APPLICATION PACKAGE

Please complete all pages and return to Ahoskie Christian Center

Please **sign** all forms and **fax completed application** package to

252-209-5447

0r

deliver to our office at 309 Church Street West, Ahoskie, NC 27910

CHILD CARE
APPLICATION/REGISTRATION

Enrollment	Withdrawal	Invoice	Repeat	R	Source	CACFP

Name of Child (Last, First, Middle Initial)	Child's Date of Birth		
Name of Enrolling Adult	Relationship to Child		
Mailing Address	City	State	Zip Code
Email Address	Home Phone	Cell Phone	
Employer Name	Hours of Employment	Employers Phone Number ( )	
Name of Non-Enrolling Adult Living in the Home	Relationship to Child		
Email Address	Cell Phone		
Employer Name	Hours of Employment	Employers Phone Number ( )	

Child's allergies, fears, behavior issues or other special health conditions, if any. (Identify medications needed)

PERSON(S) TO BE NOTIFIED IN EMERGENCY SITUATIONS WHEN ENROLLING ADULT IS NOT AVAILABLE

Name	Phone Number ( )		
Address	City	State	Zip Code

Name	Phone Number ( )		
Address	City	State	Zip Code

Name of Child's Physician or Health Clinic	Office Hours		Phone Number ( )
Address	City	State	Zip Code
Hospital Preferred for Emergency Treatment	Health Insurance Policy Name and Number		
Name of Child's Dentist	Office Hours		Phone Number ( )
Dentist Address	City	State	Zip Code

Emergency treatment and transportation:

I hereby give permission to ACC Child Care Center Licensed by the Division of Child Development to secure emergency medical, dental, and/or emergency surgical treatment and to provide emergency transportation for the above named minor child while in care.

Non-emergency medical treatment or elective surgery is not included in this authorization

Signature of Parent or Guardian	Date Signed

I, as the operator, do agree to provide transportation to an appropriate medical resource in the event of an emergency. In an emergency, 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 Business Administrator____
Date Signed____________________

Child Release Authorization Form

This form serves as my official authorization to add or remove persons from the list of persons who have my permission to pick up my child in the event of my inability to do so. I understand that the center will utilize the most current information that I provide.

(CHECK ONE)

Name of person authorized to pick up your child (ren)	Person's Phone Number	Add to the List	Remove from the List

Signature

Date

Please Fax this form to 252-209-5447

Ahoskie Christian Center

Travel and Activity Authorization

_____ Blanket permission for this activity
_____ Special 1-time permission only
__X__ Blanket permission for all given activities

I, ____ parent/guardian of
name of parent/guardian

____ give my permission to

AHOSKIE CHRISTIAN CENTER CHILD CARE ____________ for my child to participate in the
name of

following activating Trips in the van/automobile (facility or parent – owned)

Field trips away from the facility

____
Explain planed activity –where and when

I understand that the facility will use the appropriate child restraint devises and abide by all the safety rules in Rule1000 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 ______/______/______

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 #**______________

IMMUNIZATION HISTORY

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 may not attend the facility until submitted.

Child's full name:	Date of birth:

Enter each 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, OPV	IPOL	Pediarix, Pentacel, Kinrix					
Haemophilus influenza type B	Hib	Act HIB, Pedvax HIB **	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, PCV-13, PPV-23	Prevnar, Pneumovax***						

*Required by state law for children born on or after 7/1/2015.
**3 shots of Pedvax HIB are equivalent to 4 Hib doses. 4 doses are required if a child receives more than one brand of Hib shots.
***Pneumovax is a different vaccine than Prevnar and may be seen in high risk children.
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 DTaP	1 Polio		1 Hib	1 Hep B	1 PCV	
5 months	2 DTaP	2 Polio		2 Hib	2 Hep B	2 PCV	
7 months	3 DTaP	2 Polio		2-3 Hib**	2 Hep B	3 PCV	
12-16 months	3 DTaP	2 Polio	1 MMR	3-4 Hib**	3 Hep B	4 PCV	1 Var
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
4 years and older (in kindergarten)	5 DTaP	4 Polio	2 MMR	3-4 Hib**	3 Hep B	4 PCV	2 Var

Updated 6/19

Discipline and Behavior Management Policy

Name of Facility: Ahoskie Christian Center Date Adopted September 2020

No child shall be subjected to any form of corporate 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"

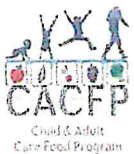
"Time-out" is the removal of a child for a short period of time (3 to 5 minutes) from a situation in which the child is misbehaving and has not responded to other discipline techniques. The "time-out" space, usually a chair, is located away from classroom activity but within the teacher's sight. During "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

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: Ahoskie Christian Center FACILITY NAME: ACC Child Care Center AGREEMENT#: 8352

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 infant/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 infant/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 infant/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 infant/child is eligible for free or reduced-price meals and for administration and enforcement of the Program.

