Office Use Only

Class _____

_____

First Baptist Church
7th & Walnut, Lumberton, NC
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First Baptist Early Childhood Ministry

Application for Childcare

Complete each line of the attached application. If the information does not apply, write "n/a" on the line.

Date of Application: _____ Date of Enrollment: _____

Name of Child: _____

Child's Date of Birth: _____

Parent/Guardian(s): _____

Phone: _____ Email: _____

Will you be applying for NC Pre-K? _____ If yes, notify us of child's enrollment status.

Has your child been previously enrolled in childcare? _____ Name of Facility: _____

School-age applicants, please complete:

School for the current school year: _____ Grade: _____

School for the upcoming school year: _____ Grade: _____

Get updates through Remind by texting @fbcecm to 81010. Emergency information is sent through Facebook, Remind, and Email. Please provide at least one email address.

Checklist

I have completed:

_____ the registration packet completely and attached the registration fee. Packets are not accepted without fee attached. Registration fees are $60.00 for Daycare, $50.00 for PreK Wraparound care, $50.00 for Afterschool care, $20.00 for Summer only care.

_____ an Emergency Card and a Transportation Emergency Card and have attached them.

_____ a Medical Report and Immunization Record. These forms are due within 14 business days of child's first day. If not received within that time period, the child cannot attend until the forms are submitted.

Upon enrollment, your child will be issued an ID Card to use to check in/out daily.

The ECM is a participant in the Federal Food Program, and sponsored by Cape Fear Tutoring, Inc. You will receive a food program enrollment form. A completed Federal Food Program form is due within 3 days of enrollment.

Other information needed to process your application will be requested as necessary.

_____ Please send me bank draft information to the email address listed above.

Updated March 2019

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First Baptist Early Childhood Ministry Application for Day Care

Full Name of Child: _____
Last First Middle Nickname

Physical Address: _____
Street City State Zip

Birth Date: _____ Sex: _____ Race: _____ Phone: _____

FAMILY INFORMATION

Father's Name _____ Employer _____
Address (if different from child's) _____

Father's Phone #s:
Home _____
Work _____
Cell _____

Mother's Name _____ Employer _____
Address (if different from child's) _____

Mother's Phone #s:
Home _____
Work _____
Cell _____

If parents are separated or divorced, who has custody of the child: _____

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. Include any additional authorized individuals on a separate sheet to be attached to this application.

1. _____
Name Relationship Address Phone

2 _____
Name Relationship Address Phone

3. _____
Name Relationship Address Phone

In the event of an emergency, if the parents/guardians cannot be reached, the facility has permission to contact the following individuals.

1. _____
Name Relationship Address Phone

2 _____
Name Relationship Address Phone

3. _____
Name Relationship Address Phone

EMERGENCY MEDICAL CARE INFORMATION

Name of health care professional _____ Office Phone _____
Name of child's dentist _____ 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 an emergency. In an emergency situation, 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, or full-time custodian.

Signature of Administrator _____ Date _____

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Heath Care Needs

HEALTH CARE NEEDS: For any child with health care needs such as allergies, asthmas, 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:
_____
_____
_____

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Parent-Center Agreement

Name of Child: _____

I agree to pay a non-refundable registration fee in the amount of $_____ at the time I register my child.

_____ Initial

I agree to pay $_____ per week on Monday of each week in accordance to the Fee Schedule and Payment Policy for the following care:

Full Day Care, Hours: _____ until _____

2-year-old _____

3-year-old _____

4-year-old _____

Pre-K Wraparound Care _____

Afterschool Care, Grade: _____

_____ Initial

General Permissions

I give permission for my child to go on any supervised trip with the Early Childhood Ministry during the year. The center will notify me when and where my child will go. _____ Initial

I give permission for the Early Childhood Ministry to give my child medicine during the day when I bring it daily with a completed medical form. _____ Initial

I give permission for the operator to provide transportation to a suitable medical facility in case of emergency. _____ Initial

Signature: _____ Date: _____

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Multimedia Consent & Release Form

Throughout the year, children may be highlighted in efforts to promote ECM activities and achievements. For example, children may be featured through printed photographs in classrooms, in newsletters, on the web, in videos, in brochures, in class displays, and other types of media.

I, as the parent or guardian of _____, give the First Baptist Early Childhood Ministry, First Baptist Church, and its employees permission to photograph, print, and record my child for use in audio, video, film, or any other electronic digital and printed media. This is done periodically and the child's full name will not be released.

A. This is with the understanding that neither the ECM, First Baptist Church, nor its employees will reproduce said photograph, interview, or likeness for any commercial value or receive monetary gain for use. I am also fully aware that I will not receive monetary compensation for my child's participation.

B. I further release and relieve the ECM, the Early Childhood Ministry Committee, First Baptist Church, employees, and other representatives from any liabilities, known or unknown, arising out of the use of this material.

I certify that I have read the Multimedia Consent and Release Form and full understand its terms and conditions.

Parent Signature: _____Date: _____

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Travel and Activity Permission

_____ Blanket Permission for this activity
_____ Special 1-time permission only
____X___ Blanket Permission for all given activities

I, _____, parent/guardian of _____, give my permission to First Baptist Early Childhood Ministry for my child to participate in the following activities:

Trips in the van/automobile (facility-owned)

We will notify you of each trip.
Explain planned activity

I understand that the facility will use the appropriate child restraint devices 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 Signature: _____Date: _____

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

_____ I will allow my child to walk outside the fenced area with teacher supervision; or

_____ I will not allow my child to walk outside the fenced area with teacher supervision.

Parent Signature: _____Date: _____

This authorization is valid from 8/20/20___ to 8/30/20___.

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Policy Acknowledgements

I have received copies of following polices, found within the First Baptist Parent Handbook, provided with this application. I understand the policies of First Baptist Early Childhood Ministry.

- General Policies;
- Discipline and Behavior Management Policy;
- Dismissal Policy;
- Fee and Regulations;
- Payment Policy;
- Prevention of Shaken Baby Syndrome and Abusive Head Trauma Policy;
- Tobacco and Drug Use Policy.

_____ _____

Parent/Guardian Signature Date

NCDCDEE Summary Brochure Acknowledgement

I, the parent or guardian of _____ acknowledges that I have read and received a copy of the brochure "Summary" North Carolina Child Care Laws and Rules."

_____ _____

Signature of parent/guardian Date

This space intentionally left blank.

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Medical Report & Immunization Records
Return to the Office or Fax: 910-739-7858 within 14 days of child's first day.

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 #**_____

This space intentionally left blank.