

# Baptist Education Center Preschool

## Application Packet



A Ministry of the New River Baptist Association, Inc.

2734 Commerce Road

Jacksonville, NC 28546-7511

Telephone: (910) 347-0704

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**Baptist Education Center**  
2734 Commerce Road  
Jacksonville, NC 28546  
(910) 347-0704

# Enrollment Checklist

I \_\_\_\_\_, parent/guardian of \_\_\_\_\_ have received the following information/documents/items from the Director of the Baptist Education Center Preschool (check boxes as completed).

Application Packet with all required documents.  
(Please fill out completely, date and sign where applicable)

- Application to include emergency contact information
- Emergency Medical Care information
- Up-to-date Immunization Record (must have to enroll)
- Medical exam (if over a year old, need new one within past 30 days)
- Discipline Policy
- Receipt of Center Operational Policies/Parent Agreement
- Child's Personal Profile Information
- Off Premise Authorization
- Permission to Video/Photograph
- Opt-out Meal Form
- Meal Plan/preparing lunches
- Release of children to anyone under the influence of drugs or alcohol
- Permission to Administer Medication (if applicable)
- Scheduled Closings (complimentary)
- Enrollment Checklist
- Developmental Milestone and Screening for Young Children
- Shaken Baby Syndrome Policy (New 8/18)

Discipline and Behavior Management Policy

Parents/Guardian Agreement

Summary of NC Child Care Laws

Parent/Guardian Signature \_\_\_\_\_ Date \_\_\_\_\_

Director Signature \_\_\_\_\_ Date \_\_\_\_\_

# BEC PRESCHOOL ENROLLMENT REQUIREMENTS

Updated 08/18/2021

Completed Enrollment Package  
Up-to-date Immunization Record  
Well Child Check (if over a year a new one within 30 days is needed)

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## ***Effective as of August 30, 2021***

### **Tuition due upon Enrollment**

*Full Time:*      Registration Fee:      \$30.00  
                         Supply fee, Annual:      \$10.00  
                         First Week's Tuition:      \$120.00  
                         **Total to start: \$160.00**

***After enrollment, full time weekly = \$120.00***

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*Part Time*      Registration Fee:      \$ 30.00  
                         Supply fee, Annual:      \$ 10.00  
                         First Week's Tuition:      \$110.00  
                         **Total to start: \$150.00**

***After enrollment, part time weekly = \$110.00***

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*Multi-child reduced tuition: 2 Children (-\$5.00 per child discount)  
Based on full time:*

Registration Fee:      \$60.00 (\$30 per child)  
Supply fee, Annual:      \$20.00 (\$10 per child)  
First Week's Tuition:      \$230.00  
**Total to start: \$310.00**

***After enrollment, 2 children discount = \$230.00 weekly***

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### **From Home:**

- Complete change of clothes to include undergarments and footwear
- Child's Size Blanket
- Small Travel Size Pillow (*Optional*)
- Lunch/Snack (2)



**Baptist Education Center Preschool  
Enrollment Application**

Child's Birthday \_\_\_\_\_  
Start Date \_\_\_\_\_  
Date of Application \_\_\_\_\_

*To be completed, signed and placed on file in facility prior to enrollment and updated as needed.*

Child: \_\_\_\_\_  
Last First Middle Nickname?

Address: \_\_\_\_\_  
# Street City Sate Zip Code

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**Family Information**

**Mother/Guardian:** \_\_\_\_\_ Primary Contact # \_\_\_\_\_

Address is different from child: \_\_\_\_\_ Zip Code \_\_\_\_\_

Where Employed? \_\_\_\_\_ Work # \_\_\_\_\_

**Father/Guardian:** \_\_\_\_\_ Primary Contact # \_\_\_\_\_

Address is different from child: \_\_\_\_\_ Zip Code \_\_\_\_\_

Where Employed? \_\_\_\_\_ Work # \_\_\_\_\_

Does child live with both parents? Yes \_\_\_\_ No \_\_\_\_

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 parent or guardians cannot be reached, the facility has permission to contact the individuals named below.

