



First Baptist Church Mother's Morning Out Child's Application

(To be completed and placed on file prior to enrollment)



Child Lives With _____

Name of Child _____ Birth Date _____
(Last) (First) (MI)

Address _____ ZipCode _____

Father/Guardian's Name _____ Home Phone _____ Mobile _____

Address _____ Zip Code _____

Employer _____ Business Phone _____ Extension _____

Email address _____

Mother/Guardian's Name _____ Home Phone _____ Mobile _____

Address _____ Zip Code _____

Employer _____ Business Phone _____ Extension _____

Email address _____

Insurance Carrier _____ Policy # _____

Do you attend church? () Yes () No If yes, which one? _____

Does your child have any allergies? () Yes () No **If yes, to what?** _____

Explain Reaction: _____

Please give any information concerning your child that will be helpful in his/her experience in group settings (such as play, eating and sleeping habits, special fears, special likes or dislikes). Attach a separate sheet if necessary.

EMERGENCY INFORMATION (Please complete entirely)

Name of child's doctor _____ Office Phone _____

Address _____

Name of child's dentist _____ Office Phone _____

Address _____

Hospital Preference _____ Phone _____

If the father or mother (or guardian) cannot be reached, please call:

Name _____ Home Phone _____ Office Phone _____

Name _____ Home Phone _____ Office Phone _____

If you cannot call for your child, please list the names of all persons to whom the child may be released: _____

I agree that the Coordinator/Director may authorize the physician of her choice to provide emergency care in the event that neither I, nor the family physician, can be contacted immediately.

(Signature of Parent)

(Date)

I, as the Coordinator/Director, do agree to provide transportation to an appropriate medical resource in the event of an emergency. In an emergency situation, the children remaining in the facility will be supervised at all times by a responsible adult. I will not administer any drug or any medication without specific instructions from the physician or the child's parents, guardian or full time custodian.

(Signature of Coordinator)

(Date)

(Enrollment Date)

(Registration Amount Received)

Entered in ProCare? YES _____ NO _____

First Baptist Church Mother's Morning Out 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 #** _____

First Baptist Church

Mother's Morning Out

120 North Lafayette Street

Shelby, NC 28150

704-482-9456

Discipline and Behavior Management Policy

Praise and positive reinforcement are effective methods of the behavior management of children. When children receive positive, nonviolent 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 Center will practice the following discipline 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 misbehavior.
10. DO explain things to the children on their levels.
11. DO use short supervised periods of "time-out".
12. DO stay consistent in our behavior management program.

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, 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 facilities Discipline and Behavior Management Policy.

Date of child's enrollment: _____

Signature of Parent or Guardian: _____

Date: _____

TIME-OUT

"Time-Out" is the removal of a child for a short period of time (1 minute per year of age) 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 the opportunity to think about the misbehavior that led to his/her removal from the group. After a brief interval, 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.

At First Baptist Church Mother's Morning Out, we use 1 minute for every year of age of the child.

First Baptist Church Mother's Morning Out

Prevention of Shaken Baby Syndrome and Abusive Head Trauma Policy

Belief Statement

First Baptist Church Mother's Morning Out believes that preventing, recognizing, responding to, and reporting shaken baby syndrome and abusive head trauma (SBS/AHT) is an important function of keeping children safe, protecting their healthy development, providing quality child care, and educating families.

Background

SBS/AHT is the name given to a form of physical child abuse that occurs when an infant or small child is violently shaken and/or there is trauma to the head. The National Center on Shaken Baby Syndrome states that shaking may last only a few seconds but can result in severe injury or even death. According to NC Division of Child Development and Early Education and the North Carolina Child Care Rule (child care centers, 10A NCAC 09 .0608, family child care homes, 10A NCAC 09 .1726), each child care facility licensed to care for children up to five years of age shall develop and adopt a policy to prevent SBS/AHT.

Procedure/Practice

Recognizing:

- Children are observed for signs of abusive head trauma including irritability and/or high pitched crying, difficulty staying awake/lethargy or loss of consciousness, difficulty breathing, inability to lift the head, seizures, lack of appetite, vomiting, bruises, poor feeding/sucking, no smiling or vocalization, inability of the eyes to track and/or decreased muscle tone. Bruises may be found on the upper arms, rib cage, or head resulting from gripping or from hitting the head.

Responding to:

- If SBS/ABT is suspected, staff will do as stated in *Shaken Baby Syndrome*, the Mayo Clinic:
 - o Call 911 immediately upon suspecting SBS/AHT and inform the director.
 - o Call the parents/guardians.
 - o If the child has stopped breathing, trained staff will begin pediatric CPR according to *Pediatric First Aid/CPR/AED*, the American Red Cross.

Reporting:

- Instances of suspected child maltreatment in child care are reported to Division of Child Development and Early Education (DCDEE) by calling 1-800-859-0829 or by emailing webmasterdcd@dhhs.nc.gov.
- Instances of suspected child maltreatment in the home are reported to the county Department of Social Services at 707-487-0661.

