Student File Checklist

Child's Name: _____ Enrollment Date: _____ / _____ / _____

The following items are required to be in each student file:

_____ Enrollment Form

_____ Children's Medical Report

_____ Immunization Record

_____ Sickness Policy

_____ Discipline Policy

_____ Bite Policy

_____ Environmental Health Policy

_____ Prevention of Shaken Baby/Head Trauma Policy

_____ Safe Sleep Policy (0-12 months only)

_____ EFT Authorization Form with a voided check

In addition to these items, student files also contain incident reports, doctor notes and any other information that may help Lambs of Grace serve the student and their family.

Additional items to be kept on file by the teacher in the classroom include: permission forms, medication administration forms, infant feeding schedules, emergency cards and any other forms that may be required for classroom procedures.

Enrollment Form

Enrollment Date: _____ /_____ /_____ **Registration Payment:** $100.00 **Check No. _____**

Student Information

Name: _____ / _____ / _____ /_____
Last *First* *Middle* *Male or Female*

Address: _____ City: _____ State: _____ Zip: _____

Home Phone: _(_____)_____ Birth/Due Date: ____ / ____ / ____ Baptism Date: ____ / ____ / ____

Father Information

Father's Name: _____

Address: _____ City: _____ State: _____ Zip: _____

Phone Numbers: (_____)_____ (_____)_____ (_____)_____
Home *Work* *Cell*

E-mail Addresses: _____ _____
Primary E-mail *Secondary E-mail*

Occupation: _____ Employer: _____

Father's Marital Status: First Marriage Separated Divorced Remarried Widowed
(Circle One)

Mother Information

Mother's Name: _____

Address: _____ City: _____ State: _____ Zip: _____

Phone Numbers: (_____)_____ (_____)_____ (_____)_____
Home *Work* *Cell*

E-mail Addresses: _____ _____
Primary E-mail *Secondary E-mail*

Occupation: _____ Employer: _____

Mother's Marital Status: First Marriage Separated Divorced Remarried Widowed
(Circle One)

Sibling Information

Name: _____ / _____ / _____ /_____
Last *First* *Relationship* *Age*

Name: _____ / _____ / _____ /_____
Last *First* *Relationship* *Age*

Name: _____ / _____ / _____ /_____
Last *First* *Relationship* *Age*

Emergency Contact Information

Please provide Lambs of Grace with two <u>local</u> contacts in the event that a parent cannot be reached:

Name: _____ / _____ / _____
Last *First* *Relationship*

Phone Numbers: (_____)_____ (_____)_____ (_____)_____
Home *Work* *Cell*

Name: _____ / _____ / _____
Last *First* *Relationship*

Phone Numbers: (_____)_____ (_____)_____ (_____)_____
Home *Work* *Cell*

Please list any people who are <u>NEVER</u> allowed to pick up your child:

Name: _____ / _____ / _____
Last *First* *Relationship*

Name: _____ / _____ / _____
Last *First* *Relationship*

Name: _____ / _____ / _____
Last *First* *Relationship*

Medical Information

Doctor's Name: _____ Address: _____ Phone: _____

Hospital: _____ Address: _____ Phone: _____

Medications to be administered at Lambs of Grace:_____

Allergies: _____

Medical/Developmental Concerns: _____

_____

If your child has health needs such as asthma, allergies, or chronic illness that requires special services, a medical action plan completed by the pediatrician must be included. Is a medical action plan included? **YES** or **NO** ***(circle one)***

Other Information

Has your child attended daycare elsewhere? If so, where and how long?_____

Please provide any information about your child that will help Lambs of Grace best care for them. (likes/dislikes, fears, favorite activities, sleeping habits, etc.) _____

_____

_____

Please describe the goals you would like your child to accomplish at Lambs of Grace. _____

_____

_____

Estimated Drop-off Time: _____ Estimated Pick-up Time: _____

Local church your family attends: _____ How long have you attended?: _____

Your Pastor's Name: _____

If you are looking for a church, please visit Grace! Sunday Worship at 10:00AM

Agreement Statements

1. Medical Consent
I agree that Lambs of Grace may authorize the physician of their choice to provide emergency care in the event that the parents or physician cannot be contacted. I, as the parent or guardian, will assume all cost of medical care.

