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_____

Discipline and Behavior Management Policy

Name of Facility:_____Date Adopted:_____

No child shall be subjected to any form of corporal punishment. 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 age and developmentally appropriate 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 level.
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 handle children roughly in any way, including shaking, pushing, shoving, pinching, slapping, biting, kicking, or spanking.
2. DO NOT place children in a locked room, closet, or box or leave children alone in a room separated from staff.
3. DO NOT delegate discipline to another child.
4. DO NOT withhold food as punishment or give food as a means of reward.
5. DO NOT discipline for toileting accidents.
6. DO NOT discipline for not sleeping during rest period.
7. DO NOT discipline children by assigning chores that require contact with or use of hazardous materials, such as cleaning bathrooms, floors, or emptying diaper pails.
8. DO NOT withhold or require physical activity, such as running laps and doing push-ups, as punishment.
9. DO NOT yell at, shame, humiliate, frighten, threaten, or bully children.
10. DO NOT restrain children as a form of discipline unless the child's safety or the safety of others is at risk.

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: _____

"Time-Out"

"Time-out" is the removal of a child for a short period of time (3 to 5 minutes) from a situation in which the child is misbehaving and has not responded to other discipline techniques. The "time-out" space, usually a chair, is located away from classroom activity but within the teacher's sight. During "time-out," the child has a chance to think about the misbehavior which led to his/her removal from the group. After a brief interval of no more than 5 minutes, the teacher discusses the incident and appropriate behavior with the child. When the child returns to the group, the incident is over and the child is treated with the same affection and respect shown the other children.

Adapted from original prepared by Elizabeth Wilson, Student, Catawba Valley Technical College

Distribution: one copy to parent(s) and a signed copy in child's facility record

Child Immunization History

G.S. 130A-155. Submission of certificate to child care facility/G.S.130A-154. Certificate of immunization.

The parent/guardian must submit a certificate of immunization on child's first day of attendance or within 30 calendar days from the first day of attendance.

Child's full name:	Date of birth:

Enter the date of each dose received (Month/Day/Year) or attach a copy of the immunization record.

Vaccine Type	Abbreviation	Trade Name	Combination Vaccines	1 date	2 date	3 date	4 date	5 date
Diphtheria, Tetanus, Pertussis	DTaP, DT, DTP	Infanrix, Daptacel	Pediarix, Pentacel, Kinrix					
Polio	IPV	IPOL	Pediarix, Pentacel, Kinrix					
Haemophilus influenza type B	Hib (PRP-T) Hib (PRP-OMP)	ActHIB, PedvaxHIB **, Hiberix	Pentacel					
Hepatitis B	HepB, HBV	Engerix-B, Recombivax HB	Pediarix					
Measles, Mumps, Rubella	MMR	MMR II	ProQuad					
Varicella/Chicken Pox	Var	Varivax	ProQuad					
Pneumococcal Conjugate*	PCV, PCV13, PPSV23***	Prevnar 13, Pneumovax***						

*Required by state law for children born on or after 7/1/2015.
**3 shots of PedvaxHIB are equivalent to 4 Hib doses. 4 doses are required if a child receives more than one brand of Hib shots.
***PPSV23 or Pneumovax is a different vaccine than Prevnar 13 and may be seen in high risk children over age 2. These children would also have received Prevnar 13.
Note: Children beyond their 5th birthday are not required to receive Hib or PCV vaccines.

Gray shaded boxes above indicate that the child should not have received any more doses of that vaccine.

Record updated by:	Date	Record updated by:	Date

Minimum State Vaccine Requirements for Child Care Entry

By This Age:	Children Need These Shots:						
3 months					1 Hep B		
5 months		2 Polio			2 Hep B		
7 months	3 DTaP	2 Polio		2-3 Hib**	2 Hep B	3 PCV	
12 months	3 DTaP	2 Polio		2-3 Hib**	2 Hep B	3 PCV	
16 months	3 DTaP	2 Polio	1 MMR	3-4 Hib**	2 Hep B	4 PCV	
19 months	4 DTaP	3 Polio	1 MMR	3-4 Hib**	3 Hep B	4 PCV	1 Var
4 years or older (in child care only)	4 DTaP	3 Polio	1 MMR	3-4 Hib**	3 Hep B	4 PCV	1 Var

Note: For children behind on immunizations, a catch-up schedule must meet minimal interval requirements for vaccines within a series. Consult with child's health care provider for questions.

Updated May 2023

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Child Immunization History

G.S. 130A-155. Submission of certificate to child care facility/G.S.130A-154. Certificate of immunization.