**Contacts:**

1 \_\_\_\_\_

2 \_\_\_\_\_

3 \_\_\_\_\_

**Healthcare Needs:**

*For any child with healthcare needs such as allergies, asthma or other 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 responses required for allergic reactions. \_\_\_\_\_

\_\_\_\_\_

List any healthcare needs or concerns, symptoms of and type of response for these healthcare needs or concerns. \_\_\_\_\_

\_\_\_\_\_

List any particular fears or unique behavior characteristics the child has. \_\_\_\_\_

\_\_\_\_\_

List any types of medication and reason taken for healthcare needs. \_\_\_\_\_

\_\_\_\_\_

Share any other information that has a direct bearing on assuring safe medical treatment for you child.

\_\_\_\_\_

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**Emergency Medical Care Information**

Name of Healthcare Professional \_\_\_\_\_ Office # \_\_\_\_\_

Hospital Preference \_\_\_\_\_ Phone # \_\_\_\_\_

Insurance information/Carrier \_\_\_\_\_ Policy # \_\_\_\_\_

I, as the parent or guardian, authorize the Center to provide medical attention for my child in an emergency.

Parent Signature \_\_\_\_\_ 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 any medication without specific instruction from the physician or the child's parent, guardian or full time custodian.

Signature of Administrator \_\_\_\_\_ Date \_\_\_\_\_

## Child's Personal Profile

Child: \_\_\_\_\_

Nickname \_\_\_\_\_ Last \_\_\_\_\_ First \_\_\_\_\_ Middle \_\_\_\_\_ Age \_\_\_\_\_ Date of Birth \_\_\_\_\_

Child's favorite things (activities, toys, blanket, stuffed animal, movie/show) \_\_\_\_\_  
\_\_\_\_\_

Least favorite things or fears \_\_\_\_\_

Has your child had previous preschool/daycare experience? Yes \_\_\_\_\_ No \_\_\_\_\_  
If yes, what type of center was it? Church, national chain, privately owned center, home childcare,  
government such as Head Start, More at 4 \_\_\_\_\_

How would you describe your child's experience in that setting? \_\_\_\_\_  
\_\_\_\_\_

Is your child currently on a waiting list for another preschool program? Yes \_\_\_\_\_ No \_\_\_\_\_

How does your child handle "drop off" or departure time from Mom or Dad?  
Confident \_\_\_\_\_ Hesitant/Shy \_\_\_\_\_ May cry for short time \_\_\_\_\_  
Kick, scream and try to run out of the door after you \_\_\_\_\_ Other \_\_\_\_\_

Is there anything about your child's behavior that concerns you at home or school? Yes \_\_\_\_\_ No \_\_\_\_\_  
If yes, please describe \_\_\_\_\_  
\_\_\_\_\_

### Eating Habits

What is your child's best meal of the day? Breakfast \_\_\_\_\_ Lunch \_\_\_\_\_ Dinner \_\_\_\_\_ Snack \_\_\_\_\_

What are some favorite foods? \_\_\_\_\_

Does your child have any food allergies? Yes \_\_\_\_\_ No \_\_\_\_\_ If yes, to what? \_\_\_\_\_

How is it treated? \_\_\_\_\_

How many meals each day does your family eat together? \_\_\_\_\_

How would you describe your child's appetite? \_\_\_\_\_

### Bedtime Habits

Awakens at \_\_\_\_\_ AM Naps Yes \_\_\_\_\_ No \_\_\_\_\_ Goes to bed at \_\_\_\_\_ PM

Does your child sleep through the night regularly? Yes \_\_\_\_\_ No \_\_\_\_\_

Does child stay dry through the night? Yes \_\_\_\_\_ No \_\_\_\_\_

What term does your child use when they have to go to the bathroom? (i.e., I have to go "potty")  
\_\_\_\_\_

Does/can your child verbally communicate to you the need to potty when he/she feels the urge to go?  
Yes \_\_\_\_\_ No \_\_\_\_\_

## Family Members

Siblings:	Name:	Sex	Age/Grade
	_____	_____	_____
	_____	_____	_____
	_____	_____	_____

Does your child live in a two parent or single parent household? \_\_\_\_\_

*Please note as a matter of record: Parents who are in the process of a legal separation and/or a divorce must provide to the center any documentation necessary pertaining to custody rights in the event they are ordered by the court.*

Does your child have a military deployed parent? Yes \_\_\_\_\_ No \_\_\_\_\_ How long deployed? \_\_\_\_\_

## Parenting

How do you see yourself in the parenting role? (Percentage of time)

Permissive \_\_\_\_\_ Disciplinarian \_\_\_\_\_

Consistent \_\_\_\_\_ Hesitant \_\_\_\_\_

Other: \_\_\_\_\_

What method of discipline is most effective with your child? \_\_\_\_\_

What is the primary reason(s) that you wish to enroll your child at the Baptist Education Center?

