Application Packet
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:  
Full Name: ____________________________________________  
Date of Birth: _________________________________________

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: ___________________
Email: ___________________  required for weather related updates and digital daily reports.

Mother/Guardian’s Name: ___________________  Home Phone: ___________________
Address (if different from child’s) ___________________  Zip Code: _____________
Work Phone: ___________________  Cell Phone: ___________________
Email: ___________________  required for weather related updates and digital daily reports.

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: ___________________

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: ___________________
STEM Preschool- Science, Technology, Engineering, and Math
Receipt of Handbook Acknowledgement
I have read and received a copy of Little Believer’s Academy Handbook. I have read the rules of Little Believer’s Academy carefully and I am aware of my responsibilities under this agreement.

Parent/Guardian Signature: ___________________________ Date: ____________

Summary of the NC Child Care Law Acknowledgement
I have received a copy of the Summary of the North Carolina Child Care Law.

Parent/Guardian Signature: ___________________________ Date: ____________

Transportation Agreement
When going on field trips by car or walking I will always strive to provide the safest way to transport children to and from trips. Each child will be in an age appropriate child restraint at all times. The children will never be left unattended. Emergency information and identification for each child will be in the vehicle whenever children are being transported. The parent will be notified of each trip prior to the date of the trip.

Parent/Guardian Signature: ___________________________ Date: ____________

Permission to Play Outside Day Care Yard Area
I will allow my child to go on walks, rides in the stroller and/or play outside the yard with adequate supervision.

Parent/Guardian Signature: ___________________________ Date: ____________

Photographic Permission
I give permission _____ I do not give permission _____ for Little Believer’s Academy to take photos and video of my child/children. These photos may be displayed in the center for special occasions and/or projects. They may also be placed on the LBA website and Facebook page.

Parent/Guardian Signature: ___________________________ Date: ____________

Prevention of Shaken Baby Syndrome and Abusive Head Trauma
I acknowledge that I have read and received a copy of the facility’s Shaken Baby Syndrome/Abusive Head Trauma Policy.
Childs Name: ___________________________ Date of Child’s Enrollment: ___________________________
Parent Name: ___________________________ Date Policy Given/Explained: ___________________________
Parent/Guardian Signature: ___________________________ Date: ____________

Smoking and Tobacco Restriction
I agree to abide by Little Believer’s Academy’s policy to not smoke or use tobacco products on the premises.

Parent/Guardian Signature: ___________________________ Date: ____________
Children's Medical Report

Name of Child ___________________________ Birthdate __________
Name of Parent or Guardian __________________________________________
Address of Parent of Guardian _______________________________________

A. Medical History (May be completed by parent)

1. Is child allergic to anything? No___ Yes___ If yes, what? __________________________

2. Is child currently under a doctor's care? No___ Yes___ If yes, for what reason? _________________

3. Is the child on any continuous medication? No___ Yes___ If yes, what? __________________________

4. Any previous hospitalizations or operations? No___ Yes___ If yes, when and for what? __________________________

5. Any history of significant previous diseases or recurrent illness? No___ Yes___; diabetes No___ Yes___;
   convulsions No___ Yes___; heart trouble No___ Yes___; asthma No___ Yes___.
   If others, what/when? __________________________________________________________

6. Does the child have any physical disabilities: No___ Yes___ If yes, please describe: __________________________

Any mental disabilities? No___ Yes___ If yes, please describe: __________________________

Signature of Parent or Guardian _________________________ Date __________

B. Physical Examination: This examination must be completed and signed by a licensed physician, his authorized
   agent currently approved by the N. C. Board of Medical Examiners (or a comparable board from bordering
   states), a certified nurse practitioner, or a public health nurse meeting DHHS standards for EPSDT program.
   Height ________ % Weight ________ %

   Head ________ Eyes ________ Ears ________ Nose ________ Teeth ________ Throat ________
   Neck ________ Heart ________ Chest ________ Abd/GU ________ Ext ________
   Neurological System ________ Skin ________ Vision ________ Hearing ________

   Results of Tuberculin Test, if given: Type ________ date ________ Normal___ Abnormal___ followup ________
   Developmental Evaluation: delayed___ age appropriate___
   If delay, note significance and special care needed: __________________________
   Should activities be limited? No___ Yes___ If yes, explain: __________________________
   Any other recommendations: __________________________
   __________________________
   __________________________
   __________________________
   __________________________

   Date of Examination __________

Signature of authorized examiner/title _________________________ Phone # ________
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.

