Families First Success Starts Early

Cabarrus Bilingual Preschool

Three Cabarrus County Immersion Preschools

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Aurora Swain, Director of Operations

Enrollment Application

To be completed and placed on file prior to enrollment

Date of Enrollment _____

Name of Child _____ _____ ___ _____ **Birth Date**_____
Last First MI Nickname

Address_____ **Zip Code**_____

INFORMATION ABOUT THE FAMILY

Parent/Guardian's Name _____ Male/Female (circle) Phone _____
Address _____ Zip Code _____
Where Employed _____Business Phone _____
Email _____

Parent/Guardian's Name _____ Male/Female (circle) Phone _____
Address _____ Zip Code _____
Where Employed _____Business Phone _____
Email _____

INFORMATION ABOUT YOUR CHILD

Does your child have any known allergies? No _____ Yes _____ Explain: _____
Does your child take medicine every day? No _____ Yes _____ Explain: _____
Does your child have any chronic conditions? No _____ Yes _____ Explain: _____
_____
Please give any information concerning your child which will be helpful in his/her experience in group setting (such as play, eating and sleeping habits, special fears, special likes or dislikes: _____
_____
_____

EMERGENCY CARE INFORMATION

Insurance Carrier _____ Group/Policy # _____
Name of Child's Doctor _____ Office Phone _____
Address _____
Hospital Preference _____ Office Phone _____
If neither father nor mother (or guardian) can be contacted, call (please list relationship to child)
Name _____ Home Phone _____ Cell/Office Phone _____
Name _____ Home Phone _____ Cell/Office Phone _____
If you cannot pick up your child, please give the names of the 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/Guardian_____ Date _____

Signature of Administrator _____ Date _____

Discipline and Behavior Management Policy

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 the alternatives for inappropriate behavior to the children
7. Do provide the children with natural and logical consequences of their behavior.
8. Do treat the children as people and respect their needs, desires, and feelings.
9. Do ignore minor behaviors.
10. Do explain things to children on their levels.
11. Do use short supervised periods of "time out''. (Time out is described on reverse side.)
12. Do stay consistent in our behavior management program.

We:

1. Do Not spank, shake, bite, pinch, 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 children alone.
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 other-wise belittle children's parents, families, or ethnic groups.

The understanding parents 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/coordinator (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:_____

Date adopted 07/01/15

Parent Agreement

(After reading carefully, please initial each entry, date, and sign.)

_____ Give permission for my child to go on walks and field trips under the supervision of the Center Staff, including well supervised, planned activities outside the fenced area of the Cabarrus Bilingual Preschools Center.

_____ I understand that it will be necessary to have the medical information form completed by a physician including current immunization records at the time my child enters the Cabarrus Bilingual Preschools Center.

____ I have received a copy of the Center's Discipline Policy and understand the policy as written as explained.

____ I understand the fee schedule and payment requirements as stated in the policies and agree to keep fee payments current. I agree to pay the 25.00 registration fee on my child's anniversary date, any late charges incurred, and the tuition every two weeks in advance. I understand that notification will be given in advance when it is necessary for the Center to increase fees.

___I have read all the Centers policies and shall strive to follow the policies and regulations governing its operation

___I understand that any concerns, questions, or grievances should be brought to my child's teacher or to the Director of the Cabarrus Bilingual Preschools Child Development Center.

___I have received a copy of the summary of the North Carolina Child Care Law.

___I give permission for my child's photograph to be used in pictures that may appear in the newspaper, Cabarrus Bilingual Preschools website, magazine articles about Cabarrus Bilingual Preschools, and presentations given in class by college students. College students and visitors may observe and participate with Center activities. The pictures and information gathered may be shared in classroom settings. Only the child's first name will be published and the name will not appear with the picture on the Webpage.

___I agree to adhere to the confidentiality policy when volunteering at Cabarrus Bilingual Preschools. Confidentiality includes not disclosing personal information or identification of a student from your friends and relatives as well as the citizenry at large. Public Law 94-142.

_____ _____

Child's Name Birthdate

_____ _____

Parent/Guardian Signature Date

Family Questionnaire

Our goal is to spend less time trying to connect the dots and more time connecting with children. We will provide a safe and fun place for children with highly trained staff using the best teaching tools available to impact each child, one at a time, in a high quality and bilingual developmentally appropriate learning environment.
Please complete this questionnaire as completely and honestly as you can. Feel free to include any additional information you think can help us to better understand your child's need and circumstances. Be assured this information is confidential.

