CHILD CARE REGISTRATION AND EMERGENCY INFORMATION

A Place To Grow - Three Rivers, Wingate
3620 US-74
Wingate, NC 28174
Maureen@aplace2grow.com
704-776-4344

TO THE PARENT OR GUARDIAN: *This form must be completed for **each** of your children enrolled in the program, and must be updated whenever information changes, and annually by NC state law.*

Child's name:	Date of birth:
Child's name:	Date of birth:
Child's name:	Date of birth:

IDENTIFYING INFORMATION OF PARENT/S OR GUARDIAN/S LEGALLY RESPONSIBLE FOR CHILD:

Name:	Name:
Date of Birth:	Date of Birth:
Address:	Address
Home phone number:	Home phone number:
Cell phone number:	Cell phone number:
Email:	Email:
Indicate where parent/guardian above can be reached while the child is in care. Include name, address and phone number of business if applicable. Include any special instructions, e.g. pager, cell phone, etc.	
Business Name:	Business Name:
Address:	Address
Phone number: Hours:	Phone number: Hours:
Email:	Email:
Special Instructions for reaching parent/guardian:	
Marital Status (separated or divorced parents are required to leave a copy of parenting plans on file)	

ENROLLMENT SCHEDULE

First Day of Care (MM/DD/YYYY):	Select Enrollment Period: ☐ Full Year ☐ School Year (Sept-Mid-June) ☐ Summer Only (Mid-June-Late August)	Daily Schedule: ☐ Full Time (+5.5 hours/day) ☐ Part Time (5 hours/day or less)

Please indicate approximate drop-off and pick up time for each day your child will be enrolled.

	Monday	Tuesday	Wednesday	Thursday	Friday
Drop Off Time					
Pick Up Time					

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PAYMENT OPTIONS

Payments can be made in cash, check, debit from checking account through Tuition Express. Tuition is due by the last school day of the month for monthly invoicing or Fridays for weekly invoicing. Failure to pay accounts in full may result in withdrawal of your child from our program. Account balances can be viewed at any time at www.myprocare.com.

Families on child care subsidy programs are required to pay their estimated family responsibility (cost share and difference between state rate and A Place to Grow - Three Rivers, Wingate) in advance of care, including weeks for which our facility is closed for summer and winter break. Registration amount is equal to estimated family responsibility as calculated on the estimated family responsibility worksheet. This amount is subject to change pending final approval from the state.

Registration fee in the amount of one month's tuition $_____________ was paid on (date) ____/____/____

ELECTRONIC FUNDS TRANSFER AUTHORIZATION FOR BANK ACCOUNT

I (we) hereby authorize Eco Child Care of Charlotte, LLC, DBA A Place to Grow at Three Rivers, Wingate to initiate debit entries to my (our) checking or savings account, as indicated below.

To properly affect the cancellation of this agreement, I (we) are required to give 10 days written notice. ________ (initial)

Credit union members: please contact your credit union to verify account and routing numbers for automatic payments.

____

Your Name Phone #

____

Address City State Zip

____

Bank or Credit Union Name Bank or Credit Union Address City State Zip

____

Routing Transit Number Account Number Checking or Savings?

____

Authorized Signature

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EMERGENCY CONTACT PERSONS: You (parent/guardian) are required to list *at least 1* person with whom you would feel comfortable leaving your child, and who could assume responsibility for your child if you could not be reached immediately in an emergency, or if for some reason you could not pick up your child and were unable to communicate with the program. Examples: if your child were sick and you were not accessible, or if you experienced sudden illness between work and picking up your child.

Name:	Name:
Relationship:	Relationship:
Address:	Address:
Phone number:	Phone number:

NON-EMERGENCY ALTERNATE PICK-UP PERSON/S: I,___________________________(Parent/Guardian Signature) authorize the following individual(s) to pick up my child from the program on a non-emergency basis.

