Albemarle Preschool

"Inspiring excellence and character in a nurturing environment."

2024-2025 Enrollment Contract

In consideration of having your child enrolled in Albemarle Preschool, the undersigned jointly and separately promise to pay Albemarle Preschool the sum hereinafter stated.

Preschool Programs

$140.00 Weekly Rate

Annual Enrollment and Materials Fee: $100.00

The Annual Enrollment and Materials Fee is charged at the time of enrollment and renewed on August 15th of each year.

*Albemarle Preschool does not offer part-time care. Tuition will not be prorated for absences, facility closings, weather closings, holidays, or any other unforeseen reasons. In the event of a closing, the child's spot will be held until we reopen again but your tuition balance must be paid up to date in order to maintain the child's enrollment. A calendar of holiday closings is provided to parents upon enrollment. Our parent handbook has further information about financial responsibilities. We do charge extra fees for late pickups, late payments and declined credit cards.

Name of Child: _____ Date of Birth: _____

_____

Printed Name of Parent/Guardian | Parent Social Security # | Parent Date of Birth

_____

Mailing Address | City | State | Zip Code

_____

Home Phone # | Cell Phone # | Email Address

Albemarle Preschool is able to provide meals and snacks for students because of the Cape Fear Program. Parents are required to complete Cape Fear enrollment forms.

By signing below, I am agreeing to the following: Each payment is due on the first day of the week until the child is withdrawn by submitting a written two-week notice of withdrawal or the school session ends. Payments not received by Friday of that week will be assessed a $20.00 late fee for EACH week the payment is late. Monthly payments are also acceptable and should be made at the beginning of each month. Accounts past due over 3 weeks will be subject to dismissal. Re-enrollment will only be allowed if space is available and financial obligations have been met. Accounts in default of payment are subject to collection action. If you are signed up for automatic payments, and the above amount is different than the amount we are already charging you each week, we reserve the right to change the automatic payment amount to reflect the most up to date contract.

Parent Signature: _____ Date: _____

Date Application Completed: _____ Date of Enrollment: _____

CHILD'S APPLICATION FOR ENROLLMENT

To be completed, signed, and placed on file in the facility on the first day and updated as changes occur and at least annually
Do not leave any spaces blank. Write n/a if needed.

CHILD INFORMATION: Date of Birth: _____

Full Name: _____
Last First Middle Nickname

Child's Physical Address: _____

FAMILY INFORMATION: Child lives with: _____

Father/Guardian's Name _____ Home Phone _____
Address (if different from child's) _____ Zip Code _____
Work Phone _____ Cell Phone _____

Mother/Guardian's Name _____ Home Phone _____
Address (if different from child's) _____ Zip Code _____
Work Phone _____ Cell Phone _____

CONTACTS:

Child will be released only to the parents/guardians listed above. The child can also be released to the following individuals, as authorized by the person who signs this application. In the event of an emergency, if the parents/guardians cannot be reached, the facility has permission to contact the following individuals.

Name	Relationship	Address	Phone Number
Name	Relationship	Address	Phone Number
Name	Relationship	Address	Phone Number

HEALTH CARE NEEDS:

For any child with health care needs such as allergies, asthma, or other chronic conditions that require specialized health services, a medical action plan shall be attached to the application. The medical action plan must be completed by the child's parent or health care professional. Is there a Medical action plan attached? Yes ☐ No ☐ (Medical action plan must be updated on an annual basis and when changes to the plan occur)

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 _____

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 #**_____

Child Immunization History

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

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

Child's full name:	Date of birth:

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

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

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

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

Record updated by:	Date	Record updated by:	Date

Minimum State Vaccine Requirements for Child Care Entry

By This Age:	Children Need These Shots:						
3 months	1 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

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

Child Immunization History

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

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

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

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COVID-19 Waiver, Release and Hold Harmless Agreement

The novel coronavirus, COVID-19, has been declared a worldwide pandemic by the World Health Organization. COVID-19 is extremely contagious and is believed to spread mainly from person-to-person contact. As a result, international governments and health agencies recommend social distancing, frequent hand-washing and the use of masks. Albemarle School and Preschool has put preventative measures in place to curtail the spread of COVID-19. However, we cannot guarantee that you or your child(ren) will not become infected. Further, attending operations on campus could increase your risk and your child(ren)'s risk of contracting COVID-19.

