Huckleberry's Friends
Child Care Center Pre-School
CHILDREN'S FILE CHECKLIST

Child Name: _____ Enrollment Date: _____

Parent Name: _____ Date Updated: _____

Date of Birth: _____ Current Age: _____ years

The following items must be present in each child's file.

Item	Due Date	Date Completed
Application *(containing the following)*		
- *Emergency Medical Care Authorization*		
- *Emergency Medical Care Information*		
Medical Exam		
Immunization record	Updated Regularly	
Documentation of Receipt of Parent Handbook		
- *Center Operational Policies*		
- *Discipline Policy*		
- *Summary of Child Care Law*		
Children Less than 15 Months Old		
Feeding Schedules		
Sleep Position Waivers		
Documentation of Safe Sleep Policy Receipt		
Children Requiring Routine Transportation (to/from School, etc.)		
Authorization for Transportation	Annually	
As Needed/Applicable *(as occurs)*		
Copies of Incident Reports		
Medication Authorization		
Off Premise Activities Authorization (Field Trips)		
Emergency and Identifying Information		

Immunization History

As of Immunization Record Dated:

Months	**0**	**1**	**2**	**4**	**6**	**12**	**15**	**18**	**48**	**72**
Due										
DTaP*			#1	#2	#3		#4		#5	
Hep B	#1	#2			#3					
Hib*			#1	#2	#3	#4				
IPV*		#1	#2		#3				#4	
MMR						#1			#2	
Varicella						#1			*Not Required*	

**DTaP, Hib, & IPV offered in combined doses*

DTaP*	*Diptheria, Tetanus, Pertussis*	**IPV***	*Polio*
Hep B	*Hepatitis B*	**MMR**	*Measles, Mumps, Rubella*
Hib*	*Haemophilus influenzae (b)*	**Varicella**	*Chicken Pox*

Date of Enrollment_____

CHILD'S APPLICATION FOR CHILD CARE

To be completed and placed on file prior to enrollment

Name of Child _____ Birth date _____
(Last) (First) (MI) (Nickname)
Address_____Zip Code_____

INFORMATION ABOUT THE FAMILY:

Father/Guardian's Name_____Home Phone _____
Address_____ Zip Code_____
Where Employed _____ Business Phone _____

Mother/Guardian's Name_____Home Phone _____
Address_____ Zip Code_____
Where Employed _____ Business Phone _____

Insurance Carrier _____Policy # _____

INFORMATION ABOUT YOUR CHILD:

Does your child have any known allergies: No____ Yes____ Explain: _____

Does your child have any chronic illnesses/conditions: No____ Yes____ Explain: _____
_____

Please give any information concerning your child which will be helpful in his experience in group setting (such as play, eating and sleeping habits, special fears, special likes or dislikes).____
_____

EMERGENCY CARE INFORMATION:

Name of child's doctor _____ Office Phone_____
Address_____ _____
Hospital preference_____ Phone _____

If neither father nor mother (or guardian) can be contacted, call (please list relationship):
Name_____ _____ Home Phone _____ Office Phone _____
Name_____ _____ Home Phone _____ Office Phone _____
If you cannot call for your child, please give the names of persons to whom the child can be released:_____
_____

I agree that the operator may authorize the physician of his/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 drug or any medication without specific instructions 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.

Emily Sauls
_____
(Signature of Operator) (Date)

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 #**_____

Off-Premise Activity Authorization

(to be completed annually)

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

I, _____ parent/guardian of _____ (child name), give my permission to Huckleberry's Friends Child Care Center & Pre-School for my child to participate in an off-premise activity.

Location of off-premise activity: Areas outside of fenced in playground to include parking lot, neighboring business locations, nearby natural areas

Purpose of the activity: Nature walks, visits with residents at neighboring assisted living center, activities in facility parking lot, etc.

Additional information: This authorization is for walking distances only and does NOT permit travel in any motorized vehicle

_____ _____

Parent/Guardian Signature Date Signed

This authorization is valid from: January 1, 2013 to December 31, 2013

(up to 12 months)

C:\Users\Administrator\Forms\Child\Off-Premise Activity Authorization.dotx

Acknowledgments

Please complete one Acknowledgment Form for ***each*** child enrolled.

Child Name: _____ Date of Enrollment: _____

I/we acknowledge that a copy of the Parent Handbook of Huckleberry's Friends Child Care Center and Pre-School has been provided to my family. I understand that this handbook contains facility policies and procedures and also provides and explains relevant child care laws and regulations. Information provided in this handbook includes (but is not limited to):

- Discipline and Behavior Management Policy
- Safe Sleep Policy
- Center Operational Policies
- Summary of North Carolina Child Care Law

It is further acknowledged that I/we have received clarification of any items within the Parent Handbook which were not understood and thereby agree to abide by the policies set forth.