Name:	Name:
Relationship:	Relationship:
Address:	Address:
Phone number:	Phone number:

EMERGENCY MEDICAL CARE INFORMATION

Child's Usual Physician:	Phone number:
Physician's Address:	
Hospital Preference:	
Insurance Carrier and Policy #:	

EMERGENCY MEDICAL TREATMENT AUTHORIZATION

I hereby give permission for the staff of Eco Child Care of Charlotte, LLC, DBA A Place to Grow at Three Rivers, Wingate to provide simple first aid treatment to my child(ren) when necessary. In the event of a more serious illness or injury, I give permission for my child to be transported to a hospital or other emergency medical facility to receive emergency medical treatment. I also authorize ambulance/rescue squad attendants to administer such treatment as is medically necessary, and I authorize licensed health practitioners working in the hospital or emergency medical facility to examine and provide emergency medical treatment to my child if warranted. I understand that I will be contacted by child care program personnel as soon as possible regarding any emergency involving my child.

Parent/Guardian Signature: ____ **Date** _______________

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CHILD CARE REGISTRATION AND EMERGENCY INFORMATION

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 __ (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 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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CHILD CARE REGISTRATION AND EMERGENCY INFORMATION

I, ________________________________ (Parent/Guardian/Payment Guarantor), accept the above the above information to be true and accurate and will make payments as stated above and acknowledge and agree to adhere to the center policies for A Place to Grow Three Rivers, Wingate. The center policies outline discipline policies and parent participation opportunities.

Policies and fees regarding tuition and late payments are outlined in the schedule of fees, which I have seen and accepted. Registration fees are a guarantee that you will be enrolling your child at A Place to Grow and that we will ensure availability for the agreed upon start date. All registration fees are non-refundable. Registration fees are the equivalent of one month's tuition. If enrollment begins in the middle of a month, the next month's tuition is prorated at a per diem rate for the actual number of days attended in the first month. Families on child care subsidy are responsible for the full monthly tuition amount minus actual payments received for state assistance.

Child's First Day of Care: ____

Signature of Parent/Guardian ____ Date __________

I, ________________________________ (Parent/Guardian/) of (child's name) ________________________ _______ agree to adhere to the center policies for safe pick up/drop off at A Place to Grow Three Rivers, Wingate. Children should be walked from the parking lot to the child's classroom at arrival. At no time should other children be left alone in a vehicle while a child is checked into or out of our care. Parents should electronically sign their child in and out of the program through the Procare app or via a physical chart if the app is unavailable. At dismissal, the child will only be released to a parent/guardian/caretaker who has the express written permission of the child's primary caregivers to do so. The child and adult must exit the building, and make their way to the vehicle together. Observe a speed limit of 5 MPH in our parking lot to prevent accidents.

Signature of Parent/Guardian____ Date __________

My signature below signifies that I have received and reviewed the Summary of Childcare Law, Prevention of Shaken Baby Syndrome and Abusive Head Trauma Policies, Notification of Smoking and Tobacco Restrictions, and Weapons Policy. These documents are provided electronically on our school website and are available for reference at any time.

Signature of Parent/Guardian ____ Date __________

Photographs or videos of children may be taken and posted to document their experiences at A Place to Grow Three Rivers, Wingate. A Place to Grow Three Rivers, Wingate may take photographs or videos of children for any legal use, including but not limited to: publicity, copyright purposes, illustration, advertising, web content, and social media. No royalty, fee or other compensation shall be payable to any family by reason of such use. By signing below I grant permission to A Place to Grow Three Rivers, Wingate permission to use photos or videos for the purposes described above.

Choose only ONE:

- ☐ Yes, my child's photos/videos may be used in social media
- ☐ NO, my child's photos/videos may NOT be used in social media
- ☐ No photos/videos may ever be taken of my child except to communicate with parents/guardians who have access on the Procare app (your child's face will NOT be shown in group shots that are shared via Procare with other families)

Signature of Parent/Guardian____ Date __________

My signature in the box below also signifies that I am aware of and give permission for my child to participate in walking field trips within the 1.5 acres of forest area at the school, to the front parking lot, and inside other classrooms in the building

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located on site. All offsite walks will follow all licensing rules including staff to child ratios and may be taken on any day or time at the discretion of the staff of A Place to Grow Three Rivers, Wingate. ***Please leave box C blank***, as we will hopefully have the opportunity to do this often!

