Date Application Completed_____ ___ Date of Enrollment_____

CHILD'S APPLICATION FOR ENROLLMENT

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

CHILD INFORMATION: Date of Birth: _____

Full Name:_____

Last First Middle Nickname

Child's Physical Address:_____

FAMILY INFORMATION: Child lives with: _____

Father/Guardian's Name_____ Home Phone_____

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

Work Phone_____ Cell Phone_____

Mother/Guardian's Name _____ Home Phone_____

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

Work Phone_____ Cell Phone_____

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, the facility has permission to contact the following individuals.

Name	Relationship	Address	Phone Number
Name	Relationship	Address	Phone Number
Name	Relationship	Address	Phone Number

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__

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_____

_____

EMERGENCY MEDICAL CARE INFORMATION:

Name of health care professional _____ Office Phone _____

Hospital preference _____ Phone _____

I, as the parent/guardian, authorize the center to obtain medical attention for my child in an emergency.

Signature of Parent/Guardian_____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 drug or any medication without specific instructions from the physician or the child's parent, guardian, or full-time custodian.

Signature of Administrator_____Date_____

DCD 0108
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 #**_____

emergency information

Child's Name: _____

Date of Birth: _____

Home Address: _____

Home Phone: _____

Father's Name: _____

Mother's Name: _____

Important Phone Numbers (check best number to contact in emergency)

Parent/Guardian: home: _____ work: _____ cell: _____ email: _____

Parent/Guardian: home: _____ work: _____ cell: _____ email: _____

Alternate Emergency Contact Person(s)

Name: _____ Relationship: _____ Phone: _____

Name: _____ Relationship: _____ Phone: _____

Name: _____ Relationship: _____ Phone: _____

Others: _____

NC CACFP PARENT/GUARDIAN HOUSEHOLD LETTER

Dear Parent/Guardian:

Your day care provider participates in the Child and Adult Care Food Program (CACFP) funded by the U.S. Department of Agriculture and administered by the North Carolina Department of Health and Human Services. Please help us comply with the CACFP requirements by completing, signing, and returning the attached Eligibility Application to the address provided. This information is necessary so that your day care provider is paid for the meals served to the children in their care. All children in our program receive their meals free of charge, but the income eligibility category determines the amount of funding your day care provider will receive. The information you provide on this form will be confidential and will **NOT** be shared with your day care provider or anyone else without your permission.

Complete the application as follows:

- **HOUSEHOLD MEMBERS:** List the name of the enrolled child(ren), and the child's parent(s) or guardian, and any other dependent children who live in the household.
- **SNAP, TANF/WORK FIRST, FDPIR, WIC, FREE/REDUCED PRICE SCHOOL LUNCH:** If a household member is currently receiving benefits from any of these programs, provide the program case/identification number as requested. Do not complete Part 2B.
- **CURRENT INCOME:** List the amount of income each person earned **last** month before deductions for taxes, social security, etc.), the frequency of income, and where it is from, such as wages, retirement, or welfare. If any household member's income last month was higher or lower than usual, list that person's usual average monthly income.
- **SIGNATURE:** An adult household member must sign the income eligibility application.
- **Last Four Digits of the Social Security Number:** List the last four digits of the social security number of the adult who signs the income eligibility statement. If that adult does not have a social security number, print "None"

REDUCED GUIDELINES EFFECTIVE JULY 1, 2022 - JUNE 30, 2023*

HOUSEHOLD SIZE	YEARLY	MONTHLY	TWICE PER MONTH	EVERY TWO WEEKS	WEEKLY
1	$25,142	$2,096	$1,048	$967	$484
2	$33,874	$2,823	$1,412	$1,303	$652
3	$42,606	$3,551	$1,776	$1,639	$820
4	$51,338	$4,279	$2,140	$1,975	$988
5	$60,070	$5,006	$2,503	$2,311	$1,156
6	$68,802	$5,734	$2,867	$2,647	$1,324
7	$77,534	$6,462	$3,231	$2,983	$1,492
8	$86,266	$7,189	$3,595	$3,318	$1,659
For each additional family member add:	$8,732	$728	$364	$336	$168

