

CHILD DEVELOPMENT CENTER
3802 Princess Place Drive
Wilmington, NC 28405

PARENT RESPONSIBILITIES FOR ENROLLING CHILD AT CDC

_____ Visit the Center and/or contact CDC Administration to obtain information about available slot, programs and fees.

Complete, sign and return the attached packet of forms including:

- _____ "Child's Application for Enrollment/Emergency Medical Plan & Consent" (be sure to complete both sides)
- _____ "Children's Medical Report"
(must be completed by child's doctor within 30 days of starting CDC)
- _____ "Consents and Rights"
- _____ "Consent for Exchange of Information"
- _____ "Consent for Release of Information and Assignment of Insurance Benefits"
- _____ "Discipline Policy"
- _____ "Classroom Video Cameras"
- _____ "Child Care Food Program Eligibility Application"
- _____ "Child Care Food Program Participant Enrollment Form"
- _____ "Prevention of Shaken Baby Syndrome and Abusive Head Trauma Acknowledgement Form"
- _____ "After-School Care Policies and Procedures" (if child is to be enrolled in After-School Program)

Provide copies of the following documents:

(CDC can make copies for you)

- _____ Birth Certificate
- _____ Immunization (Shot) Record
- _____ Social Security Card
- _____ Medicaid Card (if applicable, and child has "special needs")

_____ Visit DSS to apply for Daycare Subsidy Voucher if applicable.

_____ Determine a starting date for the child in discussion with CDC staff.

Date Application Completed _____

Date of Enrollment _____

CHILD'S APPLICATION FOR ENROLLMENT EMERGENCY MEDICAL PLAN AND CONSENT

Child Development Center

To be completed, signed, and placed on file at CDC on the first day and updated as changes occur and at least annually

Please complete both sides of form.

A. INFORMATION ABOUT THE CHILD:

Child's Full Legal Name: _____

Name Child Is Called (Nickname): _____

Child's Physical Address: _____ Zip Code _____

Child's County of Residence : _____ Child's Birth Date: _____

Race (for statistical purposes only): _____ Child's Social Security #: _____

B. INFORMATION ABOUT THE FAMILY:

Child lives with: _____

Father/Guardian's Name: _____ Home Phone #: _____

Address (if different from child's): _____ Zip Code: _____

Employed By: _____ Work Phone #: _____

Cell Phone #: _____ E-mail Address: _____

Mother/Guardian's Name: _____ Home Phone #: _____

Address (if different from child's): _____ Zip Code: _____

Employed By: _____ Work Phone #: _____

Cell Phone #: _____ E-mail Address: _____

C. 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. In the event of an emergency, if the parents/guardians cannot be reached, Child Development Center has permission to contact the following individuals. **The individuals listed below are the only people the child will be released to without written notice from the parent/guardian.**

1.	Name	Relationship	Home Phone #	Work/Cell Phone #
2.	Name	Relationship	Home Phone #	Work/Cell Phone #
3.	Name	Relationship	Home Phone #	Work/Cell Phone #
4.	Name	Relationship	Home Phone #	Work/Cell Phone #
5.	Name	Relationship	Home Phone #	Work/Cell Phone #

Please complete back of form.

Child's Application for Enrollment/Emergency Medical Plan and Consent, *continued*

Child's Name: _____

D. 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/guardian or health care professional. Is there a medical action plan attached? Yes ___ No ___ (Medical action plan must be updated on an annual basis and when changes to the plan occur)

List any allergies and the symptoms and type of response required for allergic reactions: _____

List any foods NOT to be given: _____

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:

Name of medication	Strength	Time(s) of day	Prescribing MD
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Share any other information that has a direct bearing on assuring safe medical treatment for your child: _____