Child's name_____
Birth date_____ Sex _____ Race_____
Household Members (do **not** include the above child's name)

Name	Age	Relationship to Child

Have there been any significant changes in the child's home situation of the past year? If yes, please describe
_____

Is anyone in the child's home/primary care location using any of the following?
Tobacco____ Alcohol_____ Drugs_____ Kerosene Heat_____

Has your child previously attended any preschool or daycare program? If so, please identify the school.
_____

Did your child experience any difficulties in a group session? _____ if so please explain.
_____

Has your child ever received special therapies or services to assist with developmental, cognitive, physical delays or handicaps? If so please list.
_____
_____
_____

Are there any special programs/community agencies currently involved with the child/family? _____
If yes please list: _____

What is your child usual sleep pattern?
Awakens: _____ Naps: _____ Bedtime: _____

Does your child sleep alone? _____ In which type of bed does your child sleep? _____What are your child's favorite activities?
_____

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_____
_____

Does your child have difficulties with any of the following?
__using eating utensils to feed himself
__brushing own teeth
__speaking clearly
__independently using the toilet
__stuttering or lisping speech
__walking or running
__self- control/impulsive behavior
__understanding/following simple one/two-step directions

What is your child's usual appetite? _____

Does your child have a favorite toy? What is it? _____

What would you say are your child's greatest strengths?
_____
_____
_____

Are there any concerns we should know about?
_____
_____
_____

What are your expectations of our program?
_____
_____
_____C

Child's primary language: _____ Parent's Primary Language: _____
Does the home of the child have? Electricity _____ Running Water _____
Telephone_____ Smoke detector _____
If well water, is the child on fluoride? _____

What do you most want us to know about your child?
_____
_____
_____

Signature of person filling out this form: _____

Date: _____

Relationship to child: _____

EMERGENCY INFORMATION ON PARENTS

Name _____
Address_____
Name of Doctor _____Phone ( ) _____-_____
Hospital Preference _____Phone ( ) _____-_____
Name of Dentist _____Phone ( ) _____-_____
To avoid any adverse drug reaction during an emergency, please list medications you are taking:
_____
Allergies: _____
Blood Type (if known) _____
List operations/hospitalizations within the past year
_____
List chronic medical problems requiring a doctor's care
_____

Emergency Contact Persons

Name _____ Relationship _____
Contact number ( ) _____-_____ Contact number ( ) _____-_____
Address _____
Name _____ Relationship _____
Contact number ( ) _____-_____ Contact number ( ) _____-_____
Address _____

Parent Information Health Questionnaire

Important current health information must be completed annually by: All staff (including the director). (2) All volunteers* and substitutes* prior to their coming into contact with the children.

Name _____
Last First Middle/Maiden
Home Address _____
_____
Telephone Number ( ) _____-_____

1. I am in excellent mental and physical health and am free of communicable disease. (If not, please explain): _____
2. I take the following medications regularly (please explain):
   _____

This health statement is accurate to the best of my knowledge. I will advise the director if my health status changes.

_____ _____/_____/_____
Signature Date

Home Visit Procedure

A home visit will be made before the child is enrolled with the lead and assistant teachers. Home visits allow the child's teachers to get to know the child and help ease the transition into a new school. It provides enjoyable opportunities for children to share with their teachers things that are special to them. As teachers become familiar, the child's fears about school become greatly reduced. It also fosters an opportunity for the teacher to establish good rapport with the child and family.

Goals and Purpose of Home Visit:

1. To assist in promoting, within the parents, a feeling of accomplishment and self-worth as a result to their participation in the program.
2. To involve parents directly in the educational development of their children.
3. To develop individual and family goals.

Home Visitor Responsibility:

1. Set a time for home visits and always keep appointments.
2. Include parents in planning so home visits reflect family needs.
3. Do necessary referral and follow-up.
4. Include other siblings and family members if they show an interest in participating.
5. Home visitors cannot be left alone to attend to any of the family's children.

Parent Responsibility:

1. Parents are to be at home for the scheduled home visit.
2. Parents are to participate in planning for home visits.
3. Parents are to participate in the home visit.
4. Parents will provide an atmosphere that will contribute to a good home visit, which may mean turning off the T.V. or radio.
5. Parents will allow siblings and family members to be included.

Child'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___.
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 DEHNR standards for EPSDT program.

Height _____% Weight _____%

Head_____ Eyes_____ Ears_____ Nose_____ Teeth_____

Throat_____ Neck_____ Heart_____Chest_____Abd/GU_____

Ext_____Neurological System_____Skin_____

Results of Tuberculin Test, if given: Type_____date_____Normal___Abnormal____
Food/Drug Allergies: _____ Other allergies: _____
Does this child have asthma? No___ Yes ___ If yes, explain treatment plan: _____
_____
Should activities be limited? No___ Yes___ If yes, explain:_____
Any other recommendations: _____
_____ Date of
_____ Examination_____
Signature of authorized examiner/title_____
Phone #_____