South Carolina Department of Social Services
Child Care Regulatory Services

GENERAL RECORD AND STATEMENT OF CHILD'S HEALTH FOR ADMISSION TO CHILD CARE FACILITY

This form is to be completed for each child at the time of enrollment in the child care facility, updated as needed when changes occur, and maintained on file at the facility.

GENERAL INFORMATION: (to be completed by Parent or Guardian)

Name of Facility: _____ County: Select County ...

Address: _____
Street Address – no Post Office Boxes | City, State, Zip

Child's Name: _____
Last | First | Middle Initial | Nick Name

Date of Birth: _____ Enrollment Date: _____

Child's Current Home Address: _____
Street Address | City, State, Zip

Parent/Guardian's Full Name: _____

Home Phone: _____ Work Phone: _____ Other Phone: _____

Parent/Guardian's Full Name: _____

Home Phone: _____ Work Phone: _____ Other Phone: _____

You must have two individuals who have the authority to obtain emergency medical treatment for the child.

1. Person responsible if parent/guardian unavailable for emergency medical services:

_____
Full Name | Relationship

Address: _____
Street Address | City, State, Zip

Telephone Number(s): _____ Family Code Word(s): _____

2. Person responsible if parent/guardian unavailable for emergency medical services:

_____
Full Name | Relationship

Address: _____
Street Address | City, State, Zip

Telephone Number(s): _____ Family Code Word(s): _____

Is Child currently enrolled in school? (5K up to 6 years old) ☐ Yes ☐ No

My Child will regularly attend this facility **FROM** _____ am/pm **TO** _____ am/pm

If Child is a drop-In, indicate hours of care: **FROM** _____ am/pm **TO** _____ am/pm

Check all days Child will regularly attend this facility: ☐ **Mon** ☐ **Tue** ☐ **Wed** ☐ **Thurs** ☐ **Fri** ☐ **Sat** ☐ **Sun**

Check all meals Child will receive daily: ☐ **Meals are not offered** ☐ **Breakfast** ☐ **Morning Snack** ☐ **Lunch** ☐ **Afternoon Snack** ☐ **Dinner** ☐ **Evening Snack**

HEALTH INFORMATION: (to be completed by Parent or Guardian)

Family Physician or Health Resource: _____
Name

_____
Street Address | City, State, Zip | Telephone

Emergency Care Provider: _____
Emergency Facility Name

_____
Street Address | City, State, Zip | Telephone

Dental Care Provider: _____
Name

_____
Street Address City, State, Zip Telephone

Health Insurance Provider: _____

Certificate of Immunization: ☐ Yes ☐ No ☐ N/A Please explain: _____

My child has the following health conditions such as allergies, asthma, diabetes, epilepsy, etc., and/or takes the following medications on a regular basis:

Additional Comments: _____

I certify that to the best of my knowledge _____
Child's Name
is in good mental and physical health and able to participate in the child care program at

_____
Name of Child Care Facility

Signature: _____ Date: _____
Parent or Guardian

Signature: _____ Date: _____
Director/Operator/Staff Designee

The King's Kids of Greenwood
Childcare Application

Today's Date: _____Start Date: _____Classroom_____

CHILD INFORMATION: 114-503 (G) (5) (a) CODE WORD _____

Name _____ Name child is called _____

Date of Birth _____ Male _____ Female _____

Home Address _____

Street City State Zip _____

PLEASE PROVIDE BIRTH CERTIFICATE (ORIGINAL) OR PASSPORT (ORIGINAL) and we will make a copy.

PARENT OR GUARDIAN INFORMATION: 114-503 (G) (5) (b)

Name _____ E-mail _____

Address _____

If different from child's Street City State Zip

Driver License # _____ (Include state) Cell _____

Place of Employment & Occupation _____

Home _____ Work _____

PARENT OR GUARDIAN INFORMATION: 114-503 (G) (5) (b)

Name _____ E-mail _____

Address _____

If different from child's Street City State Zip

Driver License # _____ (Include state) Cell _____

Place of Employment & Occupation _____

Home _____ Work _____

Are Parent's divorced/separated? _____ Who has Custody? _____

Responsible party to appear on billing statements? _____

CHILD'S PERSONAL HISTORY:

Is the child right-handed or left handed? _____

Please list any other persons living with the child and their relationship (if any) to the child:

_____

_____

Previous preschool experience: _____ Where and when: _____

Allergies: _____ If so, please list: _____

Are there any medical or emotional problems of which we should be aware? _____

_____

Please list any other information such as premature birth, napping/eating instructions, discipline, communication, fears: _____

Languages spoken at home: _____

Feeding habits or traditions at home (e.g., how does your family eat dinner?)