Households with income less than or equal to these levels are eligible for free or reduced-price meals.
Monthly Income Conversion: Weekly X 4.33 Every 2 Weeks X 2.15 Twice a Month X 2

You may submit a program 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 Public Health

North Carolina Department of Health and Human Services
Division of Public Health
Women's & Children's Health Section
Nutrition Services Branch
Child and Adult Care Food Program

CACFP

Infant Feeding Consent Form

NOTE TO PARENTS: When a parent or guardian chooses to provide breastmilk (expressed breastmilk or breastfeed on-site) or a creditable infant formula and the infant is consuming solid foods, the center or day care home must supply all other required meal components for the meal to be reimbursable.

NOTE TO INSTITUTION/FACILITY: This document is required for all enrolled infants.

North Carolina Public Health

Department of Health and Human Services
Division of Public Health
Women's & Children's Health Section
Nutrition Services Branch
Child and Adult Care Food Program

CACFP Child & Adult Care Food Program

Infant Feeding Consent Form

Institution/Facility Name: Harris Learning Academy

TO BE COMPLETED BY THE PARENT/GUARDIAN

Please select from the following choice(s):

☐ **I will breastfeed my infant on-site and/or provide expressed breastmilk.**

The Child and Adult Care Food Program (CACFP) encourages and supports breastfeeding. The American Academy of Pediatrics (AAP) recommends exclusively breastfeeding and/or provision of expressed breastmilk for six months; and continued breastfeeding after six months with the introduction of solid foods until at least one year. There is no age limit on breastfeeding or provision of expressed breastmilk. Mothers and infants/children may continue to breastfeed as long as mutually desirable. The North Carolina CACFP aims to help families meet their breastfeeding goals. For breastfeeding support, contact your local Women, Infant, and Children (WIC) agency or visit www.zipmilk.org to find local breastfeeding resources.

☐ **I will accept the iron-fortified formula provided by the institution/facility.**

The facility offers: Similac - Pro Advanced

Enter the Name of the Iron-Fortified Infant Formula Provided by this Institution/Facility

I give permission for this institution/facility to prepare my infant's formula. When breastmilk is not available, infants must receive iron-fortified formula until 12 months of age. It is the parent's or guardian's choice to accept the formula provided by the institution/facility or provide an alternative formula.

NOTE: Infants receiving formula through the WIC Program are also eligible to receive formula from this center or day care home

☐ **I decline the iron-fortified formula provided by the institution/facility**

I will provide my infant with the following formula: _____

NOTE: If providing formula, it must be iron-fortified. If the formula provided is a special formula, a medical statement will be requested

Please select one of the following:

☐ **My infant is less than 6 months old.**

☐ **My infant is around 6 months of age and is developmentally ready to accept solid foods. I want the institution/facility to provide solid food(s) allowed under 7 § C.F.R. 226.20 (b) and policy memo 17-01.**

It is important to delay the introduction of solid foods until around 6 months of age as most infants are not developmentally ready to safely consume them. There is no single, direct signal to determine when an infant is developmentally ready to accept solid foods. An infant's readiness depends on his or her unique rate of development. Centers and day care homes should be in constant communication with parents/guardians about when and what solid foods should be served while the infants are in their care. The AAP provides the following guidance to help determine if your infant is ready for solid foods. Check all, if any, that apply to your infant:

- ☐ **My infant can sit in a high chair, feeding seat, or infant seat with good head control.**
- ☐ **My infant is watching me and others eat, reaching for food, and seems eager to be fed.**
- ☐ **My infant can move food from a spoon into the throat and does not push it out of the mouth and/or dribbles onto his or her chin.**
- ☐ **My infant has doubled his or her birth weight and now weighs around 13 pounds or more.**

Infant's Name: _____ **Infant's Age** _____ **Date of Birth** _____

Parent/Guardian Signature: _____ **Date:** _____

Infant Feeding Plan

As your child's caregivers, an important part of our job is feeding your baby. The information you provide below will help us to do our very best to help your baby grow and thrive. Page two of this form must be completed and posted for quick reference for all children under 15 months of age.