\_\_\_\_\_  
\_\_\_\_\_

Is there anything else that you would like for us to know about your child that would help make your child's experience with us the best possible? \_\_\_\_\_

\_\_\_\_\_

Thank you for helping us to understand the unique needs of your little one. We look forward to getting to know him/her and nurturing the special gifts that God has equipped him/her with. Thank you for entrusting their daily care and early learning to us. Please don't hesitate to inform us of any changes that occur in your family that may affect your child's emotional and social wellbeing. We are here to help and to support you.

Sincerely, BEC Staff

## Contact and Emergency Information Update

Child's Name \_\_\_\_\_

Home Address \_\_\_\_\_

City, State, Zip \_\_\_\_\_

Home Phone \_\_\_\_\_

Father's Name \_\_\_\_\_

Mother's Name \_\_\_\_\_

Work # \_\_\_\_\_

Work # \_\_\_\_\_

Cell # \_\_\_\_\_

Cell # \_\_\_\_\_

### Emergency Contact Information:

Contact's Name \_\_\_\_\_

Relationship \_\_\_\_\_

Work # \_\_\_\_\_

Cell # \_\_\_\_\_

Contact's Name \_\_\_\_\_

Relationship \_\_\_\_\_

Work # \_\_\_\_\_

Cell # \_\_\_\_\_

### Others who are allowed to pick up your child

Name \_\_\_\_\_

Name \_\_\_\_\_

Home # \_\_\_\_\_

Home # \_\_\_\_\_

Cell # \_\_\_\_\_

Cell # \_\_\_\_\_

Work # \_\_\_\_\_

Work # \_\_\_\_\_

Name \_\_\_\_\_

Name \_\_\_\_\_

Home # \_\_\_\_\_

Home # \_\_\_\_\_

Cell # \_\_\_\_\_

Cell # \_\_\_\_\_

Work # \_\_\_\_\_

Work # \_\_\_\_\_



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**Notice:**

In order to maintain the safety of your child(ren), we will not release your child(ren) to anyone who appears to be under the influence of alcohol or drugs. This policy is in effect for anyone picking up the child(ren), including parent/guardian.

We will contact your next available emergency contact on your list to transport your child home safely.

\_\_\_\_\_

Father/Guardian Signature

\_\_\_\_\_

Date

\_\_\_\_\_

Mother/Guardian Signature

\_\_\_\_\_

Date

\*\*\*\*\*

**BAPTIST EDUCATION CENTER**

**NO SMOKING POLICY**

Smoking and the use of any tobacco product is prohibited in the school and on school property. This policy includes vehicles that are parked in the parking lot.

Please sign to acknowledge that you have read and understand our no smoking policy.

Printed Name \_\_\_\_\_

Signature \_\_\_\_\_

Date \_\_\_\_\_

## **Baptist Education Center**

### **Shaken Baby Syndrome (Abusive Head Trauma) Prevention Policy**

This policy is designed to inform and assist parents and caregivers in recognizing the signs and symptoms of Shaken Baby Syndrome and to aid in preventing the possibility of abusive head trauma during care. Abusive head trauma (also referred to as Shaken Baby Syndrome) occurs in infants and young children, whose neck muscles are not well-developed and whose heads are larger relative to their bodies. As a result, they are especially susceptible to head trauma caused by any type of forceful or sudden shaking, with or without blunt impact. Damage can occur in as little as five seconds.

Abusive head trauma can occur in children up to five years of age; however, infants less than one year are at greater risk of injury. Shaken baby syndrome can lead to serious conditions including:

- Brain damage, problems with memory and attention, cerebral palsy
- Blindness or hearing loss
- Intellectual, speech or learning disabilities
- Developmental delays

#### **Signs and Symptoms**

The signs and symptoms of Shaken Baby Syndrome or head trauma include:

- Seizures
- Bruises which may be found on the upper arms, rib cage or head resulting from gripping or hit the head
- Lack of appetite, vomiting or difficulty sucking or swallowing
- Lack of smiling or vocalizing
- Rigidity, inability to lift the head
- Difficulty staying awake, altered consciousness
- Difficulty breathing, blue color due to lack of oxygen
- Unequal pupil size, inability to focus the eyes or track movement
- Irritability and/or high pitched crying

#### **Injury Prevention**

Infant crying is normal behavior, which improves as a child ages. Caregivers should develop proactive strategies to manage stress levels and appropriate responses to a crying child. This includes being self-aware and noticing when the caregiver may become frustrated or angry. Parents/guardians, caregivers and coworkers should discuss those calming strategies are successful with a particular child at home or in the center.