NC Division of Child Development
and Early Education

Off Premise Activity Permission

A. Parent and Child Information	
Name of Parent ☐ Emergency Contact	Telephone Number - Primary
Name of Child ☐ Picture attached	Telephone Number - Secondary

B. Emergency Contact Information (non-parent)	
Name	Telephone Number

C. Authorized Destination and Departure and Return Times		
Location of off premise activity **N/A**	Departure Time **N/A**	Return Time **N/A**

D. Parent Signature and Date	
Permission to participate is valid from [give date] to [give date]. From To (up to 12 months)	
Signature of Parent or Guardian	Date

Parents of Infants (***Children age 12 months or younger***) ONLY:

I, ________________________________ (Parent/Guardian/) of (child's name) ________________________________ agree to adhere to the center policies for A Place to Grow Three Rivers, Wingate. Infant and Toddler Safe Sleep policies are outlined in our Center Policies, which I have seen and accepted. This agreement will be retained as long as the child is enrolled at the center. If A Place to Grow Three Rivers, Wingate amends the safe sleep policy we will provide written notice at least 14 days before the implementation date.

Date the Center Safe Sleep Policy was Received and explained____________________________

Signature of Parent/Guardian____ Date __________

ANNUAL UPDATE: Make necessary changes to this document, initial, and date below to verify that the information is current for each year your child is in our care.

Parent/Guardian Initials:	Date:
Parent/Guardian Initials:	Date:
Parent/Guardian Initials:	Date:
Parent/Guardian Initials:	Date:

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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 #**_______________

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 Hep B		
5 months		2 Polio			2 Hep B		
7 months	3 DTaP	2 Polio		2-3 Hib**	2 Hep B	3 PCV	
12 months	3 DTaP	2 Polio		2-3 Hib**	2 Hep B	3 PCV	
16 months	3 DTaP	2 Polio	1 MMR	3-4 Hib**	2 Hep B	4 PCV	
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

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.

NORTH CAROLINA
Child Care Health and Safety Resource Center
800-367-2229
healthychildcare.unc.edu

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.					
Coronavirus disease 2019	COVID-19	Comirnaty, Spikevax, Nuvaxovid, Jcovden	Annually after age 6 months.					

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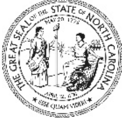
NC DEPARTMENT OF
HEALTH AND HUMAN SERVICES
Division of Child Development and Early Education

Nutrition Opt Out Form

Child Care Rules .0901(d) and .1706(c) state:

When children bring their own food for meals and snacks to the program, if the food does not meet the nutritional requirements specified in Paragraph (a) of this Rule, the operator must provide the additional food necessary to meet those requirements unless the child's parent or guardian opts out of the supplemental food provided by the operator as set forth in G.S. 110-91(2) h.1. A statement acknowledging the parental decision to opt out of the supplemental food provided by the operator signed by the child's parent or guardian shall be on file at the facility. Opting out means that the operator will not provide any food or drink so long as the child's parent or guardian provides all meals, snacks, and drinks scheduled to be served at the program's designated times. If the child's parent or guardian has opted out but does not provide all food and drink for the child, the program shall provide supplemental food and drink as if the child's parent or guardian had not opted out of the supplemental food program.

I ______________________________ plan to provide all meals, snacks and
(Parent/Guardian Print Name)
drinks for my child and do not want his/her meals, snacks or drinks supplemented to meet the Meal Patterns for Children in Child Care Programs from the United States Department of Agriculture (USDA), which are based on the recommended nutrient intake judged by the National Research Council to be adequate for maintaining good nutrition.

Since I opted out, if I do not provide all the meals, snacks or drinks for my child, I understand that the program will provide supplemental food and drink.

____________________________ ________________
Parent/Guardian Signature Date

Permission to Apply Topical Lotions

I, ______________________________(parent/guardian's name) give permission to the staff of A Place to Grow to apply the following topical lotions to ________________________ (child's name). Sunscreen and bug spray are generally applied twice a day, in the morning and afternoon, or as needed. Diaper creams are applied as needed.

I have provided the following lotions and have clearly labeled them with my child's name.

- □ Sunscreen brand______________________________
- □ Bugspray brand______________________________
- □ Diaper rash cream brand________________________

This permission is granted indefinitely, unless a new form has been received and signed by the parent/guardian.

Signed (parent/guardian)__________________________________ Date ____________

In the event that a lotion such as sunscreen, bug spray, or diaper rash cream has not been provided, I give permission to A Place to Grow staff to use an alternative if, using their best judgment, it is in the best interest of the child at the time.

Signed (parent/guardian)__________________________________ Date ____________