Child's name: _____ Birthday: _____
mm / dd / yyyy

Parent/Guardian's name(s): _____

Did you receive a copy of our "Infant Feeding Guide?" Yes No

If you are breastfeeding, did you receive a copy of:
"Breastfeeding: Making It Work?" Yes No
"Breastfeeding and Child Care: What Moms Can Do?" Yes No

TO BE COMPLETED BY PARENT

At home, my baby drinks (check all that apply):

- Mother's milk from (circle)

  Mother bottle cup other
- Formula from (circle)

  bottle cup other
- Cow's milk from (circle)

  bottle cup other
- Other: _____ from (circle)

  bottle cup other

How does your child show you that s/he is hungry?

How often does your child usually feed?

How much milk/formula does your child usually drink in one feeding?

Has your child started eating solid foods?

If so, what foods is s/he eating?

How often does s/he eat solid food, and how much?

TO BE COMPLETED BY TEACHER

Clarifications/Additional Details:

At home, is baby fed in response to the baby's cues that s/he is hungry, rather than on a schedule?

Yes No

If NO,

- I made sure that parents have a copy of the "Infant Feeding Guide" or "Breastfeeding: Making it Work"
- I showed parents the section on reading baby's cues

Is baby receiving solid food? Yes No

Is baby under 6 months of age? Yes No

If YES to both,

- I have asked: Did the child's health care provider recommend starting solids before six months?

  Yes No

If NO,

- I have shared the recommendation that solids are started at about six months.

Handouts shared with parents:

Child's name: _____ Birthday: _____
mm / dd / yyyy

Tell us about your baby's feedings at our center.
I want my child to be fed the following foods while in your care:

	Frequency of feedings	Approximate amount per feeding	Will you bring from home? (must be labeled and dated)	Details about feeding
Mother's Milk				
Formula				
Cow's milk				
Cereal				
Baby Food				
Table Food				
Other (describe)				

I plan to come to the center to nurse / feed my baby at the following time(s): _____

My usual pick-up time will be: _____

If my baby is crying or seems hungry shortly before I am going to arrive, you should do the following (choose as many as apply):
__ hold my baby __ use the teething toy I provided __ use the pacifier I provided
__ rock my baby __ give a bottle of milk __ other Specify: _____

I would like you to take this action _____ minutes before my arrival time.

At the end of the day, please do the following (choose one):
____ Return all thawed and frozen milk / formula to me. _____ Discard all thawed and frozen milk / formula.

We have discussed the above plan, and made any needed changes or clarifications.

Today's date: _____

Teacher Signature: _____ Parent Signature _____

Any changes must be noted below and initialed by both the teacher and the parent.

Date	Change to Feeding Plan (must be recorded as feeding habits change)	Parent Initials	Teacher Initials

CAROLINA GLOBAL BREASTFEEDING INSTITUTE
Breastfeeding-Friendly CHILD CARE

In Collaboration With:
NC Department of Health and Human Services
NC Child Care Health and Safety Resource Center
NC Infant Toddler Enhancement Project

Infant/Toddler Safe Sleep Policy

Child Care Facility: Harris Learning Academy

A safe sleep environment for infants reduces the risk of sudden infant death syndrome (SIDS) and other sleep related infant deaths. According to N.C. Law, child care providers caring for infants 12 months of age or younger are required to implement a safe sleep policy and share the policy with parents/guardians and staff. We implement the following safe sleep policy.
References: N.C. Law G.S. 100-91 (15), N.C. Child Care Rules .0606 and .1724, Caring for Our Children