<table>
<thead>
<tr>
<th>Vaccine Type</th>
<th>Abbreviation</th>
<th>Trade Name</th>
<th>Combination Vaccines</th>
<th>1 date</th>
<th>2 date</th>
<th>3 date</th>
<th>4 date</th>
<th>5 date</th>
</tr>
</thead>
<tbody>
<tr>
<td>Diphtheria, Tetanus, Pertussis</td>
<td>DTaP, DT, DTP</td>
<td>Infanrix, Daptacel</td>
<td>Pediarix, Pentacel, Kinrix</td>
<td></td>
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<tr>
<td>Polio</td>
<td>IPV, OPV</td>
<td>IPOL</td>
<td>Pediarix, Pentacel, Kinrix</td>
<td></td>
<td></td>
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<td></td>
</tr>
<tr>
<td>Haemophilus influenza type B</td>
<td>Hib</td>
<td>Act HIB, Pedvax HIB **</td>
<td>Pentacel</td>
<td></td>
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</tr>
<tr>
<td>Hepatitis B</td>
<td>HepB, HBV</td>
<td>Engerix-B, Recombivax HB</td>
<td>Pediarix</td>
<td></td>
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<td></td>
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</tr>
<tr>
<td>Measles, Mumps, Rubella</td>
<td>MMR</td>
<td>MMR II</td>
<td>Proquad</td>
<td></td>
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<tr>
<td>Varicella/Chicken Pox</td>
<td>Var</td>
<td>Varivax</td>
<td>Proquad</td>
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<tr>
<td>Pneumococcal Conjugate*</td>
<td>PCV, PCV-13, PPV-23</td>
<td>Prevnar, Pneumovax***</td>
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</tbody>
</table>

*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

<table>
<thead>
<tr>
<th>By This Age:</th>
<th>Children Need These Shots:</th>
</tr>
</thead>
<tbody>
<tr>
<td>3 months</td>
<td>1 DTaP 1 Polio 1 Hib 1 Hep B 1 PCV</td>
</tr>
<tr>
<td>5 months</td>
<td>2 DTaP 2 Polio 2 Hib 2 Hep B 2 PCV</td>
</tr>
<tr>
<td>7 months</td>
<td>3 DTaP 2 Polio 2-3 Hib** 2 Hep B 3 PCV</td>
</tr>
<tr>
<td>12-16 months</td>
<td>3 DTaP 2 Polio 1 MMR 3-4 Hib** 3 Hep B 4 PCV 1 Var</td>
</tr>
<tr>
<td>19 months</td>
<td>4 DTaP 3 Polio 1 MMR 3-4 Hib** 3 Hep B 4 PCV 1 Var</td>
</tr>
<tr>
<td>4 years or older (in child care only)</td>
<td>4 DTaP 3 Polio 1 MMR 3-4 Hib** 3 Hep B 4 PCV 1 Var</td>
</tr>
<tr>
<td>4 years and older (in kindergarten)</td>
<td>5 DTaP 4 Polio 2 MMR 3-4 Hib** 3 Hep B 4 PCV 2 Var</td>
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</tbody>
</table>

The North Carolina Child Care Health and Safety Resource Center and NC DHHS DCDEE
Updated November 2017
## Immunization History