Vaccines Recommended (not required) by the Advisory Committee on Immunization Practices (ACIP)

Vaccine Type	Abbreviation	Trade Name	Recommended Schedule	1 date	2 date	3 date	4 date	5 date
Rotavirus	RV1, RV5	Rotateq, Rotarix	Age 2 months, 4 months, 6 months.					
Hepatitis A	Hep A	Havrix, Vaqta	First dose, age 12-23 months. Second dose, within 6-18 months.					
Influenza	Flu, IIV, LAIV	Fluzone, Fluarix, FluLaval, Flucelvax, FluMist, Afluria	Annually after age 6 months.					
Coronavirus disease 2019	COVID-19	Comirnaty, Spikevax, Nuvaxovid, Jcovden	Annually after age 6 months.					

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ITS-SIDS Alternative Sleep Position/Use of Wedge Health Care Professional Waiver

This must be completed by a physician, nurse practitioner, or physician's assistant – 10A NCAC 09 .0606(e) and 10A NCAC 09 .1724(e)

This form must be used for an infant aged six months or less. This form may be used for an infant older than six months.

Parent/guardian completes this section.

Child's name _____ Date of birth _____ Age in months _____

Parent/guardian name _____

Address _____

City _____ State _____ Zip _____

Home phone _____ Work phone _____ Cell phone _____

Email _____

Child's primary health care professional completes this section.

Health care professional's name _____

Name of practice _____

Address _____

City _____ State _____ Zip _____

Phone _____ Cell or Pager _____ Fax number _____

Email _____

N.C. Child Care Law requires that child care facilities place all infants on their backs to sleep. At the advice of the infant's primary health care professional, the parent/guardian may authorize the facility to place their infant in an alternative sleep position or to use a wedge for medical reasons. The center shall retain the waiver in the child's record as long as the child is enrolled at the center.

Medical reason for alternative sleep position or use of wedge for infant named above _____

The recommended sleep position for this infant is _____

Specific placement and directions for use of wedge:_____

Effective Dates of Waiver: **from _____/_____/_____ to _____/_____/_____**

Health Care Professional's Signature _____ Date _____

Parent/guardian signs this statement.

I, as the parent or guardian of the above mentioned child, do hereby release and hold harmless the child care facility listed below, its officers, directors, and employees, from any and all liability whatsoever associated with harm to my child due to Sudden Infant Death Syndrome (SIDS). I affirm and acknowledge that the child care facility named above gave me information about SIDS. I authorize this child care facility and its employees to place my child in the alternative sleep position/use a wedge as described above at the recommendation of my child's primary health care professional.

Parent/guardian signature _____ Date _____

An authorized facility representative of the child care facility completes this section.

Name of Child Care Facility _____ID #_____

Facility Representative's Signature _____ Date _____

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Infant/Toddler Safe Sleep Policy

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.

_____(facility name) implements the following safe sleep policy:

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 12 months of age on their backs to sleep, unless:
   - **the infant is 6 months or younger** and a signed ITS-SIDS Alternate Sleep Position Health Care Professional Waiver is in the infant's file and a notice of the waiver is posted at the infant's crib.
   - **the infant is 6 months or older** (choose one)
     - ❑ We do not accept the ITS-SIDS Alternate Sleep Position Parent Waiver.*
     - ❑ We accept the ITS-SIDS Alternate Sleep Position Parent Waiver.

   We retain the waiver in the child's record for as long as they are enrolled.
3. We place infants on their back to sleep even after they are able to independently roll back and forth from their back to their front and back again. We then allow the infant to sleep in their preferred position.
   - ❑ We document when each infant is able to roll both ways independently and communicate with parents. We put a notice in the child's file and on or near the infant's crib.*
4. We visually check sleeping infants every 15 minutes and record what we see on a Sleep Chart. The chart is retained for at least one month.
   - ❑ We check infants 2-4 month of age more frequently.*
5. We maintain the temperature between 68-75°F in the room where infants sleep.
   - ❑ We further reduce the risk of overheating by not over-dressing infants*
6. We provide infants supervised tummy time daily. We stay within arm's reach of infants during tummy time.
7. 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

8. 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.
9. We do not allow pacifiers to be used with attachments.
10. Safe pacifier practices:
    - ❑ 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 allow infants to be swaddled.
    - ❑ We do not allow garments that restrict movement.*
12. We do not cover infants' heads with blankets or bedding.
13. We do not allow any objects other than pacifiers such as, pillows, blankets, or toys in the crib or sleep space.
    - ❑ We do not allow any weighted blankets or clothing in the crib.*
14. Infants are not placed in or left in car safety seats, strollers, swings, or infant carriers to sleep.
15. We give all parents/guardians of infants a written copy of this policy before enrollment. We review the policy with them and ask them to sign the policy.
    - ❑ We encourage families to follow the same safe sleep practices to ease infants' transition to child care.*
16. Posters and policies:
    - **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.
    - **Centers:** We post a copy of this policy in the infant sleep room where it can easily be read.
      - ❑ We also post a safe sleep practices poster in the infant sleep room where it can easily be read.*