Parent or Guardian Signature: _____

I, as the operator, agree to provide transportation to an appropriate resource in the event of a medical emergency.

Director Signature: Brent R. Bitter

2. First Aid Treatment
I give Lambs of Grace permission to provide my child with basic first aid, including the use of Bactine.

Parent or Guardian Signature: _____

3. Parent Handbook
I have read and understand the Lambs of Grace Family Handbook and will abide by all its policies and procedures.

Parent or Guardian Signature: _____

4. Child Abuse & Neglect
I have read and understand Lambs of Grace's policy regarding child abuse and neglect and will support its practice.

Parent or Guardian Signature: _____

5. Outside Fenced Area
I agree that my child can be escorted by an adult outside of the fenced area for fire drills and other required activities.

Parent or Guardian Signature: _____

6. Photos and Videos
I agree that photos or videos of my child may be used by Lambs of Grace in promotional materials such as brochures, flyers, websites or promotional videos.

Parent or Guardian Signature: _____

7. Snacks
I understand and accept that Lambs of Grace provides two daily snacks to my child, which may include 100% juice.

Parent or Guardian Signature: _____

8. Spiritual Consent
I understand and accept that my child will learn about their sin and God's love at Lambs of Grace. I understand that my child will be taught that faith in Jesus Christ's payment for sin is the one and only way to heaven.

Parent or Guardian Signature: _____

9. Summary of North Carolina Child Care Law & Rules.
I have received and read the Summary of North Carolina Child Care Laws & Rules from the NC Division of Child Development and Early Education.

Parent or Guardian Signature: _____

10. Financial Agreement
I agree to pay all tuition and applicable fees outlined in the Family Handbook. I understand that I am charged for care one week prior to my child receiving it. I understand that all EFT payments are made on Mondays. If I choose not to use the EFT service, my paper check must be submitted by Monday at 6 :00PM. If my paper check payment is late, I understand that I will be assessed the late fee outlined in the Family Handbook. I understand that after 2 late payments I will be required to pay tuition and fees by EFT.

Parent or Guardian Signature: _____

Grow in the grace and knowledge
of our Lord and Savior Jesus Christ.
To him be the glory now and forever!

2 Peter 3:21

EFT Authorization

Effective Date of Authorization: _____ / _____ / _____

- ❒ New authorization
- ❒ Change payment amount
- ❒ Change banking information
- ❒ Termination of enrollment: _____ / _____ / _____ (Note: A two week notice is required)

Last Name: _____ First Name: _____

Address: _____ City: _____ State _____ Zip: _____

Phone: _____ E-mail: _____

Routing Number: _____ Account Number: _____

Please attach a voided check if available.

Authorized charges:

☑	Annual Fee:	$100.00____ / year
❒	Infant Room Tuition	$_____ / week
❒	Toddler Room Tuition	$_____ / week
❒	Two's Room Tuition	$_____ / week
❒	Three's Room Tuition	$_____ / week
❒	Four's Room Tuition	$_____ / week

- Tuition payments will be deducted from your account every Monday, except the last Monday of the year.
- Annual registration fees will be deducted upon new enrollment and on every July 1st.
- Accounts with insufficient funds will be charged a $25.00 fee.
- Account debits will be listed as "Grace Lutheran Church & Child Care Center" in your account records.

I authorize Grace to process debit entries to my listed account for the above selected payments. I understand that this authority will remain in effect until I provide reasonable notification of changes or termination of enrollment.

Signature of Account Holder: _____ 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 #**_____

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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: