Enrollment Date: _____/_____/__________

**Registration for Childcare**

**This information will be kept confidential at all times.**

**Child's Full Name: _____________________________________________ D.O.B.: ____/____/________**

Nickname: _________________________ Child's Address: ___________________________________________________

Lives With (circle one): MOM DAD OTHER: _______________________

**Parent Contact Information:**

Mother's Name: _____________________________________________________

Cell: __________________________ Work: __________________________ Home: _________________________

Mother's Email: ________________________________________________________________________________

Father's Name: ______________________________________________________

Cell: __________________________ Work: __________________________ Home: __________________________

Father's Email: __________________________________________________________________________________

**Child's Physician:**

Name: _____________________________________________ Phone: ________________________________________

Address: ___________________________________________________________________________________________

**Health Information:**

Medical Conditions: __________________________________________________________________________

Allergies: ____________________________________________________________________________________________

Additional Information: ______________________________________________________________________

**Person(s) other than parents who may be contacted in case of an emergency:**

1) Name: _________________________________ Phone: _______________________ Phone: ____________________

Relationship: ______________________________ Address: ____________________________________________

2) Name: _________________________________ Phone: _______________________ Phone: ____________________

Relationship: ______________________________ Address: ____________________________________________

**Person(s) other than parents who are authorized to pick up your child:**

1) Name: _________________________________ Phone: _______________________ Phone: ____________________

Relationship: ______________________________ DL #: ________________________________________________

2) Name: _________________________________ Phone: _______________________ Phone: ____________________

Relationship: ______________________________ DL #: ________________________________________________

***DO NOT PICK UP- Please list any individuals who are NOT allowed to have contact with or pick up your child(ren):***

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UPDATED: ____/____/________

Enrollment Date: _____/_____/__________

# Vehicle Emergency Medical Information

**This information will be kept confidential at all times**

Child's Name: ______________________________________________DOB: __________________________

Home Address: ____________________________________________________________________________

Mother's Name ____________________________________________________

Work _______________________ Cell ________________________ Home _________________________

Father's Name _____________________________________________________

Work _______________________ Cell ________________________ Home _________________________

Person(s) to notify in case of an emergency when parents cannot be reached:

Name: _____________________________________________ Relationship: ___________________________

Phone: ______________________________________ Phone: _____________________________________

Child's Doctor: __________________________________________ Phone ____________________________

Allergies __________________________________________________________________________________

Current Prescribed Medications: _____________________________________________________________

Medical Conditions: ________________________________________________________________________

In the event of illness or accident, which requires immediate medical treatment at a time when a parent cannot be located, I give permission for Little Lights Learning Center staff personnel to authorize such treatment. I will not hold the center or medical personnel responsible. This is done with the understanding that every attempt will have been made to contact the parents, the child's physician, and other persons listed for emergency contact. I agree to be fully responsible for all medical expenses incurred for the treatment of my child.

Child's Name: ____________________________________________________________________________

Parent Signature: ________________________________________________ Date: __________________

Witnessed by: ____________________________________________________ Date: __________________

UPDATED: ____/____/________

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: ______________

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

**Please initial by each policy below stating that you have read the parent handbook in its entirety and understand the following:**

__________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.

__________ I understand that no swimming activities will take place at LLLC.

__________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.

___________I understand that occasionally, LLLC uses photographs of children in their publications and I hereby give my permission for LLLC to use and identify my child in publications such as church newsletters, bulletin boards, brochures, church and center website, LLLC FaceBook Page, videos, and local newspapers.

___________I have received and read a copy of the LLLC Parent handbook and agree and understand the Policies and Procedures for Little Lights Learning Center.

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**Sunscreen Application Permission Statement:**

I, _________________________________, am the parent/legal guardian of ________________________.
I acknowledge that I have read the ingredients on the label of the sunscreen I have provided for my child. I agree for the staff of Little Lights Learning Center to apply the sunscreen I have provided to my child daily, prior to sun exposure. I have labeled my child's sunscreen with their full name.

**Parent Signature:** _____________________________________ **Date:** ___________________________

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***Please sign and return to the Director prior to your child's first day of attendance at LLLC.**