(A) By signing this agreement, I acknowledge the contagious nature of COVID-19 and voluntarily assume the risk that my child(ren) and I may be exposed to or infected by COVID-19 by attend Albemarle School and that such exposure or infection may result in personal injury, illness, permanent disability, and death. I understand that the risk of becoming exposed to or infected by COVID-19 at Albemarle School and Preschool may result from the actions, omissions, or negligence of myself and others, including, but not limited to, our employees, volunteers, and program participants and their families.

(B) I voluntarily agree to assume all of the foregoing risks and accept sole responsibility for any injury to my child(ren) or myself (including, but not limited to, personal injury, disability, and death), illness, damage, loss, claim, liability, or expense, of any kind, that I or my child(ren) may experience or incur in connection with my child(ren)'s attendance at Albemarle School and Preschool ("Claims"). On my behalf, and on behalf of my child(ren), I hereby release, covenant not to sue, discharge, and hold harmless Albemarle School and Preschool, its employees, agents, and representatives, of and rom the claims, including all liabilities, claims, actions, damages, costs or expenses of any kind arising out of or relating thereto. I understand and agree that this release includes any claims based on the actions, omissions, or negligence of Albemarle School and Preschool, its employees, agents, and representatives, whether a COVID-19 infection occurs before, during, or after participation in any Albemarle School and Preschool program.

I HAVE READ THIS WAIVER, RELEASE AND HOLD HARMLESS AGREEMENT, FULLY UNDERSTAND ITS TERMS, UNDERSTAND THAT I HAVE GIVEN UP SUBSTANTIAL RIGHTS BY SIGNING IT, AND SIGN IT FREELY AND VOLUNTARILY WITHOUT ANY INDUCEMENT.

Name of Participant: _____

PARENT/GUARDIAN Signature: _____

PARENT/GUARDIAN Signature: _____

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Parent Health Agreement

As we are faced with life during a pandemic, we commit these new norms to promote wellness and protection for our School community. As an Albemarle School and Preschool parent, I understand that my commitment to following these requirements promotes health, wellness and safety for our entire school community.

My family commits to these health expectations:

_____ My child will not be sent to school when sick.

_____ My child will be free from vomiting, diarrhea, abdominal pain and upset stomach for 72 hours before returning to school.

_____ My child will not attend school if he/she.is experiencing active allergy symptoms (including skin rashes, sneezing, sore throat, headaches, couth, runny nose, irritated or red eyes, itching, labored breathing, etc.)

_____ My child will be fever free without the use of fever-reducing medications (acetaminophen ibuprofen, etc.) for 72 hours before returning to school. Fever is defined as a temperature equal to or greater than 100.4 degrees Fahrenheit (taken by any method).

_____ My child will not attend school if he/she has been in the presence of a friend or family member exhibiting covid-like symptoms (fever, cough, shortness of breath, chills, body aches, loss of taste/smell, rash, sore throat, headache) or around another who has been recently diagnosed with COVID-19. | will contact my pediatrician and my child will quarantine for 14 days.

_____ My child will not attend school with any active skin rashes. Lesions, or eruptions including bruises of unknown cause.

_____ My child will not attend school if they are exhibiting extreme fatigue, persistent crying, or unusual irritability.

_____ My child will not attend school if he/she exhibits difficulty breathing or is requiring breathing treatments (nebulizers, or inhalers) during the school day.

_____ My child will not attend school if he/she has a physician's diagnosis of strep throat until he/she has been on antibiotics and fever free without the use of fever reducing medications for 72 hours.

Parent Full Signatures: _____ _____

Our teachers will strictly adhere to these expectations as they provide excellent care for your child and his/her community. While these requirements are not ideal, our Albemarle on strict adherence to them in order to adapt to the current times. These requirements are subject to change and new requirements may be added as COVID-19 and its side effects become available.