### Vaccines Recommended by the Advisory Committee on Immunization Practices (ACIP) NOT Required

<table>
<thead>
<tr>
<th>Vaccine Type</th>
<th>Abbreviation</th>
<th>Trade Name</th>
<th>Recommended Schedule</th>
<th>1 date</th>
<th>2 date</th>
<th>3 date</th>
<th>4 date</th>
<th>5 date</th>
</tr>
</thead>
<tbody>
<tr>
<td>Rotavirus</td>
<td>RV, Rota</td>
<td>Roteteq</td>
<td>Age 2 months, 4 months, 6 months.</td>
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<td></td>
<td></td>
<td>Rotarix</td>
<td></td>
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<tr>
<td>Hepatitis A</td>
<td>Hep A</td>
<td>Havrix</td>
<td>First dose, 12-23 months. Second dose, within 6-18 months.</td>
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<td></td>
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<td>Vaqta</td>
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<tr>
<td>Influenza</td>
<td>Flu</td>
<td>Fluzone, Fluarix, FluLaval, Fluvir, FluMist, Afluria</td>
<td>Annually after age 6 months.</td>
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</table>
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 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 levels.
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 spank, shake, bite, pinch, push, 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 the children alone, unattended, or without supervision.
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 otherwise belittle children's parents, families, or ethnic groups.

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 __________________________

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

Revised 8.09
"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
OFF-PREMISE ACTIVITY AUTHORIZATION

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

__________________________________________ parent/guardian of

__________________________________________ give my permission to

Little Believers Academy for my child to participate in an off-premise activity.

Name of child

Name of facility

Location of off-premise activity: Emergency evacuation locations

Purpose of the activity: Move children to a safer location

Additional information: __________________________________________________________

__________________________________________ Parent/Guardian Signature

__________________________________________ Date Signed

This authorization is valid from _______/_____/______ to _______/_____/______ (up to 12 months)
provided for rest. The staff must provide a clean, well-organized, and safe environment for children. A facility must provide a minimum of 1.5 square feet of floor space for each child at all times. To provide food, the facility must have the necessary equipment and staff to prepare and store food safely. The facility must also provide for the children's safety and health, including adequate supervision, rest periods, and access to medical care. The facility must be free from hazards, and the equipment and toys must be safe. The facility must also have emergency procedures in place for any unexpected events. The facility must be open for 12 hours per day, and the children must be supervised by at least one adult at all times. The facility must also provide for the children's mental and emotional well-being, including activities that promote social interaction and promote the development of skills. The facility must also provide for the children's physical well-being, including activities that promote physical development and motor skills. The facility must also provide for the children's cognitive development, including activities that promote language and cognitive skills. The facility must also provide for the children's social development, including activities that promote social skills and relationships. The facility must also provide for the children's spiritual development, including activities that promote values and beliefs. The facility must also provide for the children's emotional development, including activities that promote emotional well-being. The facility must also provide for the children's cultural development, including activities that promote cultural awareness and appreciation. The facility must also provide for the children's physical development, including activities that promote physical well-being.
North Carolina Department of Health and Human Services  
Women's and Children's Health  
CHILd AND ADULT CARE FOOD PROGRAM  
CHILd ELIGIBILITY APPLICATION

1. PRINT PARTICIPANT'S NAME & DATE OF BIRTH:
   - First Name  
   - Last Name  
   - Date of Birth

2. SNAP, TANF or FDPIR: If a child is a member of a SNAP or FDPIR household or TANF recipient, the child is automatically eligible to receive free Program meal benefits, subject to the completion of the application. If the household currently receives SNAP, TANF or FDPIR benefits give the case number.
   - Case number is: SNAP #:  
   - TANF #:  
   - FDPIR #:  
   - If you have provided the case number, DO NOT complete #3 and #4. Complete #5 and #6.