E. EMERGENCY MEDICAL CARE INFORMATION:

Name of designated physician/health care professional: _____

Address: _____

Office Phone # : _____

Hospital preference: _____

Phone #: _____

F. CONSENT FOR TREATMENT/TRANSPORT:

I consent for my child to receive education and therapeutic services from Child Development Center. I understand that provisions will be made for adequate and appropriate nutrition, rest and outdoor play during the instructional day. In the event of illness or injury, the Director, administrative staff or classroom teacher will determine whether the situation requires (1) simple first aid, (2) advice from the parent/guardian or designated physician, or (3) a call for emergency services (911). In all cases, an attempt will be made to notify the parent/guardian, and if the situation warrants and no one can be reached, transportation may be arranged to the nearest medical resource. As parent/guardian, I have been informed and agree with Child Development Center's medical policies, and I consent for the emergency medical plan outlined above. For children in foster care, DSS caseworkers must also sign consent.

Parent/Guardian Signature: _____ Date: _____

DSS Caseworker Signature: _____ Date: _____

As the operator, I agree to provide or arrange transportation to an appropriate medical resource as needed in the event of a medical emergency. In an emergency transport situation, the child may be accompanied by Center staff or by Emergency Medical personnel. Center staff will not administer any medication without specific direction from the child's physician or the parent/guardian.

Signature of Administrator: _____ Date: _____

Child Development Center Children's Medical Report

Name of Child _____ Birthdate _____

Name of Parent or 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 # _____

CHILD DEVELOPMENT CENTER

CONSENTS AND RIGHTS

Child's Name _____ Birth Date _____ Record # _____

A. General Consents: I give consent for my child to:

- _____ be observed in the classroom, playground or therapy sessions by authorized individuals visiting the Center.
- _____ be photographed for Center activities and the Center newsletter, Web site and Facebook page.
- _____ be pictured in the newspaper.
- _____ be included in filming for television.
- _____ go on field trips with his/her class.
- _____ be transported on CDC mini-bus or chartered bus for field trips.
- _____ go on walks beyond the fenced playground area.
- _____ be evaluated, both formally and informally, by CDC staff and therapists.

B. Client Rights: Students and parents/guardians are assured of the following:

1. The right to participate in a nurturing environment which places emphasis on the positive attributes of the child and/or family.
2. The right of children to expect confidentiality, dignity, and humane and loving care.
3. The right to expect freedom from mental/physical abuse, neglect or exploitation.
4. The right of children to receive developmental programming regardless of their degree of developmental disability.
5. The right of families to participate in the development of Individualized Education Plans or Individualized Family Service Plans and to receive information about their child's progress whenever requested.

C. I understand and have received copies of the following documents from CDC:

1. CDC Parent Manual
2. CDC Discipline Policy
3. CDC Classroom Video Policy
4. CDC Safe Arrival and Departure Procedures
5. CDC Shaken Baby Syndrome/Abusive Head Trauma Policy
6. School Calendar
7. North Carolina Daycare Law and Rules

Parent Signature

Witness

Date

Date

CONSENT FOR EXCHANGE OF INFORMATION

Child Development Center, Inc.

Child's Name: _____ Record #: _____

Child's Birthdate: _____ Social Security #: _____

I hereby authorize the mutual exchange of relevant information regarding my child between Child Development Center, Inc. and the following agencies that I have indicated below (please place your initials in appropriate boxes):

<u>Agency</u>	<u>YES</u>	<u>NO</u>
Public School _____		
Health Department _____		
Department of Social Services _____		
CDSA/Developmental Evaluation Center _____		
TEACCH _____		
Child's Physician _____		
Other (specify) _____		
Other (specify) _____		

This data shall include: any information relating to the child's educational or therapeutic program.

Examples of types of information that may be exchanged include:

- | | |
|----------------------------------|---------------------------|
| History and Physical Exam | Diagnostic Test Results |
| Admission Information | Psychological Assessments |
| Developmental Evaluation Results | Medication Records |
| Physician's Orders | Screening Results |
| Treatment Plans | Progress Notes |

If you wish to exclude the exchange of any specific information, please state the type and nature of information that you do NOT want exchanged: _____

The specific purpose for the exchange of information between agencies is:

for the planning and implementation of the educational and therapeutic program for your child while he/she attends Child Development Center.