#### **Emergency Response**

If a child presents any of the above symptoms or it is suspected that a child has suffered abusive head trauma:

- Call 911, call the parent/guardian and inform your Director and Regional Manager.
- Report to the appropriate child protective services agency (or law enforcement, if applicable) within 24 hours or less as required by law. See Child Abuse/Neglect and Mandated Reporting Policy and Procedure for further information.
- See Medical Emergencies - Calling 911 for additional information.

#### **Strategies for Caregivers and Parents**

A child is usually shaken out of frustration, often when the child is persistently crying or irritable. The following strategies may work some of the time; but sometimes nothing will comfort a crying child. A teacher should seek support from a coworker or center management. If a child is inconsolable on a regular basis, the Director and Regional Manager should be notified and determine if the right supports are in place for the child and for staff.

**Do:**

- Hand the child to another caregiver.
- Place the child somewhere safe in the classroom (or home) and call the office (or a neighbor) for support; take deep breaths and count to ten.
- Check to see if the baby’s diaper needs changing.
- Give the baby a bottle. If baby readily takes bottle, feed slowly stopping to burp often. Do not force the baby to eat.
- Check for signs of illness and call the parent if you suspect the child is sick.
- Give baby a pacifier.
- Hold the baby close against your body and breathe calmly and slowly.
- Gently rock the baby using slow, rhythmic movements.
- Sing to the baby or play soft, soothing music.
- Use “white noise” or rhythmic sounds that mimic the constant whirl of noise in the womb.
- Hold the baby on its side or stomach position to help with digestion. Babies should always be placed on their backs to sleep.
- Take the baby for a walk indoors or outside for a ride in the stroller.
- Be patient; let the baby cry it out if necessary.

**Never:**

- Shake a child
- Drop a child
- Throw a child into the air or into a crib, chair or car seat
- Push a child into any object including walls, doors and furniture
- Strike a child’s head, directly or indirectly

**Resources:**

In addition to any required state training, the following resources are available to parents/guardians and staff:

**Websites: Abusive Head Trauma-How to Protect Your Baby** <https://www.healthychildren.org/English/safety-prevention/at-home/Pages/Abusive-Head-TraumaShaken-Baby-Syndrome.aspx>

**National Center on Shaken Baby Syndrome** <https://www.dontshake.org>

*Growing World of Toddlers*

<https://bwadf.brighthorizons.com>

**PDF**

*Early Brain Development Research Review and Update, Exchange Magazine*

**Shaken Baby & Abusive Head Trauma Policy  
Parent/Guardian Acknowledgement Form**

I, the Parent or Guardian of \_\_\_\_\_

**Child’s Name**

Acknowledge that I have read and received a copy of the Baptist Education Center’s Shaken Baby Syndrome/Abusive Head Trauma Policy.

\_\_\_\_\_ **Date policy given/explained to Parent/Guardian**

\_\_\_\_\_ **Date of Child’s Enrollment**

\_\_\_\_\_ **Printed Name of Parent/Guardian**

\_\_\_\_\_ **Signature of Parent/Guardian & Date**

## Off Premise Activity Authorization

Off premise activities refer to any activity which takes place away from a licensed and approved space. License and approved space include primary space, outdoor space, single use rooms, or other administrative areas that have been approved for use.

I, \_\_\_\_\_, Parent/Guardian of \_\_\_\_\_  
give my permission to Baptist Education Center for my child to participate in an off premise activity.

Locations of off premise activity: Chapel, big field, corner field, parking lot, gym. This is for purposes of weekly chapel, playtime when necessary in the gym, special harvest events, fire safety week fire truck visit.