3. A foster child is automatically eligible to receive free Program meal benefits, and a Head Start participant is automatically eligible to receive free Program meal benefits, subject to submission by Head Start officials of a Head Start statement of income eligibility or income eligibility documentation.
   - Is this a Foster Child?  
   - Yes  
   - No
   - Households with foster and non-foster children may choose to include the foster child as a household member, as well as any personal income earned by the foster child, on the same household application that includes their non-foster children.

4. HOUSEHOLD MEMBERS MONTHLY INCOME: List all others living in your household, DO NOT include participant listed above.
   - List all gross income (before deductions) received last month. If you did not give a SNAP, TANF or FDPIR case number or if this is not a foster child, you must complete the income information.

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</tbody>
</table>

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) 
Printed Name |
<table>
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<tbody>
<tr>
<td>Date</td>
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</table>

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

For Institution to be classified and completed by institution/sponsor

<table>
<thead>
<tr>
<th>TOTAL HOUSHELd SIZE</th>
<th>TOTAL HOUSHELd MONTHLY INCOME</th>
</tr>
</thead>
</table>
| Approved:  
  - Free  
  - Reduced  
  - Denied |
| Reason for denial:  
  - Income too high  
  - Incomplete application  
  - Other: |
| Withdrew on (Date): |

| For state use only:  
Verified by:  
Date: |
| verified classification:  
- Free  
- Reduced  
- Denied |
| Reason for classification change: |

Signature of Eligibility Official (Individual at the Institution Level)– REQUIRED

Date

NC DHHS CACFP – Child Income Eligibility Application (6/19)  
This institution is an equal opportunity provider
NC CACFP ELIGIBILITY APPLICATION INSTRUCTIONS

Please complete the Child and Adult Care Food Program Eligibility Applications using the instructions below. Sign the certification statement and return it to your child care center.

PART 1-PARTICIPANT’S INFORMATION: Complete this part.
Print the name(s) of the child enrolled in the center.

PART 2-HOUSEHOLD GETTING SNAP, TANF, OR FDPIR BENEFITS: Complete this PART and PART 6.
(1) List your current SNAP, TANF, or FDPIR case identification number.
(2) An adult household member must sign the certification statement in PART 6.

PART 3-FOSTER or HOMELESS CHILD (Including children evacuated from Japan and Bahrain)
(1) Indicate if child is a Foster Child or is homeless. Households with foster and non-foster children may choose to include the foster child as a household member, as well as any personal income earned by the foster child, on the same household application that includes their non-foster children. Additionally, when a host family applies for free and reduced price meals for their own children, the host family 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.
(2) An Adult household Member must sign the certification statement in PART 6.

PART 4- HOUSEHOLD INCOME: Complete this PART and PART 6
(1) List the names of household members.
(2) 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.
(3) An adult household member must sign this income eligibility statement and give the last four digits of his/her social security number in PART 6.

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

PART 6-SIGNATURE AND LAST FOUR DIGITS OF SOCIAL SECURITY NUMBER: All households complete this PART.
(1) All eligibility applications must have this signature of an adult household member;
(2) 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, write “none”. If you listed a SNAP, TANF, or FDPIR number a social security number is not needed.

### INCOME TO REPORT

<table>
<thead>
<tr>
<th>Earnings from Employment</th>
<th>Pensions/Retirement/Social Security</th>
<th>Other Income</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Wage/salaries/tips</td>
<td>• Pensions</td>
<td>• Disability benefits</td>
</tr>
<tr>
<td>• Strike benefits</td>
<td>• Supplemental security income</td>
<td>• Cash withdrawn from savings</td>
</tr>
<tr>
<td>• Unemployment compensation</td>
<td>• Retirement income</td>
<td>• Interest/dividends</td>
</tr>
<tr>
<td>• Net income from self-owned business or farm</td>
<td>• Veteran’s payments</td>
<td>• Income from estates/trusts/</td>
</tr>
<tr>
<td>• Worker’s compensation</td>
<td>• Social Security</td>
<td>investments</td>
</tr>
<tr>
<td>Public Assistance/Child Support/Alimony</td>
<td>Military Households</td>
<td>• Regular contributions from</td>
</tr>
<tr>
<td>• Public assistance payments</td>
<td>• All cash income, including</td>
<td>persons not living in the</td>
</tr>
<tr>
<td>• TANF payments</td>
<td>• military housing/uniform</td>
<td>household</td>
</tr>
<tr>
<td>• Alimony/Child support payments</td>
<td>• allowances. Does not include 'in-kind' benefits</td>
<td>• Net royalties/annuities/ net</td>
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<tr>
<td></td>
<td>• NOT paid in cash (base housing, clothing,</td>
<td>rental income</td>
</tr>
<tr>
<td></td>
<td>• food, medical care, etc.)</td>
<td>• Any other income</td>
</tr>
</tbody>
</table>