This consent shall be valid for: the duration of the child's enrollment at CDC, unless a time frame is specified here: _____

I certify that this authorization is made freely, voluntarily and without coercion. I understand that the information to be released is protected under State and Federal laws and cannot be re-disclosed without my further written consent unless otherwise provided for by State and Federal law. I understand that I may revoke this authorization at any time, except to the extent that action has already been taken to comply with it. I have been given a copy of the Notice of Privacy Practices of Child Development Center, Inc.

Signed: _____ Date: _____

Relationship to child: _____

Witness: _____



CHILD DEVELOPMENT CENTER, INC.

3802 Princess Place Drive
Wilmington, North Carolina 28405
(910) 343-4245 or fax (910) 343-4254
Email cdc@bizec.rr.com

Name of Client (Child): _____

Consent for Release of Information and Assignment of Insurance Benefits

I hereby authorize the above named center to release the information requested on this form including all records from the Child Development Center to the North Carolina Center of Medical Excellence under Title XIX of the Social Security Act and to any private insurance companies as necessary. I hereby authorize payment directly to the above named center, not to exceed the center's service charges for this period of treatment.

Date: _____ **Policyholder Signature:** _____

Insurance Company Name: _____

Medicaid or Insurance Number: _____

Policyholder Name: _____

Relationship to the Client: _____

Policyholder's Employer: _____

Policyholder's Address: _____

Policyholder's Date of Birth (MM/DD/YY): _____

Child Development Center Discipline and Behavior Management Policy

Date Adopted: 8/28/2017

Praise and positive reinforcement are effective methods of the 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 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 use short supervised periods of time-out sparingly.
12. DO stay consistent in our behavior management program.
13. DO use effective guidance and behavior management techniques that focus on a child's development.

We:

1. DO NOT spank, shake, bite, pinch, push, pull, slap, or otherwise physically punish the children.
2. DO NOT make fun of, yell at, threaten, make sarcastic remarks about, use profanity, or otherwise verbally abuse the children.
3. DO NOT shame or punish the children when bathroom accidents occur.
4. DO NOT deny food or rest as punishment.
5. DO NOT relate discipline to eating, resting, or sleeping.
6. DO NOT leave the children alone, unattended, or without supervision.
7. DO NOT place the children in locked rooms, closets, or boxes as punishment.
8. DO NOT allow discipline of children by children.
9. DO NOT criticize, make fun of, or otherwise belittle children's parents, families, or ethnic groups.

I, the undersigned parent or guardian of _____ (child's full name), do hereby state that I have read and received a copy of the Child Development Center Discipline and Behavior Management Policy and that the Center's director/operator (or other designated staff member) has discussed the Center'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), signed copy in child's facility record

“Time-Out”

"Time-out" is the removal of a child for a short period of time (3 to 5 minutes) from a situation in which the child is misbehaving and has not responded to other discipline techniques. The "time-out" space, usually a chair, is located away from classroom activity but within the teacher's sight. During "time-out," the child has a chance to think about the misbehavior which led to his/her removal from the group. After a brief interval of no more than 5 minutes, the teacher discusses the incident and appropriate behavior with the child. When the child returns to the group, the incident is over and the child is treated with the same affection and respect shown the other children.

Adapted from original prepared by Elizabeth Wilson, Student, Catawba Valley Technical College

CHILD DEVELOPMENT CENTER

SUBJECT: CLASSROOM VIDEO CAMERAS

SECTION: ADMINISTRATIVE

POLICY

It is the policy of Child Development Center that video cameras are placed in every classroom. The transmissions from these cameras are visible on monitors in the Executive Director's office.