\_\_\_\_\_  
Parent/Guardian Signature

\_\_\_\_\_  
Date signed

**Baptist Education Center**  
**Permission to photograph/video**

I, \_\_\_\_\_, Parent/Guardian of \_\_\_\_\_

Please print

Give Baptist Education Center permission to photograph or videotape my child. I understand that images of my child(ren) could be used on the school's FaceBook Page or BEC/NRBA website. In addition, images taken could/will be used inside the school for projects and/or special events held at the school.

I agree to the above statement for permission to photograph or videotape my child(ren) for the school's FaceBook Page or inside the school for projects or special events, **however**, I prefer that any image captured of my child(ren) **not** include a **full face** image. Profiles, overhead or 'from the rear' photos are okay.

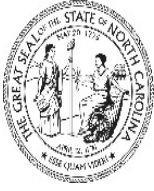
For projects and events use only.

**No**, please do not take images or videos of my child.

In addition, I agree not to post images of other children that might be captured with my child(ren) to social media without the express permission of the other child's parent.

\_\_\_\_\_  
Signature of Parent/Guardian

\_\_\_\_\_  
Date



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

## **NEED HELP PAYING TUITION?**

Call or visit One Place Onslow at [oneplaceonslow.org](http://oneplaceonslow.org) or call (910) 938-0336.

## **NEW APPLICANT INFORMATION:**

### **Documents required for Child Care Subsidy Applicants:**

- A **Work Hours Form** for all adult applicants in the household. All working parents must have this form filled out by their employers and returned at the time of application before any subsidized care can begin.
- An entire month's worth of the **paystubs** for all working parents withing the household. The pay stub should be from the **month prior** to the application. For example, if you apply in August, you should bring in July's paystubs.
- A **school schedule** (if applicable).
- **Proof of any other income you receive besides wages**, including alimony and child support, Veteran's (VA) Benefits, Social Security Benefits, pensions, Unemployment Benefits, Worker Compensation, etc.
- **Self-Employment Form**, along with income expense verifications, i.e., receipts, ledgers, etc. (if applicable).
- A **picture ID for the adults and social security cards** for all members of the family.

**Note: The last applicant will be seen at 3:50 PM to allow time for interview and processing.**

**Note: Recipients must recertify for services annually unless notified otherwise.**

**For Downloadable Documents: See One Place Onslow at [oneplaceonslow.org](http://oneplaceonslow.org) or call (910) 938-0336. They are located at 900 Dennis Rd, Jacksonville, NC 28546 off Western Blvd. Extension, between the Splash & Dash and NAPA Auto Parts.**

**Call (910) 347-0704 to enroll your child at the Baptist Education Center Preschool. Enrolling children 2 ½ and potty-trained to Pre-K 5 years old. \$100 for full week and \$90 for part time.**

## Parent(s)/Guardian(s) Agreement

The following conditions involved in the care of \_\_\_\_\_

Name of child(ren)

are understood and agreed on between the Baptist Education Center and

\_\_\_\_\_  
Parent(s)/Guardian(s)

### Responsibilities of the School

1. In return for the sum that the parent(s)/guardian(s) agree to pay, the school will give regular care to the above-named child(ren) for the agreed upon days per week.
2. The Director or a Teacher will examine the children daily for the symptoms of contagious diseases or illnesses before they are admitted for the day. A written notice will be given in the event of any exposure to a contagious disease. If a child has a fever of 100°+, that child will not be admitted until he/she IS FREE OF A FEVER FOR 24 HOURS. Children with diarrhea or vomiting DURING PREVIOUS 24 HOUR PERIOD will not be admitted.
3. In the case of an accident, emergency or illness to the child, prompt and reasonable measures in the best exercise of judgment will be taken in the best interest of the child. The school will exercise reasonable care and judgment in all matters related to the welfare and safety of the child. Parents/Guardians will be notified as soon as possible.
4. In addition to physical care, opportunities for emotional, social, mental, moral/spiritual growth will be provided.
5. The school will not release the child to anyone other than the parent/guardians and those persons listed by the parents/guardians on the application under the CONTACT section. The school will require a photo ID of all persons picking up children.
6. The school will provide resources in sufficient quantity to all for a variety of learning activities during the day.