Communication

17. We inform everyone if changes are made to this policy 14 days before the effective date.
    - ❑ We review the policy annually and make changes as necessary.*

***Best practice recommendation**

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

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

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

Facility Representative Signature: _____ Date: _____

Reference: N.C. Law G.S. 100-91 (15), N.C. Child Care Rules .0606 and .1724, Caring for Our Children

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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 #**_____

Prevention of Shaken Baby Syndrome and Abusive Head Trauma

Belief Statement

We, _____ (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

Prevention of Shaken Baby Syndrome and Abusive Head Trauma

Parent or guardian acknowledgement form

I, the parent or guardian of _____ (child or children's name) acknowledge 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**

ACKNOWLEDGEMENT OF PERSONAL LIABILITY AND WAIVER

I understand that field trips and on-site activities may expose my child to some risks and I assume any such risk that may arise there from. I accept full responsibility for all medical expenses for any injuries that might occur to my child by reason of his/her participation.

By signing this form, however, I hereby release Kids R Us Academy administrators, directors, teachers, employees, and volunteers ("released parties") from and against any and all claims, demands, actions, complaints, suits or other forms of liability that any of them may sustain (a) arising out of my child's failure to comply with rules, local, state, and federal laws and District policies, procedures, and the Code of Conduct; (b) arising out of any damage or injury caused by my child; or, (c) arising out of a parent/guardian/or other designated driver's operation of a motor vehicle in relation to this activity. I also agree to indemnify and hold harmless the released parties from the released claims, including any and all related costs, attorney fees, liabilities, settlements, and/or judgments.

SIGNATURE

I confirm that I have carefully read this CONSENT AND RELEASE and agree to its terms knowingly and voluntarily. I also confirm that I am the parent or legal guardian of the child I

I have signed this CONSENT AND RELEASE this ___ day of _____, 20__.

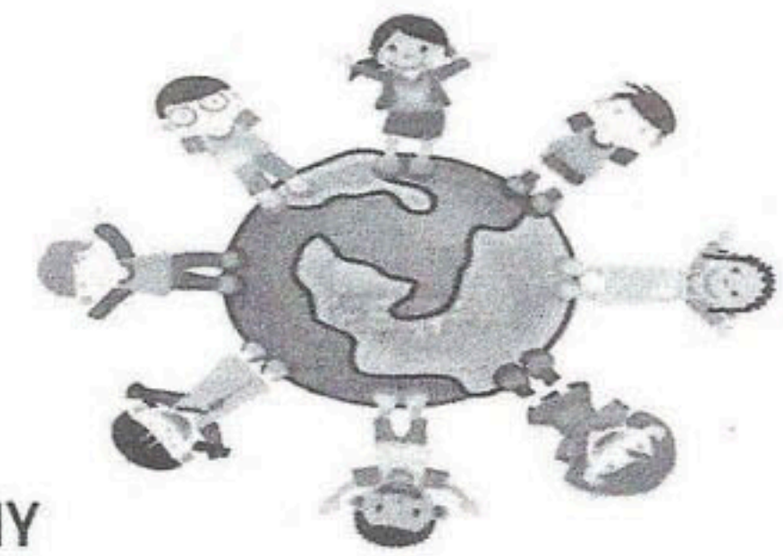
This consent and release has been read and is understood by me.