PURPOSE

1. To provide an opportunity for parents and others to observe children in a classroom without the presence of observers causing distractions.
2. To observe educational activities occurring in the classroom.
3. To observe classroom teaching strategies for developing "best practices."
4. To enable collection of data on individual children in regard to behavior, social skills, and learning needs, while protecting confidentiality.
5. To provide an extra measure of security to ensure that everything that occurs with children in a classroom is both safe and appropriate.

PROCEDURES

The video monitors showing classroom activities are placed out of public view. Only those individuals approved and authorized by Child Development Center will be allowed to view the monitors. Since the classroom cameras will provide video only, with NO audio, children will not be identifiable by name. Therefore, when any parent or authorized visitor observes on the monitors, the confidentiality of each child will be maintained.

By enclosing this policy in the enrollment packet given to each family, and by referencing this policy on the Consents and Rights form signed by parents, all families are made aware of the existence of classroom cameras when the child is enrolled. The child's actual attendance at Child Development Center implies parent/guardian consent that the child will be visible on classroom video. Parents with concerns are invited to discuss these with CDC administrative staff.

Parent/Guardian Signature

Date



North Carolina Department of Health and Human Services
 Division of Public Health
 Child and Adult Care Food Program
CHILD INCOME ELIGIBILITY APPLICATION



INSTITUTION NAME: Child Development Center, Inc. FACILITY NAME: Child Development Center, Inc AGREEMENT#: 7251

1. PARTICIPANT'S NAME & DATE OF BIRTH:

First Name Last Name Date of Birth First Name Last Name Date of Birth

2. SNAP, TANF or FDPIR case number:

SNAP # _____ TANF#: _____ FDPIR # _____

If you have provided the case number; DO NOT complete #3 and #4. Skip to complete #5 and #6.

3. Is this application for a: Foster Child? Yes No Homeless Child? Yes No Child from a migrant family? Yes No

4. HOUSEHOLD MEMBERS MONTHLY INCOME:

Names of All Other Household Members	Monthly Wages / Salaries	Monthly Social Security	Monthly Public Assistance / Child Support	Monthly Retirement Pensions	Other Monthly Income
	\$	\$	\$	\$	\$
	\$	\$	\$	\$	\$
	\$	\$	\$	\$	\$
	\$	\$	\$	\$	\$

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 (Required if qualifying by income) _____ Check if no SSN

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.

To be completed by Institution/Sponsor

TOTAL HOUSEHOLD SIZE _____ TOTAL HOUSEHOLD MONTHLY INCOME \$ _____

Approved: Free Reduced-Price Denied

Reason for denial: Income too high Incomplete application Other: _____

Withdrew on (Date): _____

For state use only:

Verified by: _____ Date: _____

Verified classification:

Free Reduced-Price Denied

Reason for classification change: _____

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

NC CACFP CHILD INCOME ELIGIBILITY APPLICATION

INSTRUCTIONS

Please complete the Child Income Eligibility Applications using the instructions below. The application must be signed in number 6 and returned to the child care center.

1-PARTICIPANT’S INFORMATION:

- a. Print the name(s) and birth date(s) of the child/children enrolled in the center.

2-HOUSEHOLD GETTING SNAP, TANF, OR FDPIR BENEFITS:

- a. If you participate in SNAP, TANF, or FDPIR provide your case or identification number and skip number 4.
- b. If you do not participate in any of these programs, go on to number 3.

3-FOSTER, HOMELESS, or MIGRANT CHILD:

- a. Indicate if either child on the application is a foster child, homeless, or a child from a migrant family.
- b. 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.
- c. Host families applying for free and reduced priced meals for their own children may include the homeless family as household members if the host family provides financial support to the homeless family. In such cases, the host family must also include any income received by the homeless family.
- d. If the child or children listed are foster, homeless, or from a migrant family, number 4 may be skipped

4- HOUSEHOLD INCOME:

- a. List the names of all other household members.
- b. Write the amount of income (the amount before taxes or anything else is taken out), the frequency of income (i.e. weekly, every two weeks, twice a month, or monthly) received **last month** for each household member and where it came from, such as earnings, public assistance, pensions and other income (refer to examples below for types of income to report). If any amount last month was less than usual, write the person’s usual income.