Face coverings for our staff, students and preschool students are optional.

We are grateful for your partnership and diligence in these unprecedented times.

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Emergency Medical Attention Authorization

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 situation, 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: _____

Albemarle Preschool Photo Release

I understand that my child may be photographed and/or videotaped while at Preschool. These photos/video clips can be used for placing photos of children within the classroom or in arts and crafts to be hung on doors, in the hallways, etc. I also give my permission for Albemarle Preschool and their associates to use photographs/videos of my child for the purpose of:

Please check all that apply:

_____ Promotional purposes, on our preschool website, on flyers.

_____ On our Albemarle School Facebook page.

_____ To create a video collage or DVD for families of enrolled children (end of the year remembrance video)

_____ For school grants and grant requests.

_____ For newsletters to be dispersed to currently enrolled families.

I also understand that if I change my mind, I must request to fill out another photo release form.

Name of Child: _____

Signature of Parent/Guardian: _____ Date: _____

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Albemarle Preschool Discipline and Behavior Management Policy

Praise and positive reinforcement are highly effective methods of behavior management with young 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 will:	We will NOT:
○ Praise, reward, and encourage the children ○ Reason with and set limits for the children ○ Model appropriate behavior for the children ○ Modify the classroom environment to attempt to prevent problems before they occur ○ Provide alternatives for the inappropriate behavior to the children ○ Provide the children with natural and logical consequences to their behaviors ○ Treat the children as people and respect their needs, desires, and feelings ○ Ignore minor misbehaviors ○ Explain things to children on their level ○ Use short, supervised periods of time out sparingly ○ Stay consistent in our behavior management program ○ Use effective guidance and behavior management techniques that focus on a child's development	○ Spank, shake, bite, pinch, pull, slap, or otherwise physically punish the children ○ Make fun of, yell at, threaten, make sarcastic remarks about, use profanity, or otherwise verbally abuse the children ○ Shame or punish children when bathroom accidents occur ○ Deny food or rest as punishment ○ Relate discipline to eating, resting, or sleeping ○ Leave the children alone, unattended, or without supervision ○ Place the children in locked rooms, closets, or boxes as punishment ○ Allow discipline of children by children ○ Criticize, make fun of, or otherwise belittle children's parents, families, or ethnic groups

"Time out" is the removal of a child for a short period of time (1 minute for each year of the child's age) from a situation in which the child is misbehaving and has not responded to other discipline techniques. This "time out" space, usually a chair, is located away from the 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 while they attempt to calm their body and mind. After that brief time, 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 to other children.

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Albemarle Preschool Acknowledgment of Receipt of Policies and Information

Name of Child: _____

Date of Enrollment: _____

I, the parent or guardian of the child named above, confirm by my signature that the following documents have been provided to me and reviewed with me (an electronic copy is acceptable). I understand that! will receive notice at least 14 days before changes made to these documents go into effect. Please initial beside each item below.

_____ Parent Handbook

_____ Summary of NC Child Care Law

_____ Discipline Policy

_____ Policy for Shaken Baby Syndrome and Abusive Head Trauma (up to 5 years old)

_____ I am aware that my child may be transported by personal vehicle of an employee in the case or an extreme emergency. | will not hold Albemarle School or the driver(s) of the vehicle responsible for any damage or injuries, which may occur as the result of any unforeseen accident.

_____ I am aware that smoking, the use of tobacco products, or other products such as e-cigarettes is prohibited on the premises, which includes cars in the parking lot.

Name of Parent/Guardian: _____

Signature: _____ Date: _____

We sometimes offer activities that require leaving the fenced-in play area. Examples include taking a nature walk around the premises, visiting a fire truck in the parking lot, and drawing with chalk in the courtyard. During this time, we maintain close supervision and required staff/child ratios at all times.

* Please note that during fire and other emergency drills, or real emergency situations, we are required to safely evacuate children outside of the fenced area.

