



A Ministry of First Baptist North Spartanburg
8740 Asheville Highway, Spartanburg, South Carolina 29316
Phone (864) 578-4238 • Fax (864) 542-1846
www.scawarriors.org

2018 SUMMER CAMP REGISTRATION

\$50.00 Non-Refundable Registration Fee Due with Application

- A weekly reservation must be made by calling 578-4238 by the Wednesday prior to the week your child will attend.
- If a weekly reservation has been made and the child does not attend, a \$50 no-show fee must be paid the following Monday your child attends. Students cannot attend Summer camp until fee has been paid.
- Summer camp is available 7am-6pm each day. Students picked up after 6pm will incur a late charge of \$10 for every 10 minutes they are picked up late. This fee is due upon pick up of the student.

STUDENT'S NAME: _____ Grade (in the Fall): _____

Address: _____

City: _____ State : _____ Zip Code: _____

Gender: Male Female Date of Birth: ____/____/____

Home Phone Number: _____

Father's Name: _____ Cell Phone: _____

Employer: _____ Work Phone: _____

Mother's Name: _____ Cell Phone: _____

Employer: _____ Work Phone: _____

Emergency contact if parents cannot be reached. Please list in the order they are to be called:

Name: _____ Phone: _____ Relationship: _____

Name: _____ Phone: _____ Relationship: _____

CHILDREN WILL ONLY BE RELEASED TO PARENTS OR TO A PERSON DESIGNATED BY THE PARENTS.

List individuals that may pick up child (Name and relationship to child):

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

PERSON RESPONSIBLE FOR BILLING ACCOUNT

Name: _____ Relationship to child: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Email Address: _____ (Bills are sent out via email.)

Registration for Summer Camp includes the Registration Form, Medical Permission Form and DSS Form 2900.

MEDICAL PERMISSION FORM

STUDENT NAME: _____ Grade (in the Fall): _____

List medication(s) taken regularly: _____

Are there any known allergies? Yes No Describe: _____

Please list any other medical problems your child has: _____

The following non-prescription medications are available in the office. Please indicate which medications your child can be given:

_____ *Tylenol* _____ *Ibuprofen* _____ *Benadryl* _____ *Tums* _____ *Pepto-Bismol*
_____ *Eye Drops* _____ *Neosporin* _____ *Vaseline* _____ *Sunscreen*

Parent must be contacted BEFORE administering approved non-prescription medications listed above: Yes No

I give permission for my child to be transported to and from Summer Day Camp for field trips: Yes No

In order to maintain DSS compliance, SCA is only authorized to accept fully potty trained students, as our caregivers may not enter the restroom with a child. These requirements have been explained to me and I understand this includes pulling clothing up/down, zipping/unzipping clothing, wiping private areas, and changing of clothes. While accidents may infrequently occur with preschool children, this should be the exception, not the norm. This policy reflects DSS guidelines and is not necessarily the opinion of school personnel. This information has been explained and I understand separation may become necessary if training issues arise.

Parent's Signature: _____

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