INCOME TO REPORT

<u>Earnings from Employment</u>	<u>Pensions/Retirement/Social Security</u>	<u>Other Income</u>
<ul style="list-style-type: none"> • Wage/salaries/tips • Strike benefits • Unemployment compensation • Net income from self-owned business or farm • Worker’s compensation 	<ul style="list-style-type: none"> • Pensions • Supplemental security income • Retirement income • Veteran’s payments • Social Security 	<ul style="list-style-type: none"> • Disability benefits • Cash withdrawn from savings • Interest/dividends • Income from estates/trusts/ investments • Regular contributions from persons not living in the household • Net royalties/annuities/ net rental income • Any other income
<p><u>Public Assistance/Child Support/Alimony</u></p> <ul style="list-style-type: none"> • Public assistance payments • TANF payments • Alimony/Child support payments 	<p><u>Military Households</u></p> <ul style="list-style-type: none"> • All cash income, including military benefits received in cash such housing/uniform allowances. 	

5-RACIAL/ETHNIC IDENTITY: Complete the Ethnic/Racial identity question.

6-SIGNATURE AND LAST FOUR DIGITS OF SOCIAL SECURITY NUMBER: All households complete this part.

All Child Income Eligibility Applications must be signed by an adult household member.

The adult household member who signs the certification statement must include the last four digits of his/her social security number. If he/she does not have a social security number, check the “No SSN” box. If you listed a SNAP, TANF, or FDIR number a social security number is not needed.

NC CACFP CHILD INCOME ELIGIBILITY APPLICATION

HOUSEHOLD LETTER FOR NON-PRICING INSTITUTIONS

Dear Parent or Guardian,

Please help us comply with the federal requirement mandating the annual submission of program Income Eligibility Applications. This application will be used only for eligibility determination, placed in our files, and treated as confidential information. In order for participants and the day care center to be considered eligible for program benefits, an adult household member must complete the program Income Eligibility Application (IEA) for each participant enrolled in the center as soon as possible, sign, date and return it to the day care center. Completion of the application is not mandatory unless you wish to be considered for eligibility as a free or reduced-price participant.

If you currently receive SNAP, Temporary Aid to Needy Families (TANF) or Food Distribution Program on Indian Reservations (FDPIR), you are not required to list household income. You may give your SNAP, TANF or FDPIR case number, sign, date and return the application. If a child is a member of a SNAP or FDPIR household or is a TANF recipient, the child is automatically eligible to receive free program meal benefits, subject to completion of the application.

You should also note that if you have a foster child the day care center is eligible for program benefits for the foster child regardless of the income of your household. 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. Please contact the institution for further instructions.

You should list the name of everyone who lives in your household, including all children, parents, grandparents, and other relatives. The Department of Agriculture defines a household as a group of related or unrelated individuals (not residents of an institution or boarding house) who are living as one economic unit (i.e. sharing living expenses).

The income reported **must** be the total gross income, before deductions, received by all members of the household last month (i.e. wages, public assistance, TANF or retirement, etc.). Military benefits received in cash, such as housing allowance for military households living off base and food or clothing allowance **must** be considered as income. If you have a household member whose last month's income was higher or lower than usual, list that person's expected average monthly income.