_____ I will allow my child, listed above, to participate in activities outside of the fenced play area.

OR

_____ I will not allow my child, listed above, to participate in activities outside of the fenced play area.

Signature: _____ Date: _____

Prevention of Shaken Baby Syndrome and Abusive Head Trauma

Belief Statement

We, _____ (name of facility), believe that preventing, recognizing, responding to, and reporting shaken baby syndrome and abusive head trauma (SBS/AHT) is an important function of keeping children safe, protecting their healthy development, providing quality child care, and educating families.

Background

SBS/AHT is the name given to a form of physical child abuse that occurs when an infant or small child is violently shaken and/or there is trauma to the head. Shaking may last only a few seconds but can result in severe injury or even death[1]. According to North Carolina Child Care Rule (child care centers, 10A NCAC 09 .0608, family child care homes, 10A NCAC 09 .1726), each child care facility licensed to care for children up to five years of age shall develop and adopt a policy to prevent SBS/AHT[2].

Procedure/Practice

Recognizing:

- Children are observed for signs of abusive head trauma including irritability and/or high pitched crying, difficulty staying awake/lethargy or loss of consciousness, difficulty breathing, inability to lift the head, seizures, lack of appetite, vomiting, bruises, poor feeding/sucking, no smiling or vocalization, inability of the eyes to track and/or decreased muscle tone. Bruises may be found on the upper arms, rib cage, or head resulting from gripping or from hitting the head.

Responding to:

- If SBS/ABT is suspected, staff will[3]:
  - Call 911 immediately upon suspecting SBS/AHT and inform the director.
  - Call the parents/guardians.
  - If the child has stopped breathing, trained staff will begin pediatric CPR[4].

Reporting:

- Instances of suspected child maltreatment in child care are reported to Division of Child Development and Early Education (DCDEE) by calling 1-800-859-0829 or by emailing webmasterdcd@dhhs.nc.gov.
- Instances of suspected child maltreatment in the home are reported to the county Department of Social Services. Phone number: _____

Prevention strategies to assist staff* in coping with a crying, fussing, or distraught child

Staff first determine if the child has any physical needs such as being hungry, tired, sick, or in need of a diaper change. If no physical need is identified, staff will attempt one or more of the following strategies[5]:

- Rock the child, hold the child close, or walk with the child.
- Stand up, hold the child close, and repeatedly bend knees.
- Sing or talk to the child in a soothing voice.
- Gently rub or stroke the child's back, chest, or tummy.
- Offer a pacifier or try to distract the child with a rattle or toy.
- Take the child for a ride in a stroller.
- Turn on music or white noise.
- Other

  _____
- Other

  _____

NORTH CAROLINA
Child Care Health and Safety Resource Center
800-367-2229
healthychildcare.unc.edu

In addition, the facility:

- Allows for staff who feel they may lose control to have a short, but relatively immediate break away from the children[6].
- Provides support when parents/guardians are trying to calm a crying child and encourage parents to take a calming break if needed.
- Other

_____

Prohibited behaviors

Behaviors that are prohibited include (but are not limited to):

- shaking or jerking a child
- tossing a child into the air or into a crib, chair, or car seat
- pushing a child into walls, doors, or furniture

Strategies to assist staff members understand how to care for infants

Staff reviews and discusses:

- The five goals and developmental indicators in the 2013 North Carolina Foundations for Early Learning and Development, ncchildcare.nc.gov/PDF_forms/NC_Foundations.pdf
- How to Care for Infants and Toddlers in Groups, the National Center for Infants, Toddlers and Families, www.zerotothree.org/resources/77-how-to-care-for-infants-and-toddlers-in-groups
- Including Relationship-Based Care Practices in Infant-Toddler Care: Implications for Practice and Policy, the Network of Infant/Toddler Researchers, pages 7-9, www.acf.hhs.gov/sites/default/files/opre/nitr_inquire_may_2016_070616_b508compliant.pdf

Strategies to ensure staff members understand the brain development of children up to five years of age