To be completed by Institution/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**

This institution is an equal opportunity provider.

INSTRUCTIONS
Please complete the Infant and Child Income Eligibility Applications using the instructions below. The application must be signed in number 6 and returned to the child care center.

1-PARTICIPANT'S INFORMATION:
a. Print the name(s) and birth date(s) of the infant(s) and/or child/children enrolled in the center.

2-HOUSEHOLD GETTING SNAP, TANF, OR FDPIR BENEFITS:
a. If you participate in SNAP, TANF, or FDPIR provide your case or identification number and skip number 4.
b. If you do not participate in any of these programs, go on to number 3.

3-FOSTER, HOMELESS, or MIGRANT INFANT/CHILD:
a. Indicate if either infant/child on the application is a foster infant/child, homeless, or an infant/child from a migrant family.
b. Households with foster and non-foster infants/children may choose to include the foster infant/child as a household member, as well as any personal income earned by the foster infant/child, on the same household application that includes their non-foster infants/children.
c. Host families applying for free and reduced priced meals for their own infants/children may include the homeless family as household members if the host family provides financial support to the homeless family. In such cases, the host family must also include any income received by the homeless family.
d. If the infant(s) and/or child/children listed are foster, homeless, or from a migrant family, number 4 may be skipped.

4- HOUSEHOLD INCOME:
a. List the names of all other household members.
b. Write the amount of income (the amount before taxes or anything else is taken out), 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, public assistance, pensions and other income (refer to examples below for types of income to report). If any amount last month was less than usual, write the person's usual income.

INCOME TO REPORT

Earnings from Employment	Pensions/Retirement/Social Security	Other Income
• Wage/salaries/tips • Strike benefits • Unemployment compensation • Net income from self-owned business or farm • Worker's compensation Public Assistance/Child Support/Alimony • Public assistance payments • TANF payments • Alimony/Child support payments	• Pensions • Supplemental security income • Retirement income • Veteran's payments • Social Security Military Households • All cash income, including military benefits received in cash such housing/uniform allowances.	• Disability benefits • Cash withdrawn from savings • Interest/dividends • Income from estates/trusts/ investments • Regular contributions from persons not living in the household • Net royalties/annuities/ net rental income • Any other income

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

6-SIGNATURE AND LAST FOUR DIGITS OF SOCIAL SECURITY NUMBER: All households complete this part.
All Infant and Child Income Eligibility Applications must be signed by an adult household member.
The adult household member who signs the certification 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 "No SSN" box. If you listed a SNAP, TANF, or FDIR number a social security number is not needed.

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: Ahoskie Christian Center FACILITY NAME: ACC Child Care Center AGREEMENT#: 9332

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 must 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.

Ahoskie Christian Center
Child Care New Fees
As of January 1, 2023

The Ahoskie Christian Center Church offers a **community grant** to parents, grandparents, or legal guardians who do not receive child-care subsidy form any other source. According to our records you qualify for our community grant.

	Without ACC Community Grant:	**With ACC Community Grant:**
Infants and Toddlers	$836.00	$544.00 per month
Pre-School (ages 3-5)	$836.00	$544.00 per month
School Age – Summer	$605.00	$394.00 per month
Before & After School	$470.00	$305.00 per month
Before School Only	$470.00	$235.00 per month
After School only	$470.00	$235.00 per month

Payment Guidelines:

- A late fee of $15.00 **per fifteen minutes** or part thereof will be charged to parents who pick up their child after 6:00 p.m.
- A Full-month payment is due each month unless absences have been pre-approved by Ahoskie Christian Center management.
- The monthly tuition fee is due the first working day of each month.
- Services will be temporarily suspended, and a late fee charged if payment is not made by the fifteen of the months.
- Services will be terminated if payment is not made by the last working day of the month.

