Office Use Only
Class ___________________
____

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 $75.00 for each child, and $50.00 for summer care only.

_____ 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.

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 July 2020

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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 _________________

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:
____
____
____

Parent-Center Agreement

Name of Child: ____

I agree to pay a non-refundable registration fee in the amount of $75.00 (or $50.00 for summer only care) 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

______ Check here if you will receive, or anticipate receiving, childcare subsidy from DSS or funds from your college so we may bill you correctly. This information is voluntary and will not affect your child's acceptance into the Early Childhood Ministry.

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: _____________________

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: _______________

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: _______________

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, including

- 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."

____ ______________

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First Baptist Church
a family of faith

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 #**______________

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