Safe Sleep Practices

1. We train all staff, substitutes, and volunteers caring for infants aged 12 months or younger on how to implement our Infant/Toddler Safe Sleep Policy.
2. We always place infants under 6 months of age on their backs to sleep, unless a signed *ITS-SIDS Alternate Sleep Position Health Care Professional Waiver* is in the infant's file and posted at the infant's crib. We retain the waiver in the child's record for as long as they are enrolled.
3. ☑ We do not accept *Parent Waivers* for infants older than six months.* -OR-
   ☐ We accept the *ITS-SIDS Alternate Sleep Position Parent Waiver.*
4. We place infants on their backs to sleep even after they can easily turn over from the back to the stomach. We then allow them to adopt their own position for sleep.
   ☑ We document when each infant can roll from back to stomach and tell the parents. We put a notice in the child's file and on or near the infant's crib.*
5. We visually check sleeping infants every 15 minutes and record what we see on a *Sleep Chart*. We document the infant's sleep position, skin color, breathing, level of sleep, and body temperature.
   ☐ We check infants 2-4 month of age more frequently.*
6. We maintain the temperature in the room where infants sleep between 68-75°F and check it on the thermometer in the room.
   ☑ We further reduce the risk of overheating by not over-dressing infants*
7. We provide all infants supervised "tummy time" daily.
8. We follow N.C Child Care Rules .0901(j) and .1706(g) regarding breastfeeding.
   ☑ We further encourage breastfeeding in the following ways:* _____

Safe Sleep Environment

9. We use Consumer Product Safety Commission (CPSC) approved cribs or other approved sleep spaces for infants. Each infant has his or her own crib or sleep space.
10. ☐ We do not allow infants to use pacifiers. -OR-
    ☑ We allow pacifiers without any attachments.*
    ☑ We do not reinsert the pacifier in the infant's mouth if it falls out.*
    ☑ We remove the pacifier from the crib once it has fallen from the infant's mouth.*
11. We do not cover infants' heads with blankets or bedding.
12. We do not allow any objects other than pacifiers in the crib or sleep space.
13. We give all parents/guardians of infants a written copy of the *Infant/Toddler Safe Sleep Policy* before enrollment. We review the policy with them, and ask them to sign a statement saying they received and reviewed the policy.
    ☑ We encourage families to follow the same safe sleep practices to ease infants' transition to child care.*
14. Family child care homes: We post a copy of this policy and a safe sleep practices poster in the infant sleep room where it can easily be read.
15. Centers: We post a copy of this policy in the infant sleep room where it can easily be read.

**Indicates we follow this best practice recommendation.*

Effective date: _____ **Review date(s):** _____ **Revision date(s):** _____

Distribution: We give parents/guardians a copy of the policy. We give all staff, substitutes, and volunteers a copy to review. We inform them of changes 14 days before the effective date. We give parents/guardians a copy of the policy they signed and put a copy in child's file.

I, the undersigned parent/guardian of _____ (child's full name), have received a copy of the facility's *Infant/Toddler Safe Sleep Policy*. I have read the policy and discussed it the facility director/owner/operator, or other designated staff member.

Child's Enrollment Date: _____ Parent/Guardian Signature: _____ Date: _____

Facility Representative Signature: _____ Date: _____

NC CACFP CHILD INCOME ELIGIBILITY APPLICATION INSTRUCTIONS

1 – PARTICIPANT'S INFORMATION: Complete this part.
Print the name of each child enrolled in the Day Care Home.
Print the name of the Day Care Home provider.

2 – HOUSEHOLD GETTING SNAP, TANF/WORK FIRST, FDPIR, NATIONAL SCHOOL LUNCH, SCHOOL BREAKFAST, OR WIC BENEFITS:
If your household participates in any of these programs, list the case number and complete number 3, 5, & 6, skip number 4. List your current SNAP case number or your TANF/Work First, FDPIR, or WIC identification number, or check yes to indicate that your child receives free/reduced priced school lunch. Do not complete number 4, skip to number 5.

3 - FOSTER CHILD: Answer this question for each foster child living in your home and enrolled in the facility Foster children are automatically eligible for program benefits at the free rate. 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.

4 - HOUSEHOLD MEMBERS MONTHLY INCOME: Complete this section if the household does NOT receive any of the benefits listed above and/or the enrolled child is NOT a foster child.
List the names of all other household members and provide the gross income (the amount before taxes or any other deductions), 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, welfare, pensions, and other income (refer to examples below for types of income to report). If any amount last month was more or less than usual, write the person's usual income.