NC DHHS CACFP – Child Income Eligibility Application (6/19) This institution is an equal opportunity provider
Dear Parent or Guardian,

Please help us comply with the federal requirement mandating the annual submission of program Income Eligibility Application. This application will be used only for eligibility determination, placed in our files and treated as confidential information. In order for participants and the day care center to be considered eligible for program benefits, an adult household member must complete the program Income Eligibility Application (IEA) for each participant enrolled in the center as soon as possible, sign, date and return it to the day care center. Completion of the application is not mandatory unless you wish to be considered for eligibility as a free or reduced price participant.

If you currently receive SNAP, Temporary Aid to Needy Families (TANF) or Food Distribution Program on Indian Reservations (FDPIR), you are not required to list household income. You may give your SNAP, TANF or FDPIR case number, sign, date and return the application. If a child is a member of a SNAP or FDPIR household or is a TANF recipient, the child is automatically eligible to receive free program meal benefits, subject to completion of the application.

You should also note that if you have a foster child the day care center is eligible for program benefits for the foster child regardless of the income of your household. Households with foster and non-foster children may choose to include the foster child as a household member, as well as any personal income earned by the foster child, on the same household application that includes their non-foster children. Please contact the institution for further instructions.

You should list the name of everyone who lives in your household, including all children, parents, grandparents and other relatives. The Department of Agriculture defines a household as a group of related or unrelated individuals (not residents of an institution or boarding house) who are living as one economic unit (i.e. sharing living expenses).

The income which you report must be the total gross income, before deductions, received by all members of your household last month (i.e. wages, public assistance, TANF or retirement, etc.). Military benefits received in cash, such as housing allowance for military households living off base and food or clothing allowance must be considered as income. If you have a household member whose last month's income was higher or lower than usual, list that person's expected average monthly income.

<table>
<thead>
<tr>
<th>HOUSEHOLD SIZE</th>
<th>YEARLY</th>
<th>MONTHLY</th>
<th>TWICE PER MONTH</th>
<th>EVERY TWO WEEKS</th>
<th>WEEKLY</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>$23,107</td>
<td>$1,926</td>
<td>$963</td>
<td>$889</td>
<td>$445</td>
</tr>
<tr>
<td>2</td>
<td>$31,284</td>
<td>$2,607</td>
<td>$1,304</td>
<td>$1,204</td>
<td>$602</td>
</tr>
<tr>
<td>3</td>
<td>$39,461</td>
<td>$3,289</td>
<td>$1,645</td>
<td>$1,518</td>
<td>$759</td>
</tr>
<tr>
<td>4</td>
<td>$47,638</td>
<td>$3,970</td>
<td>$1,985</td>
<td>$1,833</td>
<td>$917</td>
</tr>
<tr>
<td>5</td>
<td>$55,815</td>
<td>$4,652</td>
<td>$2,326</td>
<td>$2,147</td>
<td>$1,074</td>
</tr>
<tr>
<td>6</td>
<td>$63,992</td>
<td>$5,333</td>
<td>$2,667</td>
<td>$2,462</td>
<td>$1,231</td>
</tr>
<tr>
<td>7</td>
<td>$72,169</td>
<td>$6,015</td>
<td>$3,008</td>
<td>$2,776</td>
<td>$1,388</td>
</tr>
<tr>
<td>8</td>
<td>$80,346</td>
<td>$6,696</td>
<td>$3,348</td>
<td>$3,091</td>
<td>$1,546</td>
</tr>
</tbody>
</table>

*Households with income less than or equal to these levels are eligible for free or reduced-price meals.