Information contained within the Parent Handbook is subject to change at any time. Huckleberry's Friends' administrators will notify all parents and other affected individuals/organizations (in writing) accordingly of such changes as they occur.

Parent Signature: _____ Date: _____

A copy of this form will be returned to you for your records.
The original will be retained with the child's enrollment materials.

Permission VALID: From _ _/_ _/_ _ _ _To _ _/_ _/_ _ _ _

MEDICATION ADMINISTRATION PERMISSION & RECORD

Information about the child and the medicine
(Completed by parent/guardian)

Child's Name			Child's Date of Birth	
Medicine Expiration Date:	Time	Date	Dosage	Route
Special Instruction:				
Possible Reactions:				
Prescribing provider:		Phone:		
Pharmacy:		Phone:		
I give authorization to give medicine and to call the health care provider if needed. Parent/Guardian signature			Date	

RETURNED to Parent/Guardian	Date	Parent/Guardian signature	Child Care Staff signature
DISPOSED of Medicine	Date	Child Care Staff signature	Witness signature

Medication Log
(Completed by child care provider)

	Monday	Tuesday	Wednesday	Thursday	Friday
Medicine					
Date					
Actual time given	AM _____ PM _____	AM _____ PM _____	AM _____ PM _____	AM ____ PM _____	AM _____ PM _____
Dosage/Amount					
Route					
Facility staff's Signature					

	Monday	Tuesday	Wednesday	Thursday	Friday
Medicine					
Date					
Actual time given	AM _____ PM _____	AM _____ PM _____	AM _____ PM _____	AM ____ PM _____	AM _____ PM _____
Dosage/Amount					
Route					
Facility staff's Signature					

	Monday	Tuesday	Wednesday	Thursday	Friday
Medicine					
Date					
Actual time given	AM ______ PM ______	AM ______ PM ______	AM ______ PM ______	AM ____ PM ______	AM ______ PM ______
Dosage/Amount					
Route					
Facility staff's Signature					

	Monday	Tuesday	Wednesday	Thursday	Friday
Medicine					
Date					
Actual time given	AM ______ PM ______	AM ______ PM ______	AM ______ PM ______	AM ____ PM ______	AM ______ PM ______
Dosage/Amount					
Route					
Facility staff's Signature					

	Monday	Tuesday	Wednesday	Thursday	Friday
Medicine					
Date					
Actual time given	AM ______ PM ______	AM ______ PM ______	AM ______ PM ______	AM ____ PM ______	AM ______ PM ______
Dosage/Amount					
Route					
Facility staff's Signature					

Describe error or mishap in a Medical Error Form

Date/time	Error/Mishap	Parent/Guardian Notified?	Child Care Staff Signature
		__Yes __No	
		__Yes __No	

Infant Feeding Schedule

Name of Child _____Date_____

Date of Birth _____

Instructions

1. Food/Bottles Brought Daily (quantity):

2. Instructions for Feeding:

    A. Bottles (breast milk, formula, milk, juice)

    B. Food (baby food, cereal, table food)

3. I plan to nurse: (approximate time) ❑ _____

_____
Parent Signature

Changes in Schedule (Must be recorded as eating habits change)

Food:	Date to Introduce:	New Instructions:	Parent or Staff Signature:
Milk			
Baby Food			
Juice			
Cereal			
Table Food			

**Must be completed for all children less than 15 months old*

Name of Center: Huckleberry's Friends, Inc.

Infant/Toddler Safe Sleep Policy

Sudden Infant Death Syndrome (SIDS) is the unexpected death of a seemingly healthy baby for whom no cause of death can be determined based on an autopsy, an investigation of the place where the baby died and a review of the baby's clinical history.

Child care providers can maintain safer sleep environments for babies that help lower the chances of SIDS. N.C. law requires that child care providers caring for children 12 months of age or younger, implement a safe sleep policy, share this information with parents and participate in training.

In the belief that proactive steps can be taken to lower the risks of SIDS in child care and that parents and child care providers can work together to keep babies safer while they sleep, this facility will practice the following safe sleep policy:

Safe Sleep Practices

1. All child care staff working in this room, or child care staff who may potentially work in this room, will receive training on our infant Safe Sleep Policy.
2. Infants will always be placed on their backs to sleep, unless there is a signed sleep position medical waiver on file. In that case, a waiver notice will be posted at the infant's crib and the waiver filed in the infant's file.
3. The American Academy of Pediatrics recommends that babies are placed on their back to sleep, but when babies can easily turn over from the back to the stomach, they can be allowed to adopt whatever position they prefer for sleep.
4. We will follow this recommendation by the American Academy of Pediatrics. However, child care staff can further discuss with parents how to address circumstances when the baby turns onto their stomach or side.
5. **Visually checking sleeping infants**. Sleeping infants will be checked daily, every 15-20 minutes, by assigned staff. The sleep information will be recorded on a Sleep Chart. The Sleep Chart will be kept on file for one month after the reporting month. We will be especially alert to monitoring a sleeping infant during the first weeks the infant is in child care.

