2023-2024 Application

DCDEE Child Care Application – This information is required by the Division of Child Development and Early Education for enrollment in any licensed daycare/preschool facility. Please answer all questions. If something is *Not Applicable,* please write "NA" on the line.

Today's Date _____

Child's Full Name: _____ **Birthdate:** _____
(First) (Middle) (Last)

Social Security Number: _____ **Gender:** _____

Race: Is your child: ***(Please circle one)*** Hispanic/Latino or Not Hispanic/Not Latino
and circle as many as apply below
American Indian/Alaska Native Asian Black/AA Native Hawaiian/Pacific Islander White

Child's Address: _____
Street Address City State Zip P.O. Box #

Family Information: Child lives with _____

Mother's/Legal Gurdian's Name _____

Home Phone: _____ **Cell Phone:** _____

Work Phone: _____ **Email:** _____

Mother's Physical Address: (if different from child's) _____

Mother's Mailing Address: (if different from child's) _____

Where employed: _____

Father's Name/Legal Guadians's _____ **Home Phone:** _____

Cell Phone: _____ **Work Phone:** _____ **Email:** _____

Father's Physical Address: (if different from child's) _____

Pages 1-3 should be completed by all applicants/students. Children that will be 4 years of age by August 31st should also complete pages 4-6. If your child will ***not*** be 4 by August 31st, pages 4-6 are not required.

Father's Mailing Address: (if different from child's)_____

Where employed: _____

Contacts: Child will be released only to the parents/guardians listed above and to the individuals listed below, as authorized by the person who signs this application.

Name	Relationship	Address	Phone Number
1			
2			
3			

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
1			
2			
3			

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 _____

_____

Insurance Carrier for your child: _____Policy #_____

EMERGENCY MEDICAL CARE INFORMATION: (These questions REQUIRE a specific name of a health care provider and a hospital. After you list your preference, you may write "or closest" beside the name of the hospital.

Name of health care professional_____ Office Phone: _____

Hospital Preference_____ Phone:_____

Dental Provider_____ Phone: _____

I, as the parent/guardian, authorize the center to obtain medical attention for my child in an emergency.

_____ _____

Parent/Guardian Signature **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 any medication without specific instructions from the physician or the child's parent, guardian, or full-time custodian.

_____ _____

Signature of Operator of Administrator or Designee **Date**

Date Application Received by the Center:_____ **Date of Enrollment:**_____

Pages 1-3 should be completed by all applicants/students. Children that will be 4 years of age by August 31st should also complete pages 4-6. If your child will ***not*** be 4 by August 31st, pages 4-6 are not required.

The application is to be completed, signed, and placed on file in the facility on the first day and updated as changes occur and at least annually.

Is either parent currently in the Military? ( ) Yes ( ) No If yes, which parent/branch? _____

Has either parent been seriously injured while in the military? ( ) Yes ( ) No If yes, explain: _____

_____

Please complete chart below:

	MOTHER		FATHER	
	YES	**NO**	**YES**	**NO**
Are you currently looking for work?				
In post-secondary education?				
In high school or in a GED program?				
In job training?				
Other (explain)				

Does your child live with both natural parents? __Yes __No If no, please explain with whom he/she lives:
___Mother Only ___Father Only ___Mother and Stepfather ___Father and Stepmother
___Foster Parents ___Grandparents ___ Other_____

If your child is living with anyone other than natural parents, is the person(s) a legal guardian(s)? _____

Total number of children in the home_____ Total number of adults in the home____

Please list all of applicant's brothers and sisters below. Use back of sheet if needed.