All staff take training on SBS/AHT within first two weeks of employment. Training includes recognizing, responding to, and reporting child abuse, neglect, or maltreatment as well as the brain development of children up to five years of age. Staff review and discuss:

- Brain Development from Birth video, the National Center for Infants, Toddlers and Families, www.zerotothree.org/resources/156-brain-wonders-nurturing-healthy-brain-development-from-birth
- The Science of Early Childhood Development, Center on the Developing Child, developingchild.harvard.edu/resources/inbrief-science-of-ecd/

Resources

List resources such as a staff person designated to provide support or a local county/community resource:

_____

_____

Parent web resources

- The American Academy of Pediatrics: www.healthychildren.org/English/safety-prevention/at-home/Pages/Abusive-Head-Trauma-Shaken-Baby-Syndrome.aspx
- The National Center on Shaken Baby Syndrome: http://dontshake.org/family-resources
- The Period of Purple Crying: http://purplecrying.info/
- Other _____

Facility web resources

- Caring for Our Children, Standard 3.4.4.3 Preventing and Identifying Shaken Baby Syndrome/Abusive Head Trauma, http://cfoc.nrckids.org/StandardView.cfm?StdNum=3.4.4.3&=+
- Preventing Shaken Baby Syndrome, the Centers for Disease Control and Prevention, http://centerforchildwelfare.fmhi.usf.edu/kb/trprev/Preventing_SBS_508-a.pdf
- Early Development & Well-Being, Zero to Three, www.zerotothree.org/early-development
- Other _____

References

1. The National Center on Shaken Baby Syndrome, www.dontshake.org
2. NC DCDEE, ncchildcare.dhhs.state.nc.us/general/mb_ccrulespublic.asp
3. Shaken baby syndrome, the Mayo Clinic, www.mayoclinic.org/diseases-conditions/shaken-baby-syndrome/basics/symptoms/con-20034461
4. Pediatric First Aid/CPR/AED, American Red Cross, www.redcross.org/images/MEDIA_CustomProductCatalog/m4240175_Pediatric_ready_reference.pdf
5. Calming Techniques for a Crying Baby, Children's Hospital Colorado, www.childrenscolorado.org/conditions-and-advice/calm-a-crying-baby/calming-techniques
6. Caring for Our Children, Standard 1.7.0.5: Stress http://cfoc.nrckids.org/StandardView/1.7.0.5

Application

This policy applies to children up to five years of age and their families, operators, early educators, substitute providers, and uncompensated providers.

Communication

Staff*

- Within 30 days of adopting this policy, the child care facility shall review the policy with all staff who provide care for children up to five years of age.
- All current staff members and newly hired staff will be trained in SBS/AHT before providing care for children up to five years of age.
- Staff will sign an acknowledgement form that includes the individual's name, the date the center's policy was given and explained to the individual, the individual's signature, and the date the individual signed the acknowledgment
- The child care facility shall keep the signed **SBS/AHT staff acknowledgement form** in the staff member's file.

Parents/Guardians

- Within 30 days of adopting this policy, the child care facility shall review the policy with parents/guardians of currently enrolled children up to five years of age.
- A copy of the policy will be given and explained to the parents/guardians of newly enrolled children up to five years of age on or before the first day the child receives care at the facility.
- Parents/guardians will sign an acknowledgement form that includes the child's name, date the child first attended the facility, date the operator's policy was given and explained to the parent, parent's name, parent's signature, and the date the parent signed the acknowledgement
- The child care facility shall keep the signed **SBS/AHT parent acknowledgement form** in the child's file.

* For purposes of this policy, "staff" includes the operator and other administration staff who may be counted in ratio, additional caregivers, substitute providers, and uncompensated providers.

_____
Effective Date

This policy was reviewed and approved by:

_____ _____
Owner/Director (recommended) Date

_____ _____ _____ _____
DCDEE Child Care Consultant (recommended) Date Child Care Health Consultant (recommended) Date

_____ _____ _____ _____
Annual Review Dates

Prevention of Shaken Baby Syndrome and Abusive Head Trauma

Parent or guardian acknowledgement form

I, the parent or guardian of _____ (child or children's name) acknowledge that I have read and received a copy of the facility's Shaken Baby Syndrome/Abusive Head Trauma Policy.