   We will check to see if the infant's skin color is normal, watch the rise and fall of the chest to observe breathing and look to see if the infant is sleeping soundly. We will check the infant for signs of overheating including flushed skin color, body temperature by touch and restlessness.
6. Steps will be taken to keep babies from getting too warm or overheating by regulating the room temperature, avoiding excess bedding and not over-dressing or over-wrapping the baby.

Safe Sleep Environment

7. Room temperature will be kept between 68-75°F **and a thermometer kept in the infant room.**
8. Infants' heads will not be covered with blankets or bedding. Infants' cribs will not be covered with blankets or bedding. **We may use a sleep sack instead of a blanket.**
9. No loose bedding, pillows, bumper pads, etc. will be used in cribs. We will tuck any infant blankets in at the foot of the crib and along the sides of the crib mattress.
10. Toys and stuffed animals will be removed from the crib when the infant is sleeping. **Pacifiers will be allowed in infants' cribs while they sleep.**
11. A safety-approved crib with a firm mattress and tight fitting sheet will be used.
12. Only one infant will be in a crib at a time, unless we are evacuating infants in an emergency.
13. No smoking is permitted in the infant room or on the premises.
14. All parents/guardians of infants cared for in the infant room will receive a written copy of our Infant/Toddler Safe Sleep Policy before enrollment.
15. **To promote healthy development, awake infants will be given supervised "tummy time" for exercise and for play.**

Best Practices

1. All staff will participate in *Responding to an Unresponsive Infant* practice drills twice each year, in April and in October, in conjunction with fire drills.

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 Infant/Toddler Safe Sleep Policy and that the facility's director/ owner/operator (or other designated staff member) has discussed the facility's Infant/Toddler Safe Sleep Policy with me.

Date of Child's Enrollment: _____

Signature of Parent or Guardian: _____ Date: _____

Signature of Child Care Provider: _____ Date: _____

Distribution: one signed copy to parent(s)/guardian(s); signed copy in child's facility record.

Effective date: 5/1/04

Review: #1 12/15/05

Revisions: #1 1/1/06 COM;

HUCKLEBERRY'S FRIENDS
CHILD CARE CENTER & PRE-SCHOOL

Blanket Permission for Routine Transport of Children

_____ to _____
School Year

Parent/Guardian: _____

Child Name: _____
(separate form required for each child)

I hereby grant permission for Huckleberry's Friends Child Care Center & Pre-School ("Huckleberry's") and/or its employees to transport my child, using any means necessary, to and/or from the school (public, private, charter, etc.) indicated below.

Elementary / Middle School: _____

☐ Before ***and*** After School ☐ Before School ***Only*** ☐ After School ***Only***

☐ Traditional ☐ Modified ☐ Year-Round - ***Track #*** _____

Emergency Contact Person #1:

Name _____
Phone(s) _____
_____
_____

Emergency Contact Person #2:

Name _____
Phone(s) _____
_____
_____

Please notify the center no later than 1:30pm if we do not need to include your child on our regular after-school pick-up rounds. Failure to notify us accordingly causes delays in picking up other schools/children, scheduling delays for children and staff members, and other parents having an extended wait for our return at the center. Therefore, we will charge a Notification Failure Fee of $5.00 each time this occurs. Recurring offenses will result in exclusion of future pick-ups.

_____
Parent/Guardian Signature

_____
Date

Place Child Photo Here

HOMEWORK POLICY

At _____ our goal is to offer children a well
(Name of SA Program)
balanced program. While we understand the importance that homework plays in the life of a child, as well as for the families we serve, we strive to meet the needs of the whole child. In addition to helping children meet personal academic goals, we recognize our responsibility to give children a chance to socialize, have un-structured play (in well-developed centers both indoors and out), have time outdoors and have a nutritious snack.

Our schedule reflects current research showing children concentrate better and produce more work when they've had a chance for a physical break first. It also reflects current licensing standards to take children outside every day. Therefore, outdoor time is our first activity after arrival and snack. In addition, as a licensed program, we meet the NC Division of Child Development requirement to offer, at least, 3 activity choices during a 3 hour time frame.

Our philosophy is that children learn and grow through play. We reinforce this by having materials and activity choices that support the North Carolina General Course of Study.

For those choosing to do homework, while we can't promise accuracy and/or completion, we do wish to support the homework choice in the following ways:
- A 20-30 minute time frame to work on homework at the same time as other quiet activity choices
- Paper, pencils, basic resource materials such as a thesaurus and dictionary
- A place to work
- Interaction with children completing homework when appropriate