REDUCED PRICE GUIDELINES EFFECTIVE JULY 1, 2021 - JUNE 30, 2022*

HOUSEHOLD SIZE	YEARLY	MONTHLY	TWICE PER MONTH	EVERY TWO WEEKS	WEEKLY
1	\$23,828	\$1,986	\$993	\$917	\$459
2	\$32,227	\$2,686	\$1,343	\$1,240	\$620
3	\$40,626	\$3,386	\$1,693	\$1,563	\$782
4	\$49,025	\$4,086	\$2,043	\$1,886	\$943
5	\$57,424	\$4,786	\$2,393	\$2,209	\$1,105
6	\$65,823	\$5,486	\$2,743	\$2,532	\$1,266
7	\$74,222	\$6,186	\$3,093	\$2,855	\$1,428
8	\$82,621	\$6,886	\$3,443	\$3,178	\$1,589
For each additional family member add:	\$8,399	\$700	\$350	\$324	\$162

*Households with income less than or equal to these levels are eligible for free or reduced-price meals.

You may submit a Child Income Eligibility Application any time during the fiscal year. Participants having family members who become unemployed are eligible for free or reduced-price meals during the period of unemployment, provided that the loss of income causes the family's income during the period of unemployment to be within the eligibility standards for those meals.



North Carolina Department of Health and Human Services
 Division of Public Health
 Child and Adult Care Food Program
Child Participant Enrollment Form



INSTITUTION NAME: Child Development Center, Inc. FACILITY NAME: Child Development Center AGREEMENT#: 7251

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 Eaten (Circle all that apply)
			_____ to _____	M T W Th F Sat Sun	B AM L PM S LPM
			_____ to _____	M T W Th F Sat Sun	B AM L PM S LPM
			_____ to _____	M T W Th F Sat Sun	B AM L PM S LPM
			_____ to _____	M T W Th F Sat Sun	B AM L PM S LPM
			_____ to _____	M T W Th F Sat Sun	B AM L PM S LPM

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.



North Carolina WIC Program

Healthy Habits, Healthy Families

WIC can help you:

- Make healthy eating choices
- Stretch your grocery budget
- Breastfeed your baby
- Find other helpful community resources

Do you qualify?

- Are you pregnant?
- Have you recently had a baby?
- Are you a breastfeeding mom?
- Do you have a child under age five?

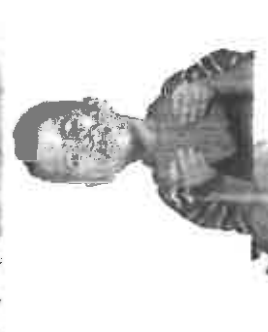
WIC Income Guidelines (effective July 1, 2016)		
Family Size	Annual Income	Monthly Income
1	\$21,978	\$1,832
2	\$29,637	\$2,470
3	\$37,296	\$3,108
4	\$44,955	\$3,747
5	\$52,614	\$4,385

For more information about WIC go to www.nutritionnc.com

This institution is an equal opportunity provider.



Public Health
HEALTH AND HUMAN SERVICES



Programa WIC

de Carolina del Norte

Hábitos saludables, familias sanas

WIC puede ayudarle a:

- Escoger alimentos saludables
- Aprovechar mejor su presupuesto de comestibles
- Amamantar a su bebé
- Encontrar otros recursos de ayuda en la comunidad

¿Cumple usted con los requisitos?

- ¿Está embarazada?
- ¿Ha tenido un bebé recientemente?
- ¿Está amamantando a su bebé?
- ¿Tiene un niño de menos de cinco años de edad?

Guías de WIC sobre ingresos máximos para 2016		
Nº. de personas en el hogar	Ingreso anual	Ingreso mensual
1	\$21,978	\$1,832
2	\$29,637	\$2,470
3	\$37,296	\$3,108
4	\$44,955	\$3,747
5	\$52,614	\$4,385

Para obtener más información sobre WIC, visite www.nutritionnc.com.

Esta institución es un proveedor que ofrece igualdad de oportunidades.



Public Health
HEALTH AND HUMAN SERVICES

Prevention of Shaken Baby Syndrome and Abusive Head Trauma

Parent or guardian acknowledgement form

I, the parent or guardian of

_____ Child's name

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/guardian

_____ Date of child's enrollment

_____ Print name of parent/guardian

_____ Signature of parent/guardian

_____ Date

