows, blankets, or toys other than pacifiers in the crib or sleep space.
14. Infants are not placed in or left in car safety seats, strollers, swings, or infant carriers to sleep.
15. We give all parents/guardians of infants a written copy of the *Infant/Toddler Safe Sleep Policy* before enrollment. We review the policy with them, and ask them to sign a statement saying they received and reviewed the policy.
    ☐ We encourage families to follow the same safe sleep practices to ease infants' transition to child care.*
16. Family child care homes: We post a copy of this policy and a safe sleep practices poster in the infant sleep room where it can easily be read.
17. Centers: We post a copy of this policy in the infant sleep room where it can easily be read.

**Indicates we follow this best practice recommendation.*

Effective date:_____ **Review date(s):** _____ **Revision date(s):** _____

Distribution: We give parents/guardians a copy of the policy. We give all staff, substitutes and volunteers a copy to review. We inform them of changes 14 days before the effective date. We give parents/guardians a copy of the policy they signed and put a copy in child's file.

I, the undersigned parent/guardian of _____ (child's full name), have received a copy of the facility's *Infant/Toddler Safe Sleep Policy*. I have read the policy and discussed it the facility director/owner/operator, or other designated staff member.

Child's Enrollment Date: _____ Parent/Guardian Signature: _____ Date: _____

Facility Representative Signature: _____ Date: _____

Prevention of Shaken Baby Syndrome and Abusive Head Trauma
SAMPLE Policy

Belief Statement
We, _____ (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: _____

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
SAMPLE Policy

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 _____

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.

Effective Date

This policy was reviewed and approved by:

Owner/Director (recommended) **Date**

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

Annual Review Dates

Acknowledgements

Documentation of Receipt: Summary of Child Care Law

By signing below, you are acknowledging you have received A Bright Start Child Care Learning Center Operational Policies

Signature: _____ Date: _____

Documentation or Receipt: Center Operational Policies

By signing below, you are acknowledging you have received the Summary of North Carolina Child Care Law for Child Care Centers

Signature: _____ Date: _____

Documentation or Receipt: Prevention of Shaken Baby Syndrome and Abusive Head Trauma Policies

I, the parent/guardian of _____, 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 or guardian: _____

Date of child's enrollment: _____

Print name of parent/guardian: _____

Signature of Parent/ guardian: _____

Date: _____

Permission to Photograph

I give permission for A Bright Start Child Care Learning Center to photograph my child for the following purposes:

Type of Use	Grant Permission	Decline Permission
Display in my child's portfolio	ð	ð
Give photographs possibly containing your child to current clients (ex: Classroom photo)	ð	ð
Display in facility's bulletin boards, shown to current and prospective clients	ð	ð

I understand that it is my responsibility to update this form in the even that I no longer wish to authorize one or more of the above uses. I agree that this form will remain in effect during the term of my child's enrollment.

Parent Guardian Signature_____ Date_____

A Bright Start Child Care Learning Center Notification of Smocking and Tobacco Restriction

Objective:

To maintain a smoke free-environment and protect the health of all those who work, attend, or visit A Bright Start Child Care Learning Center.

A Bright Start Child Care is a smoke free- environment, in accordance with the North Carolina Division of Child Care children must be in a smoke free and tobacco free environment. [Rules. 0604]

Policy: Effective May 1, 2018

Smoking and the use of any product containing, made, or derived from tobacco, is not permitted on the premises, in vehicles used to transport children, or during off premise activities.

Responsibilities and Procedures:

1. "No Smoking' signs are posted at each entrance and in vehicles used to transport children.
2. Notice will be given to all parents in writing of the smoking and tobacco restriction before their child is enrolled.
3. Notice will be given to all employees and volunteer prior to providing care or guidance to the children.
4. The smoking and tobacco restriction policy will be reviewed with staff at commencement of employment.

Print

Name_____**Signature**_____**Date**_____

Check one that applies:

ð Employer

ð Employee

ð Parent/ Guardian

ð Volunteer

A Bright Start Child Care Learning Center
Children's File Checklist

Name of Child_____ Date of Enrollment_____

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

Item	Due Date	Date Received/Completed
ð Application for enrollment	1st Day	
ð Emergency Medical Care Information/Medical Action Plan (If applicable)	1st Day/updated as changes occur	
ð Medical Report	Within 30 days of enrollment	
ð Immunization Record	Within 30 days of enrollment	
ð Documentation of Receipt: Discipline Policy	1st Day	
ð Infant feeding plan (children less than 15 months old)	1st Day	
ð Infant sleep position waivers (if applicable)	1st Day	
ð Infant safe sleep visual check chart (if applicable)	1st Day	
ð Documentation of Receipt: Center Operational Polices (if applicable)	1st Day	
ð Authorization for Transportation (if applicable)	1st Day/ As occurs	
ð Documentation of Receipt: Summary of Child Care Law	1st Day	
ð Copies of Incident Reports	As occurs	
ð Emergency Medical Care Authorization	1st Day	
ð Medication authorization, Record of Medication Administration (if applicable), and Medication Error Report (if applicable)	As occurs	
ð Off premise activities authorization	As occurs	
ð Permission to transport/participate in off premise activities (if applicable)	1st Day	
ð Nutrition opt-out form (if applicable)	As occurs	
ð Documentation of Receipt: Prevention of Shaken Baby Syndrome and Abusive Head Trauma Policies	1st Day	
ð Permission for aquatic activities (if applicable)	1st Day	
ð Notification of smoking and tobacco restriction	1st Day	
ð Photo Authorization Form	1st Day	
ð IEP/IFSP	1st Day/ As occurs	
ð Discipline Notices	As occurs	