### **Responsibilities of the Parents/Guardians**

1. **Payments**  
**Weekly**

**Payment may be made in any way listed below:**

Parents/Guardians will pay the school in advance on MONDAY of each week. The Parents/Guardians who sign the agreement from are responsible for payment on time. If payment is not received by WEDNESDAY of the same week, a late charge of \$5.00 will be added on Thursday. Written notices will be given. If payment is not received by the following MONDAY (or next school day), enrollment will be suspended until full payment is made, including the current week. After efforts have been exhausted to collect payment without response from Parents/Guardians, enrollment will be terminated and legal measures will be taken.

**Monthly**

Parents/Guardians may pay monthly within the first five days of the month for a full month. Check you calendar for five week months. Every two weeks is also an option, but must be paid on Monday of the First Week.

**Registration Fee:**

A registration fee is charged at enrollment and each time reenrollment occurs. If you chose to withdraw your child from the program, regardless of the amount of time withdrawn, a reenrollment fee will be charged.



*(Parents/Guardians Agreement continued)*

**Supply Fee:** A supply fee is charged at enrollment and again annually in September for all enrolled children. See BEC Preschool Enrollment Requirements for current rates.

Parents should drop payment in a payment envelope (available in the front office). Fill out the front of envelope with your name, payment amount and week(s) to which payment should be applied. You may drop payment in the lock box in the hall or give directly to the Director. Please do not give tuition payments to Teachers/Staff. A receipt for payment will be made for you.

**Late Pick-up:** BEC closes at 5:30 PM. If Parent Guardian arrives for a child after the contracted time for care has expired, the following *late fee* will apply. After 5:30 PM a late fee of \$2.00 per minute will be charged. Late fees may be paid upon arrival for child or the amount owed will be charged to your account. Parents/Guardians will be required to initial pick-up time as will staff on duty. If Parents/Guardians have not arrived after one hour and if emergency contacts cannot be located, the Sheriff's Department will be notified.

2. **Medication:** Parents/Guardians accept the policies related to medicine as written in the Application Package and as it appears in the Parent Handbook.
3. **Illness:** Parents/Guardians accept the policies related to illness as written in this Application Package and as it appears in the Parent Handbook.
4. **Emergencies:** In all emergencies, the school has permission to such reasonable measures that are in the judgment of the administration, necessary for the welfare and safety of the child(ren). Parents/Guardians **MUST** provide the school with current emergency information as well as the name and telephone number(s) of an emergency contact person.
5. **Theft:** The school is not responsible for lost or stolen items. ***Please clearly mark your child's belongings.*** Please discourage your child(ren) from bringing toys from home, with the exception of 'Show and Tell' Day.
6. **Accident:** The school is not liable for accidents or illnesses occurring to the child(ren) while he/she is in its care, unless proof is presented that the accident or illness was the direct result of the worker's negligence.
7. **Withdrawals:** The Parents/Guardians will fill out a prior one-week notice when the child is to be withdrawn. A Withdrawal Slip can be obtained from the Director.

**Responsibilities of the School and the Parents/Guardians**

1. This agreement is a binding contract for the school and Parents/Guardians.
2. The contract may be terminated by either the Parents/Guardians or the School with notification of intent at least one week in advance, or at any time by mutual agreement of the school and Parents/Guardians. *(A copy of this signed agreement is in the child's record at the school).*

Date: \_\_\_\_\_  
Parents/Guardians Signature

Date: \_\_\_\_\_  
Signature BEC Director

# Children's Medical Report

Name of Child \_\_\_\_\_ Birthdate \_\_\_\_\_

Name of Parent or Guardian \_\_\_\_\_

Address 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 what for? \_\_\_\_\_

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: \_\_\_\_\_

7. Any mental disabilities? No \_\_\_\_\_ Yes \_\_\_\_\_ If yes, please describe \_\_\_\_\_

Signature of Parent/Guardian \_\_\_\_\_ Date \_\_\_\_\_

\*\*\*\*\*

**B. Physical Examination:** This examination may be completed and signed by a licensed physician, his/her authorized agent currently approved by the NC Board of Medical Examiners or 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 \_\_\_\_\_

Follow-up \_\_\_\_\_

Developmental Evaluation: Delayed \_\_\_\_\_ Age appropriate \_\_\_\_\_

If delay, note significance and special care needed \_\_\_\_\_

Should activities be limited? No \_\_\_\_\_ Yes \_\_\_\_\_ If yes, explain \_\_\_\_\_

Date of Examination \_\_\_\_\_

Signature of Authorized Examiner/Title \_\_\_\_\_ Phone # \_\_\_\_\_