ACC CHILD CARE CENTER
FINANCIAL POLICIES

Tuition is paid on the first service day of the month. ACC Child Care Center imposes a late fee of $30.00 if not paid by the 15th of the month. Children whose fees are not paid by the end of the month must be dropped from enrollment and not participate until payment is up to date.

Payment Guidelines:

- A late fee of $15.00 **per fifteen minutes** or part thereof will be charged to parents who pick up their child after 6:00 p.m.
- A Full-month payment is due each month unless absences have been pre-approved by Ahoskie Christian Center management.
- The monthly tuition fee is due the first working day of each month.
- Services will be temporarily-suspended, and a $30.00 late fee charged if payment is not made by the fifteen of the month.
- Services will be terminated if payment is not made by the last working day of the month.
- If terminated a re-enrollment is required.

RETURN CHECK POLICY:

A returned check fee of $25.00 will be imposed on all returned checks. If a check is returned twice or if two incidents occur in the same family, a money order, or a credit card for future tuition is required.

I understand and agree to each of the above financial policies of ACC Child Care Center. With full understanding that as a parent, private or DSS client, I will be billed for a full month regardless of the number of days my child/children attend?

____________________________ ____________________

Signature **Date**

ACC Child Care Center

Smoking and Tobacco Restriction Policy

It is the policy of ACC Child Care Center that No Smoking of tobacco or any other legal or illegal drugs are prohibited.

ACC Child Care Center provides a smoke-free environment for its parents, students, employees, and visitors.

Smoking is prohibited throughout the premises, (means the entire child care building and grounds including natural areas, outbuildings, vehicles, parking lots, and other structures located on the property).

All children must be in a smoke free and tobacco free environment. Smoking and the use of any product containing, made, or derived from tobacco, is not permitted on the premises.

We have adopted this policy because we have a sincere interest in the health of our parents, students, employees, visitors, and in maintaining pleasant working conditions.

I, ______________________, the undersigned parent or guardian of the following Children:

________________________________ (child's full name)

________________________________ (child's full name)

________________________________ (child's full name)

do hereby state that I have read and received a copy of the facility's Smoking and Tobacco Restriction Policy and will adhere to all restriction thereof.

Signature of Parent or Guardian: ____________________________ Date: __________

Eva M. Smith

Child Care Director

12/14/2018

Ahoskie Christian Center

P.O. Box 155 Ahoskie, NC 27910 252-209-0540 accenter2@gmail.com

September 29, 2020

Dear Parent:

Our previous policy of January 14, 2015 allowing parents to opt out of our feeding program has not produced the results required by our Board of Directors nor the Division of Child Development and Early Education. Therefore, unless your child requires a special diet documented by your physician, as of Monday, October 5, 2020, only food prepared by our nutritionist will be allowed at the center.

I am sorry for any inconvenience this new policy causes, but if you have any questions, please do not hesitate to give me a call.

Eva M. Smith
Childcare Director

Prevention of Shaken Baby Syndrome and Abusive Head Trauma Policy

Parent or guardian acknowledgement form:

I, the parent or guardian of ______________________, ______________________,
Child's name Child's name

______________________, and ______________________
Child's name 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

AHOSKIE CHRISTIAN CENTER CHILD CARE

P.O. Box 155 * 309 West Church Street * Ahoskie NC 27910 * 252-209-0540

Receipt Form

I, ___________________________________ have received the following documentation from

Ahoskie Christian Center Child Care concerning theirs and state policies:

1. Discipline and Behavior Management Policy
2. Summary of North Carolina Child Care Law
3. Sample Incident Report Form
4. Permission to Administer Medication Sheet
5. First Day Check List
6. Prevention of Shaken Baby Syndrome and Abusive Head Trauma Policy
7. Smoking Tobacco Restriction policy

_____________________________________   ________________

Parent/Guardian Signature   Date

_____________________________________   ________________

Business Director   Date

Parent will receive a copy of this form

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

<u>Tell us about your baby's feedings at our center.</u>
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

©2015 Carolina Global Breastfeeding Institute
http://breastfeeding.unc.edu/

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

Name of Center: ACC CHILD CARE CENTER

Infant/Toddler Safe Sleep Policy (Revised)

Date Adopted: 2/23/2017

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: 2/23/17

Review: #1 2/1/18

Revisions:

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

Infant Feeding Consent Form

Institution/Facility Name: ______________________________

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: ______________________________
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 ______________

Parent/Guardian Signature: ______________________________ Date: ______________

***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.*