Little Lights Learning Center
—A Ministry of Clemson UMC—

Child Enrollment Form

Child's Full Name: _____ Nickname: _____

D.O.B.: ____/____/_____ Gender: _____ Preferred Enrollment Date: ____/____/_____

Parent Contact Information:

Parent/Guardian Name: _____Relationship: _____

Address: _____

Cell: _____ Home: _____ Work: _____

Employer: _____ Occupation: _____

Preferred Email Address: _____

Parent/Guardian Name: _____Relationship: _____

Address: _____

Cell: _____ Home: _____ Work: _____

Employer: _____ Occupation: _____

Preferred Email Address: _____

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Separated ☐ Other: _____

Custody Information:

☐ If custody of this child has been removed from one or both of the parents, please indicate who has legal custody of the child and provide a copy of the custody papers.

_____

☐ Please name anyone prohibited by court order from having contact with the child and provide a copy of the court order.

_____

☐ Please name all persons that you prohibit from having any interactions/contact with your child (no court documents).

_____

Emergency Medical Information Form

Child's Full Name: _____D.O.B.: ____/____/_____

Child's Home Address: _____

Parent/Guardian Name: _____ Phone: _____

Parent/Guardian Name: _____ Phone: _____

Medical History/Information

Allergies/Symptoms: _____

Previous Operations: _____

Medical Conditions: _____

Child's Physician: _____Phone: _____

Emergency Hospital Preference: _____

Child's Dentist: _____Phone: _____

Name of Insurance Company: _____ Name of Insured: _____

Group #: _____ Policy #: _____

Medical Release Statement

I hereby agree that the staff of Little Lights Learning Center may secure transportation for my child via EMS to our local preferred emergency hospital listed above if I cannot be reached in an emergency. I understand that my child may have to be taken to a closer emergency room if his/her injury/illness requires it. In the event of illness or accident, which requires immediate medical treatment at a time when a parent/guardian cannot be located/reached, I give permission for Little Lights Learning Center personnel to authorize such treatment. I also agree that the attending physician may assume treatment and diagnostics procedures, including an operation and/or the administration of the necessary anesthesia/medications in the event of serious or major injury if the parents/guardians/emergency contacts cannot be reached in advance. I will not hold LLLC or medical personnel responsible. This is done with the understanding that every attempt will have been made to contact the parents/guardians, the child's physician, and other persons listed for emergency contact. I agree to be fully responsible for all medical expenses accrued for the treatment of my child.

Signature of Parent/Guardian: _____**Date:** _____

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Emergency Contact Information

Child's Full Name: _____D.O.B.: ____/____/_____

Parent/Guardian Name: _____ Phone: _____

Parent/Guardian Name: _____ Phone: _____

The following individuals are:

- Authorized to pick up my child from Little Lights Learning Center; and
- Authorized to be called in case of an emergency, when parents/guardians cannot be reached.

Name: _____ DL #: _____
Phone #: _____ Relationship: _____

Name: _____ DL #: _____
Phone #: _____ Relationship: _____

Name: _____ DL #: _____
Phone #: _____ Relationship: _____

Name: _____ DL #: _____
Phone #: _____ Relationship: _____

Name: _____ DL #: _____
Phone #: _____ Relationship: _____

Name: _____ DL #: _____
Phone #: _____ Relationship: _____

**PLEASE NOTE: If your child becomes ill or injured at Little Lights Learning Center, and you cannot be reached, one of these people will need to be available to pick up your child.

*Signature of Parent/Guardian:*_____ *Date:*_____

Please initial beside the appropriate responses below. Please sign and return to the Director prior to your child's first day of attendance at LLLC.

Photo Release:

_____I *give* permission for photographs that include my child to be used by Little Lights Learning Center for purposes of center/classroom displays, center website, center Facebook page, and articles/advertisements.

_____I *do not give* permission for photographs that include my child to be used by Little Lights Learning Center for purposes of center/classroom displays, center website, center Facebook page, and articles/advertisements.

Field Trip Release:

_____I *give* permission for my child to participate in excursions on church property and to participate in announced field trips. I understand excursions on the church property are a part of the scheduled activities of Little Lights Learning Center. I understand that off-site, ANNOUNCED, field trips will be taken. Transportation will be provided by LLLC teachers/Directors and other parents in the class. Additional forms and permission slips will be provided regarding each field trip before children are permitted to attend.

_____I *do not give* permission for my child to participate in any field trips off-site of LLLC and CUMC.

Swimming Activities Release:

_____I *give* permission for my child to participate in swimming activities (swimming, wading, or floating in water) when the activity has been previously announced (parent permission slip required) and when the following staff:child ratios are followed: Birth to Two years 1:1; Two to Three years 1:2; Three to Four years 1:3; Four to Five years 1:6; and Five years and older 2:25.

_____I *do not give* permission for my child to participate in any swimming activities under any circumstances.

Supervised Water Activities Release:

_____I *give* permission for my child to participate in supervised water activities that are not swimming activities. I understand that my child may participate in water activities such as play at the sensory table with water, playing in a water sprinkler outside, playing with water balloons, or other water related toys.

_____I *do not give* permission for my child to participate in any supervised water activities.

Application Release:

_____I *give* permission for my child's teacher to apply diaper cream, ointment for cuts and scrapes, sunscreen and insect sting spray, as needed.

_____I *do not give* permission for my child's teacher to apply diaper cream, ointment for cuts and scrapes, sunscreen and insect sting spray, as needed.

Parent Handbook Acknowledgement:

- ☐ I acknowledge that I have received and read the Parent Handbook regarding policies and procedures of Little Lights Learning Center;
- ☐ I agree to adhere to the policies and procedures that are listed in the LLLC Parent Handbook; and
- ☐ I understand that procedures and/or policies will occasionally need to be updated, revised, added, or deleted from the LLLC Parent Handbook. I understand that I will be notified of any changes made to the handbook through email, newsletter, and/or letter sent home.

Enrollment Date: _____/_____/_____

- ☐ I understand the payment schedule and payment obligation and agree to fully comply and adhere to LLLC Policies and Procedures.
- ☐ Neither I, nor anyone authorized by me to pick up or drop off my child, will allow him/her to enter or leave the school without an escort. I understand that the school will not allow my child to enter or leave the school property without an escort.
- ☐ In case of emergency, I hereby give permission to LLLC staff to give first aid or take my child to a physician for medical or surgical care. I understand that an effort will be made to contact me or my spouse, if possible, before any action will be taken. I understand that any expense incurred will be accepted by me.
- ☐ I understand that I must sign a separate medication authorization form that allows my child to receive medication while in LLLC's care.
- ☐ I acknowledge that it is my responsibility to keep my child's records current to reflect any significant changes as they occur, i.e. address, telephone numbers, work locations, emergency contacts, physician information, health status, infant feeding plans, and immunization records, etc. I understand LLLC will keep this information confidential at all times.
- ☐ I understand that I am responsible for notifying the center of any significant changes in enrollment information such as phone numbers, work location, emergency contacts, and persons authorized to pick up child, etc. I understand LLLC will keep this information confidential at all times.
- ☐ LLLC agrees to keep me informed of any incidents, including illnesses, injuries, adverse reactions to medications, etc., which include my child.

*Signature of Parent/Guardian:*_____ *Date:*_____

Reset

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