Prevention strategies to assist staff* in coping with a crying, fussing, or distraught child:

Staff first determines if the child has any physical needs such as being hungry, tired, sick, or in need of a diaper change. If no physical need is identified, staff will attempt one or more of the following strategies as recommended in *Calming Techniques for a Crying Baby* from the Children's Hospital Colorado:

- Rock the child, hold the child close, or walk with the child.
- Stand up, hold the child close, and repeatedly bend knees.
- Sing or talk to the child in a soothing voice.
- Gently rub or stroke the child's back, chest, or tummy.
- Offer a pacifier or try to distract the child with a rattle or toy.
- Take the child for a ride in a stroller.
- Turn on music or white noise.

In addition, the facility:

- Allows for staff who feel they may lose control to have a short, but relatively immediate break away from the children as stated in *Caring for Our Children*, Standard 1.7.0.5: Stress.
- Provides support when parents/guardians are trying to calm a crying child and encourage parents to take a calming break if needed.

Prohibited behaviors

Behaviors that are prohibited include (but are not limited to):

- shaking or jerking a child
- tossing a child into the air or into a crib, chair, or car seat
- pushing a child into walls, doors, or furniture

*For purposes of this policy, "staff" includes the Director and other administration staff who may be counted in ratio, additional caregivers, substitute providers, and uncompensated providers. This policy applies to children up to five years of age and their families, operators, early educators, substitute providers and uncompensated providers.

First Baptist Church Mother's Morning Out Prevention of Shaken Baby Syndrome and Abusive Head Trauma Policy

Parent or Guardian Acknowledgement Form

I, the parent or guardian of _____ (Child's Name), acknowledge that I have read, reviewed 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)

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Travel and Activity Authorization

I, _____ parent / guardian of _____
give my permission to First Baptist Church Mother's Morning Out for my child to
participate in the following activities:

1. Buggy rides around the church grounds
2. Teacher directed walks around the Church and downtown Shelby
3. Field trips away from the facility in the Church Van/Church Bus

I understand that these activities are outside a fenced area of the facility.

Parent / Guardian Signature

Date Signed

This authorization is valid from 08/27/18 through 05/31/19.

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I do not give permission for my child to be outside the fenced areas.

Parent / Guardian Signature

Date Signed

This authorization is valid from 08/27/18 through 05/31/19.

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EMERGENCY INFORMATION

Child's Name: _____

Birthday: _____

Home Address: _____

Home Phone: _____

Father's Name: _____

Mother's Name: _____

Important Phone Numbers:

Father: Home: _____ Work: _____ Pager: _____ Cell: _____

Mother: Home: _____ Work: _____ Pager: _____ Cell: _____

Alternate Emergency Contact Person(s):

Name: _____ Phone: _____

Name: _____ Phone: _____

Name: _____ Phone: _____

Others: _____ Phone: _____

Medical Information (allergies to medications, foods, other substances, etc.)

Hospital Preference: _____

Child's Doctor: _____ Phone: _____

Child's Dentist: _____ Phone: _____

I agree that the operator may authorize the physician of her choice to provide emergency care in the event that neither I nor the family physician can be contacted immediately.

Signature of Parent _____ Date: _____

I, as the operator, do agree to provide transportation to an appropriate medical resource in the event of emergency. In an emergency situation, other children in the facility will be supervised by a responsible adult. I will not administer any drugs of any medication without specific instruction from the physician or the child's parent, guardian or full time custodian. Provisions will be made for adequate and appropriate rest and outdoor play.

Signature of Program Coordinator: _____ Date: _____

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PICK-UP AUTHORIZATION

The people listed below have my authorization to pick up my child from the program **at any time**. **The Center staff will NOT need to call me in reference to the pick-up.**

Name	Relation to Child	Phone Number
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Name	Relation to Child	Phone Number
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Name	Relation to Child	Phone Number
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The people listed below have my authorization to pick up my child from the program. **I will inform the Administrative Assistant or my child's teacher each time a special pick-up is necessary.**

Name	Relation to Child	Phone Number
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Name	Relation to Child	Phone Number
------	-------------------	--------------

Name	Relation to Child	Phone Number
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These people are NOT allowed to pick-up my child:

Name	Relation to Child	Phone Number
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Name	Relation to Child	Phone Number
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Child's Name _____ Date _____

Parent's Signature _____

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Permission Request

I do _____ I do not _____ give my permission for my child to be photographed in the program, program functions and field trips and the photographs to be displayed or posted to social media. I understand that the photographs may be taken by Center staff, professional photographers, news media or other parents. I understand that I will be notified if any photos are to be used for publicity purposes and that I have the right to refuse permission.

Child's Name: _____

Parent/Guardian Signature: _____

Date: _____



