Jellybean Island at Crossroads Benson, Inc.
301 South Walton Drive
Benson, North Carolina 27504
(919) 894-2101

Thank you for your interest in Jellybean Island. We are so excited that you have inquired about one of the exciting programs that we offer at Jellybean Island.

Enclosed is an information packet about Jellybean Island, as well as the enrollment forms that will need to be completed and returned to Jellybean Island to proceed with enrollment. **This completed enrollment packet is the only way to insure that your child is enrolled or on the waiting list.** We take all applications on a first come, first serve basis, so please respond quickly!!

If you have been told that there are no openings in the class that you are inquiring about, **do not** send the registration fee at this time. If an opening becomes available, we will contact you and you will pay the $40.00 registration fee at that time. Otherwise, please include the $40.00 registration fee along with your application. We will contact you within a few weeks to confirm that your child is enrolled. In some classes, there may only be 1 – 2 spots available, so get your application in ASAP!! If those spots have been filled before we receive your application, we will return your registration fee. Once we have received your child's application, your child will remain on the waiting list until we have a spot available or until you tell us to take them off.

NOTE: The medical forms **do not** have to be returned to hold your child's spot in the class. These forms generally take a while to get back from your doctor and may cause you to lose your child's spot in the class if you wait for them.

Please review the information packet that we have provided and feel free to call me if you have any questions. I will be happy to answer any questions you may have or we can set up an appointment for a discussion.

Thank you again for contacting Jellybean Island at Crossroads Benson,Inc. We look forward to working with you and your child.

Thank you,

Laura Johnson

ENROLLMENT APPLICATION
FOR JELLYBEAN ISLAND at CROSSROADS BENSON, INC.

Please indicate the class that you are enrolling your child in and the year of enrollment

_____ 2-Day class (2 years old) Year _____
_____ 3-Day class (3 years old) Year _____
_____ 5-Day class (5 years old) Year _____
_____ Before School (K-4 @BES & BMS) Year _____
_____ After school (K-4th @ BES& BMS) Year _____
_____ Summer (K–4th) Year _____

Name of child _____
(First) (Middle) (Last)

Name that you want your child to learn to write and be called _____

Child's Birth date _____

Address _____

_____

Home Phone _____

Business Phone (mother)_____ (father)_____

Mobile Phone (mother) _____ (father) _____

E-Mail Address _____

Mother's Name _____

Where Employed _____

Father's Name _____

Where Employed _____

Names of other persons to whom your child can be released to or can be contacted in case of an emergency, if parents cannot be reached

Name _____Relationship _____Phone _____

Name _____Relationship _____Phone _____

Name _____Relationship _____Phone _____

Name _____Relationship _____Phone _____

Name _____Relationship _____Phone _____

To the best of my knowledge, the above information is correct and accurate at the date of enrollment. It is my responsibility to inform the childcare center in writing about any changes to the above information.

Parent Signature_____Date_____

EMERGENCY CARE INFORMATION

NAME OF CHILD_____
FIRST MIDDLE LAST

AGE _____ BIRTHDAY_____

NAME OF PARENTS_____(FATHER)

_____(MOTHER)

ADDRESS_____

HOME PHONE_____ WORK PHONE_____

MOBILE PHONE_____

INSURANCE CARRIER_____

POLICY #: _____

CHILD'S DOCTOR: _____PHONE #_____

ADDRESS_____

CHILD'S DENTIST: _____PHONE#_____

ADDRESS_____

HOSPITAL PREFERENCE_____PHONE_____

ALLERGIES OR ILLNESSES: _____
_____

I agree that the operator may authorize the physician of his/her choice to provide emergency care in the event that neither I nor the family physician can be contacted immediately.

Parent Signature_____ Date_____

EMERGENCY MEDICAL PERMISSION RELEASE

I ,_____, hereby give my permission to Jellybean Island at Crossroads, Benson Inc. to secure emergency medical and or emergency surgical treatment for my child while in the care of this center. Non-emergency medical treatment or elective surgery is not included in this authorization.

Signature of Parent _____ Date_____

FIELD TRIP /OUTSIDE PLAY PERMISSION RELEASE

I, _____, hereby give my permission for my child to participate in a walking trip or be transported in a vehicle for field trips or for the transportation to and from the child care center if such transportation is necessary and requested.

Signature of Parent_____ Date_____

PHOTO RELEASE FORM

As the parent of _____ at Jellybean Island at Crossroads Benson,Inc., I agree to the following:

• I understand that my child whose name is listed above may be photographed at Jellybean Island at Crossroads Benson ,Inc. during normal daycare hours, field trips, or activities.

• I understand and give my permission that these photographs may be used in church or school videos, newspaper articles, mounted on the Jellybean Island at Crossroads Benson, Inc Facebook site, website or any other Jellybean Island at Crossroads Benson ,Inc. publication.

• I understand that I have the right to request, in writing, to have a photo removed from social media within 30 workdays.

( ) Yes, I confirm that I have read and understood the above and I grant my permission

( ) No, I do not wish to have my child photographs published.

Signature:_____ 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

Child's Name _____ **Date of Birth** _____

Instructions: *Enter each date of each dose received (Month/Day/Year)* ***or*** *attach a copy of the immunization record. G.S. 130A-155(b) requires child care facilities to file this information. Please refer to page 2 for the Minimum State Vaccine Requirements for Child Care Entry and the additional Vaccines Recommended by the Advisory Committee on Immunization Practices.*

Vaccine Type	Vaccine Abbreviation	Trade Name	Combination Vaccines	1	2	3	4	5
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***						

Legend:
*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 (and in kindergarten)	5 DTaP	4 Polio	2 MMR	3-4 Hib**	3 Hep B	4 PCV	2 Var

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

Vaccine Type	Vaccine Abbreviation	Trade Name	Recommended Schedule	1	2	3	4	5
Rotavirus	RV Rota	Roteteq Rotarix	2 months, 4 months, 6 months					
Hepatitis A	Hep A	Havrix Vaqta	12-23 months, then another dose within 6-18 months					
Influenza	Flu	Fluzone Fluarix FluLaval Fluvirin FluMist Afluria	Annually after 6 months of age					

Name of Center:_____

Discipline and Behavior Management Policy

Date Adopted _____

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"
12. DO stay consistent in our behavior management program.

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/coordinator (or other designated staff member) has discussed the facility's Discipline and Behavior Management Policy with me.

Date of Child's Enrollment:_____

Signature of Parent or Guardian_____Date_____

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

“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