	Name	Age	DOB	Lives at home?
1.	_____	_____	_____	___Yes ___No
2.	_____	_____	_____	___Yes ___No
3.	_____	_____	_____	___Yes ___No
4.	_____	_____	_____	___Yes ___No

Income Information

Please note that the income you report *needs to be exact*. Approximations of income will not allow for the calculations needed to determine your child's eligibility. Please note that PROOF OF INCOME IS REQUIRED at the time of application. If proof of income is not provided your child's application WILL NOT be assessed for eligibility. Examples of proof of income include: previous year's tax records if the information is reflective of your current income, consecutive paystubs (please provide a month's worth of paystubs if possible), a letter from an employer stating your monthly or yearly income, statements from DSS… NC Pre-K offers this guidance when calculating your income:

Count parent and stepparent's regular GROSS income. Regular *gross* income (before taxes) which may include income earned through sales commissions averaged over several months, regular employment through a temporary employment agency, child support, alimony payments, and workman's compensation. **Excluded from regular gross income** are parent, stepparent and child Supplemental Security Income, adoptive assistance, foster care payments, and irregular income (e.g., over-time, temporary unemployment pay, Work First, Food Stamps, student loans).

When calculating income convert weekly income to annual by multiplying weekly amount by 4.3 to obtain monthly amount and then multiply the monthly amount by 12 for the annual amount.

PLEASE DO NOT LEAVE BLANK IF YOU WISH YOUR CHILD'S APPLICATION TO BE ASSESSED FOR ELIGIBILITY! Proof of income is required

Mother **Average hours worked per week:_____**

Wages before taxes: _____ ( ) weekly ( ) monthly ( ) twice monthly ( ) bi-weekly ( ) yearly

Alimony: _____ ( ) weekly ( ) monthly ( ) twice monthly ( ) bi-weekly ( ) yearly

Child Support: _____ ( ) weekly ( ) monthly ( ) twice monthly ( ) bi-weekly ( ) yearly

****

Father **Average hours worked per week:_____**

Wages before taxes: _____ ( ) weekly ( ) monthly ( ) twice monthly ( ) bi-weekly ( ) yearly

Alimony: _____ ( ) weekly ( ) monthly ( ) twice monthly ( ) bi-weekly ( ) yearly

Child Support: _____ ( ) weekly ( ) monthly ( ) twice monthly ( ) bi-weekly ( ) yearly

****

***If the applicant lives with a Legal Guardian then their income is counted; however, a legal custodian's income is not counted. Please provide a copy of the court papers that address the guardian/custodian status so the proper income can be counted.**

Pages 1-3 should be completed by all applicants/students. Children that will be 4 years of age by August 31st should also complete pages 4-6. If your child will ***not*** be 4 by August 31st, pages 4-6 are not required.

Legal Guardian: (Not Parent)_____**Average hours worked per week:**_____

Wages before taxes: _____ ( ) weekly ( ) monthly ( ) twice monthly ( ) bi-weekly ( ) yearly

Legal Custodian or other caregiver: Average hours worked per week:_____

Wages before taxes: _____ ( ) weekly ( ) monthly ( ) twice monthly ( ) bi-weekly ( ) yearly

Child(ren)'s Income _____ (child's income, including Social Security Income and Child Support Payments. *Count income from any minor siblings living in the home.* Do not count Supplemental Security Income.)

Daycare Information: Has your child ever attended childcare or preschool? _____ If yes, please answer the following questions.

Name of childcare/preschool? _____

Is he/she enrolled there now? _____When did your child attend this daycare/preschool? _____

If your child is currently enrolled in daycare are any of the daycare fees being subsidized by DSS or Smart Start?
YES NO

Language: What is the first language spoken at home? _____

Assurance Statement: I certify that all information given is true and all income has been reported. I understand that if I purposely give false information, my child may lose the preschool placement, if accepted, and that I may be prosecuted.

_____ _____

PARENT/GUARDIAN SIGNATURE **DATE**

PLEASE MAIL COMPLETED APPLICATIONS TO:
Ms. Carledia Dozier
Gatesville Elementary School
709 Main Street
Gatesville, NC 27938

IF YOU HAVE QUESTIONS, PLEASE CALL
Ms. Carledia Dozier
Preschool Coordinator
357-4133
doziercv@gatescountyschools.net

****Please mail or bring your application to Gatesville Elementary School.** If brought to the school, please ask the Office Secretary to place the application in Carledia Dozier's mailbox. *Please do not send completed applications to school by students. These are easily misplaced and contain sensitive information.*

For use by the NC Pre-K Program

Application Reviewed by: _____**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 #**_____