You may submit a program Income Eligibility Application any time during the fiscal year. Participants having family members who become unemployed are eligible for free or reduced-price meals during the period of unemployment, provided that the loss of income causes the family's income during the period of unemployment to be within the eligibility standards for those meals.

In accordance with Federal civil rights law and U.S. Department of Agriculture (USDA) civil rights regulations and policies, the USDA, its agencies, offices, and employees, and institutions participating in or administering USDA programs are prohibited from discriminating based on race, color, national origin, sex, disability, age, or reprisal or retaliation for prior civil rights activity in any program or activity conducted or funded by USDA. Persons with disabilities who require alternative means of communication for program information (e.g. Braille, large print, audiotape, American Sign Language, etc.), should contact the agency (state or local) where they applied for benefits. Individuals who are deaf, hard of hearing or have speech disabilities may contact USDA through the Federal Relay Service at (800) 877-8339. Additionally, program information may be made available in languages other than English. To file a program complaint of discrimination, complete the USDA Program Discrimination Complaint Form, (AD-3027) found online at: http://www.ascr.usda.gov/complaint_filing_cust.html, and at any USDA office, or write a letter addressed to USDA and provide in the letter all of the information requested in the form. To request a copy of the complaint form, call (866) 632-9992. Submit your completed form or letter to U.S. Department of Agriculture, Office of the Assistant Secretary for Civil Rights, 1400 Independence Avenue, SW, Washington, D.C. 20250-9410 by fax (202) 690-7442 or email program.intake@usda.gov. This institution is an equal opportunity provider.
Child and Adult Care Food Program (CACFP)
Child Participant Enrollment Form

Institution Name: ____________________________ Agreement Number: 9422

Center Name: Little Believer's Academy

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 children. Please complete the table below for each child in your family that is enrolled at this center/program. Be sure to sign and date in the space below. Thank you.

The information below should be completed by the parent or guardian.

<table>
<thead>
<tr>
<th>Child's First Name</th>
<th>Child's Last Name</th>
<th>Date of Birth</th>
<th>Normal/Typical Hours of Care</th>
<th>Normal/Typical Days of Care (Circle all that apply)</th>
<th>Meals Normally Eaten (Circle all that apply)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>M T W Th F Sat Sun</td>
<td>B AM L PM S LPM</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>M T W Th F Sat Sun</td>
<td>B AM L PM S LPM</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>M T W Th F Sat Sun</td>
<td>B AM L PM S LPM</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>M T W Th F Sat Sun</td>
<td>B AM L PM S LPM</td>
</tr>
</tbody>
</table>

**Normal/Typical Hours of Care:** Please write in each child’s usual arrival and departure time. Indicate a.m. or p.m.

**Normal Days of Care:** Please circle the days of the week each 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** — Please circle the meals each 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 child withdrew: __________________________________

For State Use Only: Complete: Incomplete Reason: __________________________ Verified by: ____________ Date: ____________

This institution is an equal opportunity provider.

NC CACFP Enrollment Child (06/19)
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: _______ Date of Birth: ___________________________

Parent/Guardian Signature: ___________________________ Date: ___________________________

NC DHHS Infant Feeding Consent Form (6/2019)
Infant Feeding Consent Form

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.
# 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.**

<table>
<thead>
<tr>
<th>Child’s name:</th>
<th>Birthday: mm/dd/yyyy</th>
</tr>
</thead>
</table>

| Parent/Guardian’s name(s): |

Did you receive a copy of our “Infant Feeding Guide?”

