K3/K4 CHILD'S APPLICATION FOR ENROLLMENT

For Identity Security, DO NOT Email Completed Form. Submit in person OR via USPS

Date Application Completed or Updated: ______________________ Date of 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'S INFORMATION:

First Name: ________________Middle: ________________Last Name: ________________ D.O.B. __/__/___

Child's Physical Street Address: ________________________ City: ___________ State: ____ Zip: _________

FAMILY INFORMATION:

Child Lives With: ____

Father/Guardian Name: ____ Mobile #: ___/____/_____

Father's Address (If different from child's) ____

Employer: ______________________________________ Work #: ___/____/_____ Home #: ___/____/_____

Mother/Guardian Name: ____ Mobile #: ___/____/_____

Mother's Address (If different from child's) ____

Employer: ______________________________________ Work #: ___/____/_____ Home #: ___/____/_____

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. Also, 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 #
_________________________________	_____________	__________________________	___/____/_____
_________________________________	_____________	__________________________	___/____/_____
_________________________________	_____________	__________________________	___/____/_____
_________________________________	_____________	__________________________	___/____/_____

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 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 #: __________

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 an emergency. In an emergency, other children in the facility will be supervised by a responsible adult. I will not administer any drug or medication without specific instructions from the physician or the child's parent/guardian or full-time custodian.

Signature of Administrator: ____ Date: ______________

K3/K4 DISCIPLINE & BEHAVIOR MANAGEMENT POLICIES

Praise and positive reinforcement are effective methods of behavior management of children. When children receive positive, non-violent and understanding interactions from adults and others, they develop good concepts, problem solving abilities and self-discipline. Based on this belief of how children learn and develop values, this school will practice the following discipline and behavior management policies:

We **DO:**

1. Praise-Reward-Encourage the children.
2. Reason with and set limits for children.
3. Model appropriate behavior for the children.
4. Modify the classroom environment to attempt to modify problems before they occur.
5. Listen to the children.
6. Provide alternatives for inappropriate behavior of the children.
7. Provide the children with natural and logical consequences for their behaviors.
8. Treat the children as people and respect their needs, desires and feelings.
9. Often by choice, overlook the minor or insignificant misbehavings for purpose.
10. Explain things to the children on their levels.
11. Use short supervised periods of "Time Out."
12. Stay consistent in our classroom behavior management programs.

We **DO NOT:**

1. Spank, shake, bite, pinch, pull, slap or otherwise physically punish the children.
2. Make fun of, yell at, threaten, make sarcastic remarks about, use profanity, or otherwise verbally abuse children.
3. Shame or punish the children when restroom accidents occur.
4. Deny food, water or rest as punishment.
5. Relate discipline to eating, drinking or resting/sleeping.
6. Leave children unsupervised, unattended or alone.
7. Leave children in locked rooms, closets or boxes as punishment.
8. Allow discipline of children by other children.
9. Criticize, make fun of or otherwise belittle children's parents, families or ethnic groups.

I, the undersigned parent or guardian of (print student name) ______________________________(grade) ____________ do hereby state that I have read and received a copy of the school's Discipline and Behavior Management Policies and that a member of the School's Staff has discussed the policies with me upon enrollment.

Date of Child's Enrollment: ____

Parent/Guardian Signature: ____

K3/K4 FOOD WAIVER SHEET

Dear Parents/Guardians,

This document is required by the Division of Child Development and Early Education.

Please read the following memo and fill out the appropriate portion below.

At Living Water Christian School, students bring their own lunch to school. Therefore, since LWCS does not provide daily lunches, the Division of Child Development and Early Education (DCDEE) requires our school to have parents opt out of the supplemental food requirements. However, we do encourage every parent to provide healthy snacks and lunches daily.

Also, please note that juices cannot be served in glass containers and students cannot be given more than six (6) ounces of 100% juice per day. For example, if you provide juice for the morning snack, milk or water must be served at lunch (or vice versa). Drink Cards can be purchased in the school office for milk, water or juice.

As the parent/guardian of (name of child) ___________________________, I opt out of the supplemental food requirements for (grade): _________________.

________________________________	________________________________	_______________
Parent Name Printed	Parent Signature	Date

K3/K4 CHILDREN'S MEDICAL REPORT

Name of Child: ____ Date of Birth: _______________

Name of Parent/Guardian: ____

Address of Parent/Guardian: ____

A. Medical History (may be completed by parent/guardian)

1. Is child allergic to anything? No Yes If yes, what? ___________________________________
____

2. Is child currently under a doctor's care? No Yes If yes, what? __________________________
____

3. Is the child on any continuous medication? No Yes If yes, what? _________________________
____

4. Any previous hospitalizations or operations? No Yes If yes, 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: ________________
____

7. Any mental disabilities? No Yes If yes, please describe: __________________________________

Signature of Parent/Guardian _____________________________________ Date: __________________

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 ______ follow-up ______

Development 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 #: ____________