Date policy given/explained to parent/guardian	**Date of child's enrollment**
Print name of parent/guardian	
Signature of parent/guardian	**Date**

Prevention of Shaken Baby Syndrome and Abusive Head Trauma

Staff acknowledgement form:

I _____ (staff name) acknowledge that I have read and received a copy of the facility's Shaken Baby Syndrome/Abusive Head Trauma Policy.

_____
Date policy given/explained to staff person

_____ _____
Staff signature **Date**

NORTH CAROLINA
Child Care Health and Safety Resource Center
800-367-2229
healthychildcare.unc.edu

Medication Administration Permission for Over-the-Counter Topical Medications and Fluoridated Toothpaste

Parent/guardian must authorize staff to apply over-the-counter, topical ointments, topical teething ointment or gel, insect repellents, lotions, creams, powders and fluoridated toothpaste. Sunscreen and baby lotion are examples. Only accept items in their original containers and clearly labeled with the child's name. Keep insect repellents in locked storage and all other items out of reach of children when not in use.

Child's Name _____

Permission is given to apply the following (name/type) _____

Amount _____ Expiration date, if applicable _____
Fluoridated toothpaste should be a rice sized smear for children under 3 and pea sized for children 3 and over.

Permission may be given for up to 12 months. Permission valid from ____/____/____ to ____/____/____

Where to apply the ointment, repellent, lotion, cream, powder or fluoridated toothpaste:

- ❑ all exposed skin
- ❑ face only
- ❑ diaper area
- ❑ toothbrush
- ❑ other (specify) _____

When to apply the ointment, repellent, lotion, cream, or powder:

- ❑ before going outside
- ❑ after a bowel movement
- ❑ after each diaper change
- ❑ before tooth brushing
- ❑ other/as needed for (specify)_____

Describe how to apply the ointment, repellent, lotion, cream, or powder. _____

_____

I give permission to my child care provider to apply the medication listed above as instructed:

_____ _____ _____
Parent/guardian name Parent/guardian signature Date

Medication Administration Permission for Over-the-Counter Topical Medications and Fluoridated Toothpaste

Parent/guardian must authorize staff to apply over-the-counter, topical ointments, topical teething ointment or gel, insect repellents, lotions, creams, powders and fluoridated toothpaste. Sunscreen and baby lotion are examples. Only accept items in their original containers and clearly labeled with the child's name. Keep insect repellents in locked storage and all other items out of reach of children when not in use.

Child's Name _____

Permission is given to apply the following (name/type) _____

Amount _____ Expiration date, if applicable _____
Fluoridated toothpaste should be a rice sized smear for children under 3 and pea sized for children 3 and over.

Permission may be given for up to 12 months. Permission valid from ____/____/____ to ____/____/____

Where to apply the ointment, repellent, lotion, cream, powder or fluoridated toothpaste:

- ❑ all exposed skin
- ❑ face only
- ❑ diaper area
- ❑ toothbrush
- ❑ other (specify) _____

When to apply the ointment, repellent, lotion, cream, or powder:

- ❑ before going outside
- ❑ after a bowel movement
- ❑ after each diaper change
- ❑ before tooth brushing
- ❑ other/as needed for (specify)_____

Describe how to apply the ointment, repellent, lotion, cream, or powder. _____

_____

I give permission to my child care provider to apply the medication listed above as instructed:

_____ _____ _____
Parent/guardian name Parent/guardian signature Date

Albemarle Preschool

"Inspiring excellence and character in a nurturing environment."

Contact Information and Remind App

Preschool Director: Michele Light

Email Address: m.light@thealbemarleschool.org

Preschool Phone Number: 252.338.6496

Main Office & Finance Office: 252.338.0883

Remind App Codes:

Purple Classroom: @c9kgba23

Green Classroom: @862hgk (Previously Yellow Classroom)

Red Classroom: @a96e8a

Blue Classroom: @6fgg99