_____

Describe any cultural or religious beliefs that your child's teachers should know:

_____

_____

Please list anything else you would like your child's teacher to know:

_____

_____

What do you expect your child to gain from their experience this year at our Center?

_____

_____

EMERGENCY MEDICAL PLAN 114-505 C

In the case of a medical emergency in which emergency medical care and treatment is warranted, the following steps will be followed:

- Call 911 Emergency Medical Service for First Responders team to come to the Center and the parent/guardian will immediately be called after that.
- If parents cannot be reached, the Center will attempt to reach the emergency contacts and then the physician listed.
- If CPR or First Aid is necessary, trained staff will administer treatment until the ambulance arrives.
- First Responders will assess and determine whether the child needs to be taken to the nearest hospital or parents' preferred hospital by ambulance.
- Emergency information for the child will be taken with the child to the hospital or emergency room Emergency information for the child shall be taken with the child to the hospital or emergency location.
- A teacher will accompany the child to the hospital or emergency location and remain until a parent or guardian arrives.
- A qualified staff member will be assigned to the classroom until the regular teacher returns.

In the event of an emergency and we are unable to reach you, please give another two authorized emergency contacts:

1.Name _____ Relationship to Child _____
Address _____
Telephone_____ Driver's License # _____

2. Name _____ Relationship to Child _____
Address _____
Telephone_ _____ Driver's License # _____

Child's Physician _____ Telephone _____
Address _____ Hospital Preference _____
Child's Dentist _____ Telephone _____
Address _____

In the event of an emergency in which I cannot be reached, the physician listed above and the local hospital are hereby authorized to provide any emergency care deemed necessary for my child. I understand that every effort will be made to contact me or my spouse before such action is taken. I will be responsible for the payment for such care or treatment.

Signature of Parent or Guardian _____ **Date** _____

Medication Authorization AND ADMINISTRATION 114-505 D 114-503 F(3)e

The Center requires written authorization to administer any medication or medical treatment. Prescription medication must be in the original pharmacy-labeled container, with the child's first name, last name, name of medication, dosage amount, times of the day the medication is to be administered and frequency of dosage. Over-the-counter medication may be administered under the following conditions:

- Medication is in the original, labeled container
- All medications shall be used only for the child for whom the medication is labeled. Container has been labeled with the child's first and last name
- Written authorization is provided by parent or legal guardian
- Administered according to dosage indicated by the manufacturer, unless written authorization for an alternative dosage is provided by a licensed health care provider
- Administered for one date only unless accompanied by written authorization from a licensed health care provider

All medications shall be kept in their original labeled containers and have child protective caps. The child's first and last name shall be on all medications. All medications shall be stored in a separate locked container under proper conditions of sanitation, temperature, light, and moisture. Discontinued and expired medications shall not be used and shall be returned to the parent or disposed of in a safe manner.

Any errors in administration of medication will be reported immediately to the family and notified in writing of a medication error or a suspected adverse reaction to medication, and shall be recorded in the child's record.

To meet DHEC's standards (Department of Health and Environmental Control) if a child has an Epi-Pen, it should be stored in a First Aid Kit that is readily accessible in the event of an emergency. Staff must be trained to administer emergency medication. Parents should complete an Emergency Consent Form to allow the staff to administer an Epi-Pen.

Signature of Parent or Guardian _____ **Date** _____

PERSONS AUTHORIZED TO PICK UP CHILD 114-503 (G) (5) I

Name _____ Driver's License # _____
Name _____ Driver's License # _____
Name _____ Driver's License # _____
Name _____ Driver's License # _____
Name _____ Driver's License # _____

Signature of Parent or Guardian _____ **Date** _____

CONFIDENTIALITY 114-503 (1)

I understand _____ will keep required records on attendance, health, transportation, registration, parent/guardian and emergency contact information. Student records will be kept confidential. Files will be locked. Duplication of some information will be accessible through our Child Care Management software, which is accessible to authorized staff only. Administrators will have access for record-keeping. Staff will have access to emergency information and parent contact/address; this duplication will also be kept confidential. Administration/staff will not give out information concerning a child to other parents. Staff is to share pertinent information concerning a child with caregivers, administration and the child's parents. DSS/DHEC Law enforcement will have access to needed records per inspections/guidelines of South Carolina.

Signature of Parent or Guardian _____ **Date** _____

DISCIPLINE POLICY 114-503 (G) (5) (E)

No corporal punishment. This means that we will not inflict any physical discipline upon a child as punishment. This includes, but is not limited to, spanking, slapping, and hitting.

Signature of Parent or Guardian _____ **Date** _____

MANDATORY REPORTING

I understand _____ is mandated by state law to report any cases where there is reasonable cause to believe that a child is being neglected, exploited, deprived, sexually assaulted, sexually exploited, physically injured or suffered death by other accidental means by a parent, guardian or caretaker to the proper authorities. To avoid any misunderstandings, parents are encouraged to keep _____ (center name) aware of any unusual bruising or injuries occurring at home.