Monthly Income Conversion: Weekly X 4.33 Every 2 Weeks X 2.15 Twice a Month X 2

INCOME TO REPORT

Earnings from Employment	Pensions/Retirement/Social Security	Other Income
Wage/Salaries/Tips	Pensions	Disability Benefits
Strike Benefits	Supplemental Security Income	Cash withdrawn from savings
Unemployment Compensation	Retirement Income	Interest/Dividends
Worker's Compensation	Veteran's Payments	Income from Estates/Trusts/Investments
Net Income from Self-Owned Business or Farm	Social Security	Regular contributions from persons not living in the household
Welfare/Child Support/Alimony	**Military Households**	Net Royalties/Annuities
Public Assistance payments	All cash income including military housing/uniform allowances. Does not include "in-kind" benefits NOT paid in cash (base housing, clothing, food medical care, etc.)	Net Rental Income
Welfare payments		Any Other Income
Alimony/Child support payments		

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

6 - SIGNATURE AND LAST FOUR DIGITS OF SOCIAL SECURITY NUMBER:
All eligibility statements must have the signature of an adult household member.
The adult household member who signs the 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 box indicating no SSN. If you listed a SNAP, TANF/Work First, WIC, or FDPIR number, a Social Security number is not needed.

The section below should be returned with the CACFP Eligibility Application if consent is given to the provider to collect this form.

Written Consent Clause: Provider's Name: _____

If you choose to complete the CACFP Eligibility Application, you have the option of returning it directly to your Provider or to the Provider's Sponsor. If you want to provide the CACFP Eligibility Application directly to the sponsor, return the competed form to: _____

Name and Address of Sponsoring Organization

_____ Initial here if you consent to allowing the Family Care Home Provider to collect your form and provide it to the Sponsor.

_____ will not review your form.

(Provider's Name)

North Carolina Department of Health and Human Services
Division of Child and Family Well-Being, Community Nutrition Services Section
Child and Adult Care Food Program

INFANT AND CHILD INCOME ELIGIBILITY APPLICATION

INSTITUTION
NAME: Child Care Resources, Inc

FACILITY
NAME: Harris Learning Academy 24 AGREEMENT #: 7461

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 Infant/Child? ☐ Yes ☐ No Homeless Infant/Child? ☐ Yes ☐ No Infant/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

Check if no SSN ☐

Last Four Digits of Social Security Number (Required if qualifying by income)

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 Insitution/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 - Infant and Child Income Eligibility Application (06/2022)

This institution is an equal opportunity provider.

North Carolina Department of Health and Human Services
Division of Child and Family Well-Being, Community Nutrition Services Section
Child and Adult Care Food Program
Infant and Child Enrollment Form

INSTITUTION NAME: Child Care Resources, Inc

FACILITY NAME: Harris Learning Academy 24 AGREEMENT#: 7461

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 infants and children. Please complete the table below for each infant and/or child in your family enrolled at this center/program. Be sure to sign and date in the space below.

The information below should be completed by the parent or guardian.

Infant/Child's First Name	Infant/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: Write in each infant/child's usual arrival and departure time. Indicate a.m. or p.m.

Normal Days of Care: Circle the days of the week each infant/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 - Circle the meals each infant/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 infant/child withdrew: _____

For State Use Only: Complete: _____ Incomplete _____ Reason: _____ Verified by: _____ Date: _____

This institution is an equal opportunity provider.

NC CACFP Infant and Child Enrollment Form (05/2022)

SAMPLE Policy

Belief Statement

We, HLA (name of facility) believe 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. Shaking may last only a few seconds but can result in severe injury or even death[1]. According to 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[2]

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[3]:
  - 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[4].