<table>
<thead>
<tr>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
</table>

If you are breastfeeding, did you receive a copy of:

- “Breastfeeding: Making It Work?”
- “Breastfeeding and Child Care: What Moms Can Do?”

<table>
<thead>
<tr>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
<td>No</td>
</tr>
</tbody>
</table>

## 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: ____________

Tell us about your baby’s feedings at our center.
I want my child to be fed the following foods while in your care:

<table>
<thead>
<tr>
<th>Frequency of feedings</th>
<th>Approximate amount per feeding</th>
<th>Will you bring from home? (must be labeled and dated)</th>
<th>Details about feeding</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mother’s Milk</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Formula</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cow’s milk</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cereal</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Baby Food</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Table Food</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other (describe)</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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.

<table>
<thead>
<tr>
<th>Date</th>
<th>Change to Feeding Plan (must be recorded as feeding habits change)</th>
<th>Parent Initials</th>
<th>Teacher Initials</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
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</tr>
</tbody>
</table>

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

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http://breastfeeding.unc.edu/
Infant/Toddler Safe Sleep Policy

Child Care Facility: Little Believers Academy

A safe sleep environment for infants reduces the risk of sudden infant death syndrome (SIDS) and other sleep-related infant deaths. According to North Carolina 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. We implement the following safe sleep policy.

References: N.C. Law GS. 100-91 (35), N.C. Child Care Rules .0606 and .1724, Caring for Our Children

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 6 months of age on their backs to sleep, unless a signed ITS-SIDS Alternate Sleep Position Health Care Professional Waiver is in the infant's file and posted at the infant's crib. We retain the waiver in the child's record for as long as they are enrolled.

3. We do not accept Parent Waivers for infants older than six months.* -OR- *We accept the ITS-SIDS Alternate Sleep Position Parent Waiver.

4. We place infants on their backs to sleep even after they can easily turn over from the back to the stomach. We then allow them to adopt their own position for sleep. *We document when each infant can roll from back to stomach and tell the parents. We put a notice in the child's file and on or near the infant's crib.*

5. We visually check sleeping infants every 15 minutes and record what we see on a Sleep Chart. *We check infants 2-4 month of age more frequently.*

6. We maintain the temperature in the room where infants sleep between 68-75°F and check it on the thermometer in the room. *We further reduce the risk of overheating by not over-dressing infants*

7. We provide all infants supervised "tummy time" daily.

8. We follow N.C Child Care Rules .0901(j) and .1706(g) regarding breastfeeding. *We further encourage breastfeeding in the following ways:*

9. 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.

10. Do not allow infants to use pacifiers. -OR- *We allow pacifiers without any attachments. Pacifiers attached to clothing will be removed when placed to sleep.*

11. We do not allow infants to be swaddled.

12. We do not cover infants' heads with blankets or bedding.

13. We do not allow garments that restrict movement.*

14. We do not allow any objects, such as, pillows, blankets, or toys other than pacifiers in the crib or sleep space.

15. Infants are not placed in or left in car safety seats, strollers, swings, or infant carriers to sleep.

16. We give all parents/guardians of infants a written copy of the Infant/Toddler Safe Sleep Policy before enrollment. We review the policy with them, and ask them to sign a statement saying they received and reviewed the policy. *We encourage families to follow the same safe sleep practices to ease infants' transition to child care.*

17. 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.

18. Centers: We post a copy of this policy in the infant sleep room where it can easily be read.

*Indicates we follow this best practice recommendation.

Effective date: 11/2019 Review date(s): Revision date(s):

Distribution: We give parents/guardians a copy of the policy. We give all staff, substitutes and volunteers a copy to review. We inform them of changes 14 days before the effective date. We give parents/guardians a copy of the policy they signed and put a copy in child's file.

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

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

Facility Representative Signature: __________________________ Date: __________________________

NC Child Care Health and Safety Resource Center January 2018