Signature of Parent or Guardian _____ **Date** _____

SCHEDULED ACTIVITY

Please notify the Center if your child has any scheduled activities or will be picked up or dropped off by someone else due to any scheduled activities. A DSS form 2930 must be filled out and returned to the center for any therapy or extracurricular activities. You can request a form at the front desk.

Signature of Parent or Guardian _____ **Date** _____

SUNSCREEN/DIAPER CREAM PERMISSION

To help protect your children from the sun's rays, please provide a bottle of sunscreen for your child labeled with their name. It will be applied (as needed) before any outside activities. Spray sunscreen may not be used due to children's allergies. My Child, _____(print) has my permission to have his/her sunscreen applied prior to outside activities.

Signature of Parent or Guardian _____ **Date** _____

In the event of diaper rash, please provide diaper cream. Over the counter diaper cream can be administered with parent/guardian permission without a prescription. It will be applied as needed.
My Child, _____ (Print) has my permission to have diaper cream applied.
Signature of Parent or Guardian _____ **Date** _____

SWIM PERMISSION: 114-503 (G) (5) (h) (G) (5) (i) IF APPLICABLE

I, _____ (Print) give permission for my child,_____(Print) , to participate in swimming activities.
Signature of Parent or Guardian _____ **Date** _____

TRANSPORT/FIELD TRIP PERMISSION : 114-503 (G) (5) (h) (G) (5) (i) IF APPLICABLE

I, _____(Print) authorize _____ to transport my child, _____(Print) to and from the facility (school transport) and during field trips or in case of emergency.
Signature of Parent or Guardian _____ **Date** _____

TRACKING POLICY

A parent/guardian or another adult must accompany every child to the classroom and notify the teacher that the child is present. Please recognize that for safety reasons children may not walk to their classrooms alone. The parent/guardian must inform classroom teacher when a child leaves the classroom, goes outside on the playground and leaves at the end of the day. The Academy is not responsible for the child until a teacher recognizes the child as being present.
The classroom teachers will enter the time of each child's arrival and departure on the classroom's Tracking Sheet. Every time the children transition* to a different location, the teacher(s) will make a headcount of the students and record the information on the Tracking Sheet. Teacher will make sure to match each child with their name on the Tracking Sheet. *Transition means when children move from indoors to outdoors, from outdoors to indoors, when they enter and exit a vehicle or move to a new location in and around the center or anywhere else that we have responsibility for the child.
Signature of Parent or Guardian _____ **Date** _____

LIABILITY INSURANCE COVERAGE STATEMENT

Please be informed that we provide liability insurance coverage for this facility. By signing this form, you are acknowledging that you are fully aware of the liability insurance at this time.
Signature of Parent or Guardian _____ **Date** _____

PROVISIONAL STAFFING:

Occasionally to meet proper ratios and to ensure child safety, with approval from state licensing, we may hire provisional staffing. Until all paperwork has been approved the provisional staff will remain in direct supervision of our director or program manager.
Signature of Parent or Guardian _____ **Date** _____

FREE AND FULL ACCESS:

The _____ (center name) grant parents of children enrolled free and full access unless court order stipulates otherwise. The visit must not disrupt instructional activities or classroom routines.
Signature of Parent or Guardian _____ **Date** _____

PHOTO RELEASE FORM

I, (print name) _____, parent or official guardian of (child's name) _____hereby grant permission to _____ representatives, to take and use: photographs and/or digital images of my child for use in news releases and/or materials as follows: printed publications or materials, marketing materials, electronic publications, or Web sites. I acknowledge _____ right to crop or treat the photograph(s) at its discretion. I also acknowledge that _____may choose not to use my child's photograph(s) at this time, but may do so at its own discretion at a later date. I agree that my child's name and identity will not be revealed in descriptive text or commentary in connection with the image(s). I authorize the use of these images without compensation to me. All negatives, prints and digital reproductions shall be the property of _____. I also understand that once my child's image is posted on _____ website, the image can be downloaded by any computer user.

I give my consent for my child's photo to be used for the following purposes:

Yes No

- ☐ ☐ **Printed Publications** (News releases, brochures, newspapers, etc.)
- ☐ ☐ **Digital Publications/Marketing** (Facebook, website, marketing material)
- ☐ ☐ **Classroom Use** (Picture on cubbies, walls, tables, artwork etc.)
- ☐ ☐ **Class Private Facebook Group** (Private pages are by invitation only)

☐ **PLEASE DO NOT USE MY CHILD'S PHOTO FOR ANY OF THE ABOVE PURPOSES**

Signature of Parent or Guardian _____ **Date** _____