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. Phone number: _____

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

Staff first determine 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[5]:

- **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.**
- **Other** _____
- **Other** _____

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[6].**
- **Provides support when parents/guardians are trying to calm a crying child and encourage parents to take a calming break if needed.**
- Other _____

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

Strategies to assist staff members understand how to care for infants

Staff reviews and discusses:

- The five goals and developmental indicators in the 2013 North Carolina Foundations for Early Learning and Development, ncchildcare.nc.gov/PDF_forms/NC_Foundations.pdf
- How to Care for Infants and Toddlers in Groups, the National Center for Infants, Toddlers and Families, www.zerotothree.org/resources/77-how-to-care-for-infants-and-toddlers-in-groups
- Including Relationship-Based Care Practices in Infant-Toddler Care: Implications for Practice and Policy, the Network of Infant/Toddler Researchers, pages 7-9, www.acf.hhs.gov/sites/default/files/opre/nitr_inquire_may_2016_070616_b508compliant.pdf

Strategies to ensure staff members understand the brain development of children up to five years of age

All staff take training on SBS/AHT within first two weeks of employment. Training includes recognizing, responding to, and reporting child abuse, neglect, or maltreatment as well as the brain development of children up to five years of age. Staff review and discuss:

- Brain Development from Birth video, the National Center for Infants, Toddlers and Families, www.zerotothree.org/resources/156-brain-wonders-nurturing-healthy-brain-development-from-birth
- The Science of Early Childhood Development, Center on the Developing Child, developingchild.harvard.edu/resources/inbrief-science-of-ecd/

Resources

List resources such as a staff person designated to provide support or a local county/community resource:

_____

_____

Parent web resources

- The American Academy of Pediatrics: www.healthychildren.org/English/safety-prevention/at-home/Pages/Abusive-Head-Trauma-Shaken-Baby-Syndrome.aspx
- The National Center on Shaken Baby Syndrome: http://dontshake.org/family-resources
- The Period of Purple Crying: http://purplecrying.info/
- Other _____

Facility web resources

- Caring for Our Children, Standard 3.4.4.3 Preventing and Identifying Shaken Baby Syndrome/Abusive Head Trauma, http://cfoc.nrckids.org/StandardView.cfm?StdNum=3.4.4.3&=+
- Preventing Shaken Baby Syndrome, the Centers for Disease Control and Prevention, http://centerforchildwelfare.fmhi.usf.edu/kb/trprev/Preventing_SBS_508-a.pdf
- Early Development & Well-Being, Zero to Three, www.zerotothree.org/early-development
- Other _____

SAMPLE Policy

References

1. The National Center on Shaken Baby Syndrome, www.dontshake.org
2. NC DCDEE, ncchildcare.dhhs.state.nc.us/general/mb_ccrulespublic.asp
3. Shaken baby syndrome, the Mayo Clinic, www.mayoclinic.org/diseases-conditions/shaken-baby-syndrome/basics/symptoms/con-20034461
4. Pediatric First Aid/CPR/AED, American Red Cross, www.redcross.org/images/MEDIA_CustomProductCatalog/m4240175_Pediatric_ready_reference.pdf
5. Calming Techniques for a Crying Baby, Children's Hospital Colorado, www.childrenscolorado.org/conditions-and-advice/calm-a-crying-baby/calming-techniques
6. Caring for Our Children, Standard 1.7.0.5: Stress http://cfoc.nrckids.org/StandardView/1.7.0.5

Application

This policy applies to children up to five years of age and their families, operators, early educators, substitute providers, and uncompensated providers.

Communication

Staff*

- Within 30 days of adopting this policy, the child care facility shall review the policy with all staff who provide care for children up to five years of age.
- All current staff members and newly hired staff will be trained in SBS/AHT before providing care for children up to five years of age.
- Staff will sign an acknowledgement form that includes the individual's name, the date the center's policy was given and explained to the individual, the individual's signature, and the date the individual signed the acknowledgment
- The child care facility shall keep the **SBS/AHT staff acknowledgement form** in the staff member's file.

