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

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

Date _____ Child Lives With _____

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

Address _____ Zip Code _____

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)

_____ _____ Entered in ProCare? YES _____ NO _____
(Enrollment Date) (Registration Amount Received)

DCD 0108
12/99

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

Revised 7-09

Immunization History

Name: _____ Date of Birth: _____

Enter the date an immunization was received in the space below or attach a copy of the immunization record. G.S. 130A-155(b) requires all child care facilities to have this information on file.

Enter date of each dose - Month/Day/Year

VACCINE	#1	#2	#3	#4	#5
*DTP / DT (circle which)					
*Polio					
**Hib					
*Hepatitis B					
*MMR (combined doses)					
***Chicken Pox					
OTHER					
OTHER					

*Required by state law.
**Required by state law, however the requirement for the booster dose, #4, is temporarily suspended.
***Required by State law for children born on or after 4/1/01.

Records Updated by:	Date Updated:

First Baptist Church
Mother's Morning Out

120 North Lafayette Street Shelby, NC 28150 704-482-9456

Behavior Management and Positive Guidance 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.

The Administrator will review the Behavior Management and Positive Guidance Policy during the registration process with the parents. All children must have a signed Behavior Management and Positive Guidance Policy form in their files.

Based on the belief of how children learn and develop values, First Baptist Church Child Care will practice the following Behavior Management and Positive Guidance Policy:

WE…

- **DO** give positive and specific encouragement to children and comment frequently on children's appropriate behavior.
- **DO** post behavior expectations and review regularly.
- **DO** model appropriate behavior for children.
- **DO** design the classroom environment to attempt to prevent problems before they occur.
- **DO** listen to children.
- **DO** identify inappropriate behaviors and engage children in problem solving.
- **DO** provide the children with natural and logical consequences of their behaviors.
- **DO** treat the children as people and respect their needs, desires, and feelings.
- **DO** ignore minor misbehaviors and focus on positive behaviors.
- **DO** give instructions that are age appropriate, clear and concise.
- **DO** use a variety of developmentally and age-appropriate strategies including redirection, planned ignoring, and time-in.
- **DO** promote the acquisition of self-regulation skills by teaching feelings and emotions, calming and relaxation strategies, and teaching children responses that are socially acceptable and emotionally mature.

WE…

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

Parent or Guardian Acknowledgement

I, the parent or guardian of _____ (Child's Name), acknowledge that I have read, reviewed and received a copy of the facility's **Behavior Management and Positive Guidance** policy.

_____
(Date Policy Given to Parent/Guardian)

_____ _____ _____
(Print Name of Parent/Guardian) (Signature of Parent/Guardian) (Date)

"Sharing, caring and working together, helping to make the world a better place." ~Karen's Kids

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:
  - Call 911 immediately upon suspecting SBS/AHT and inform the director.
  - Call the parents/guardians.
  - 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)**

Distribution: one signed copy to parent(s)/guardian(s); one signed copy in child's facility file Adopted February 2, 2017

First Baptist Church
Mother's Morning Out

120 North Lafayette Street **Shelby, NC 28150** **704-482-9456**

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 08/21/23 through 05/30/24.

++

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

_____
Parent / Guardian Signature

_____
Date Signed

This authorization is valid from 08/21/23 through 05/30/24.

First Baptist Church
Mother's Morning Out

120 North Lafayette Street Shelby, NC 28150 704-482-9456

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: _____

First Baptist Church
Mother's Morning Out

120 North Lafayette Street Shelby, NC 28150 704-482-9456

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

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

These people are NOT allowed to pick-up my child:

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

Child's Name _____ Date _____

Parent's Signature _____

First Baptist Church

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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: _____

RELINK

Help First Baptist Church Mother's Morning Out program raise money by linking your loyalty card from Ingles to our school. Each time you use your cards, a percentage of the store brand products is donated directly to FBC-MMO. That means that we only receive cash when you buy Ingles brand products. It is at no cost to you and will help FBC-MMO buy school supplies and learning equipment.

IF you fill out the form below, we will relink your card for you OR you can relink them yourself.

Note: Must relink yearly.

Ingles

Tools for schools!! For more information, please visit www.Ingles-markets.com

Email Address: _____

Mr. ☐

Ms. ☐ Last Name (PLEASE PRINT IN ALL CAPITAL LETTERS)

Mrs. ☐ First Name M.I.

Inlges Advantage Card Number (12 DIGITS) School Code

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