_____

Child's Name

_____ _____

Signature of Parent or Legal Guardian Date



WELCOME TO KIDS R US ACADEMY

PLEASE INITIAL THAT YOU HAVE RECEIVED ALL FORMS OR INFORMATION

___ APPLICATION/ENROLLMENT FORM

___ MEDICAL REPORT

___ IMMUNIZATION HISTORY

___ DISCIPLINE & BEHAVIOR POLICY

___ PERSONAL LIABILITY WAIVER

___ EMERGENCY TRANSPORTATION FORM

___ SHAKEN BABY SYNDROME & ABUSIVE HEAD TRAUMA

___ FOOD PROGRAM

___ SAFE SLEEP POLICY

___ SLEEP POSITION WAVIER **(ONLY FOR 6 MONTHS AND OLDER)**

___ INFANT FEEDING SCHEDULE

___ SUMMARY OF CHILD CARE LAW

CHILD'S NAME: _____

PARENT SIGNATURE: _____ DATE: _____

EMAIL ADDRESS: _____

DIRECTOR SIGNATURE: _____ DATE: _____

Biting Policy

Biting is unfortunately not unexpected behavior for toddlers. Many toddlers/children communicate through this behavior. However, biting can be harmful to other children and to staff. As a Childcare Center, we understand that biting, unfortunately, is a part of our everyday setting. **We ask parent's to be patient with us as we deal with children who exhibit biting behaviors.** Our goal is to help identify what is causing the biting and try to resolve these issues. **Names of children are not shared with either parent. When Biting Does Occur:** The staff's job is to keep the children safe and help a child that bites learn different, more appropriate behavior. We do not use techniques to alarm, hurt, or frighten children such as biting back or physical punishment

For the child that was bitten:

1. First aid is given to the bite. It is cleaned with soap and water. If the skin is broken, the bite is covered with a bandage and Parents are notified.

For the child that bit:

1. The teacher will express to the child that biting hurts.

2. The child will be placed in quite area with the teacher for no longer than the child's age (one year old, one minute).

3. The parents are notified and "Parent Contact Form" is filled out documenting the incident.

When Biting Continues:

1. The child will be shadowed to help prevent any biting incidents and to determine what is causing the child to bite (teething, communication, frustration, etc.)

3. If a child inflicts 3 bites in a one week period (5 weekdays) in which the skin of another child or staff member is broken or bruised or the bite leaves a significant mark, a conference will be held with the parents to discuss the child's behavior and how the behavior may be modified.

3. If a child bites twice in a 4-hour period, the child will be required to be picked up from day care for the remainder of the day. *****If a child continues to inflict biting the parent's will be asked to make other Childcare arrangements.**

_____ **Date:** _____

Parent Signature

Parental Agreements with Child Care Facility

Kids R Us Academy agrees to provide childcare for _____

Enrollment Date: _____

Hours_____a.m. _____ p.m. A Late fee of $20 will be charged 5mins after the agreed upon time and $1 per min thereafter.

Tuition Fee: $_____ per week will be paid every Monday. A late fee of $25.00 will be charged if not received by closing on Tuesday. Full payment must be paid to be accepted into care on Wednesday. Minimal $30 fee for return check, fee may be higher based on bank.

Annual Supply Fee: $55.00 due at Enrollment and the first Monday of September every year thereafter.

Sick/Absent: Half tuition will be charged if your child misses a full week (5 consecutive days). You are still responsible for full tuition whether the child attends 1 or 5 days. TUITION IS BASED ON ENROLLMENT NOT ATTENDANCE.

Families are given 1 week (5 consecutive absent days) family vacation after 90 days of enrollment every year. Where you will not be charged tuition and your enrollment will be held. 2wk notice must be given.

My child will participate in the following meal plan (circle applicable meals and snacks):

- Breakfast
- Morning Snack
- Lunch
- Afternoon Snack
- Evening Snack
- Dinner
- Bedtime Snack

Parent agrees photos can be taken and used/or displayed for school related activities.

Children must report daily with all supplies to carry out the day. I agree if any items used/or purchased by Kids R Us for my child will be reimbursed.

Before any medication is dispensed to my child, I will provide a written authorization, which includes date; name of child; name of medication; prescription number; if any; dosages; date and time of day medication is to be given. Medicine will be in the original container with my child's name marked on it.

My child will not be allowed to enter or leave the facility without being escorted by the parent(s), person authorized by parent (s), or facility personnel. Person picking up must be 18 yrs. old and present ID.

Continue to back....

I acknowledge it is my responsibility to keep my child's records current to reflect any significant changes as they occur, e.g., telephone numbers, work location, emergency contacts, child's physician, child's health status, infant feeding plans and immunization records, etc.

The facility agrees to keep me informed of any incidents, including illnesses, injuries, adverse reactions to medications, etc., which include my child.

The KIDS R US ACADEMY agrees to obtain written authorization from me before my child participates in routine transportation, field trips, special activities away from the facility, and water related activities occurring in water that is more than two (2) feet deep.

I authorize the childcare facility to obtain emergency medical care for my child when I am not available.

I have received a copy and agree to abide by the policies and procedures for Kids R Us Academy

I understand that the center will advise me of my child's progress and issues relating to my child's care as well as any individual practices concerning my child's special needs. I also understand that my participation is encouraged in facility activities.

Signed: _____ Date: _____

(Parent/Guardian)

Signed: _____ Date: _____

(Facility Administrator/Person-In-Charge