Parents/Guardians

- Within 30 days of adopting this policy, the child care facility shall review the policy with parents/guardians of currently enrolled children up to five years of age.
- A copy of the policy will be given and explained to the parents/guardians of newly enrolled children up to five years of age on or before the first day the child receives care at the facility.
- **Parents/guardians will sign an acknowledgement form that includes the child's name, date the child first attended the facility, date the operator's policy was given and explained to the parent, parent's name, parent's signature, and the date the parent signed the acknowledgement**
- **The child care facility shall keep the SBS/AHT parent acknowledgement form in the child's file.**

*** For purposes of this policy, "staff" includes the operator and other administration staff who may be counted in ratio, additional caregivers, substitute providers, and uncompensated providers.**

Effective Date

This policy was reviewed and approved by:

Owner/Director (recommended) **Date**

DCDEE Child Care Consultant (recommended) **Date** **Child Care Health Consultant (recommended)** **Date**

Annual Review Dates

SAMPLE Policy

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

Name of Facility: Harris Learning Academy

Discipline and Behavior Management Policy

Date Adopted _____

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 facility's Discipline and Behavior Management Policy and that the facility's director/operator (or other designated staff member) has discussed the facility'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

Revised 8.09

TRAVEL AND ACTIVITY AUTHORIZATION

[illegible]
G.S. 110-91(6)
REV 1/97

SAMPLE FORM

☐ Blanket permission for this activity
☐ Special 1-time permission only
☑ Blanket permission for all given activities

I, _____ parent/guardian of
name of parent/guardian

_____ give my permission to
name of child

Harris Learning Academy for my child to participate in the
name of

following activities

Trips in the van/automobile (facility or parent-owned)

_____
Explain planned activity – when and where

Field trips away from the facility

_____
Explain planned activity – when and where

I understand that the facility will use the appropriate child restraint devises and abide by all the safety rules in Rule .1000 when my child is transported in a vehicle. The facility will also notify me each time that my child is to participate in an activity that would involve transportation

_____
Parent/Guardian Signature

_____
Date Signed

This authorization is valid from _____/_____/_____ to _____/_____/_____

In addition, if the facility has planned activities outside the fenced area of the facility,

_____ I will allow my child to play outside the fenced area; or

I will not allow my child to play outside the fenced area.

_____
Parent/Guardian Signature

_____
Date Signed

This authorization is valid from _____/_____/_____ to _____/_____/_____

File in child's folder

valid goes up to 12 months

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	Departure Time	Return Time

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

and Early Education

Transportation Permission

A. Parent and Child Information

Name of Parent	Telephone Number - Primary
Name of Child ☐ Picture attached	Telephone Number - Secondary

B. Emergency Contact Information (non-parent)

Name	Telephone Number

C. Departure and Return Times

Departure Time	Arrival Time	Return Time

D. Authorized Destinations

Child transported from	Child transported to

E. Parent Signature and Other

Person receiving child, if applicable ☐ On application	Method of Travel
Permission to transport is valid from [give date] to [give date]. **From** **To** (up to 12 months)	Transportation Provider
Signature of Parent or Guardian	Date

Photo Release Form for Minors (If under 18)

By signing I verify that Harris Learning Academy, LLC. has my permission to use my or my child's photograph publically to promote the center. I understand that the images may be used in print publications, online publications, presentations, websites, and social media. I also understand that no royalty, fee or other compensation shall become payable to me by reason of such use.

Parent/Guardian's signature: _____ Date _____

Parent/Guardian's Name: _____

Child's Name: _____

Phone Number: _____

Harris Learning Academy, LLC.

6141 Statesville Road

Charlotte, NC 28269

704-921-1153/704-921-1966

Parent Handbook Signature page

I have received, read & signed all documents listed below and have no questions.

-------- HLA policies & procedures/ parent handbook and understand all aspect of the policies & procedures and all questions or concerns have been addressed.

-------- HLA infant/toddler safe sleep policy or (does not apply) ----------

-------- Prevention of Shaken Baby Syndrome and Abusive Head Trauma Policy or (does not apply) --------

------- HLA Disciplinary Policy

------- The overview of North Carolina Division of Child Development & Early Education operating law

Owner/Director Signature

Parent signature

Date

Harris Learning Academy, LLC.
6141 Statesville Road Charlotte, NC 28269
704-921-1153

October 7, 2022

Dear Parents,

We offer a structured, age-appropriate environment for optimal learning and to ensure all children are happy and safe. Regrettably, we are experiencing a significant number of behavioral issues with some children. Children are refusing to listen, follow directions, and are hitting and kicking teachers. It is imperative we see immediate improvement with these behavioral problems.

As with many local businesses, we are experiencing a staff shortage. We pride ourselves on employing quality staff members to care for your young children. We will not have teachers leaving our center because of behavioral problems. We will hold parents accountable for their child(ren)'s actions. We must see immediate improvement in children with whom parents have been previously made aware of such behavioral problems. Your child(ren) will be terminated unless we see immediate improvement.

As a friendly reminder, three-year old children must be potty trained before they can transition to the three-year old classroom. The classroom does not have the ability to change diapers and/or pull-ups. We must see immediate progress with potty training children.

The NC Division of Child Development best practice states a child should not be in daycare for more than 10 hours per day. Parents who are dropping their child(ren) off between 7:00 am and 7:30 am must pick up their child(ren) between 4:30 pm and 5:00 pm. As always, your cooperation with improving these areas of concern is truly appreciated.

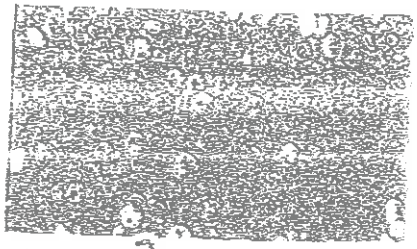
Sincerely,

Laura Harris
Director

Safe Arrival and Departure Procedures

10A NCAC 09 .0604(t) Each center shall establish safe procedures for pick-up and delivery of children. These procedures shall be communicated to parents, and a copy shall be posted in the center where they can be seen by the parents.

- Upon arrival, all children must be accompanied inside the facility by an adult.
- Staff must be notified of the child's arrival.
- Upon the child's departure, an adult must come inside the facility and notify staff that the child is leaving.
- Children will only be released to persons listed on the child's application as authorized by the parent/guardian. Staff will request to view a driver's license to verify identity of persons other than known parent/guardian.
- Authorization from parent/guardian is required in writing when anyone other than the designated person(s) as listed on the child's application arrives to pick up the child.
- **When a child is transported by the facility to the child's home, an adult must be available to receive the child from the bus or van.**
- **Sign children in and out according to the program's policies. Daily arrival and departure times must be recorded/**
- **Children must never be left unattended.**



3 Types Of Bee Grooming Beads

BEADS WILL NO LONGER BE ALLOWED on the premises. Licensing states that this is a major choking hazardous and will no longer be accepted. If your child comes in with beads in his/her head, you will be asked to remove them immediately in order for your child to enter in his/her classroom. THERE WILL BE NO EXCEPTIONS.

Harris Learning Academy policies and NC health and safety codes require that students wear shoes which fully enclose the foot at all times when they are in the building. Students are not allowed to wear sandals, flip-flops, slippers or any other type of open-toe or heel shoe without encased straps. Student arriving at HLA wearing inappropriate footwear will be given the option to go home and change or call home have someone bring them proper shoes.

Thank you for understanding,

Laura Harris

Director

Keep

Harris Learning Academy, LLC.
6141 Statesville Road Charlotte, NC 28269
704-921-1153

2023 Holiday Schedule

Harris Learning Academy will be closed for the following holidays.

Martin Luther King Jr Day	Monday, January 16, 2023
President's Day	Monday, February 20, 2023
Easter Holiday	Close @ 2:00 pm. - Thursday, April 6, 2023 Friday, April 7, 2023 Monday, April 10, 2023 Center will re-open Tuesday, April 11, 2023
Memorial Day	Monday, May 29, 2023
Juneteenth Holiday	Monday, June 19, 2023
Independence Holiday	Tuesday, July 4, 2023
Labor Day	Monday, September 4, 2023
Thanksgiving Holiday	Close @ 2:00 pm - Wednesday, November 22, 2023 Thursday, November 23, 2023 Friday, November 24, 2023 Center will re-open Monday, November 27, 2023
Christmas Holiday	December 25-29, 2023
New Year	January 1, 2024 Center will re-open Tuesday, January 2, 2024

Thank you for your continued support of our program.