WARRIOR OVERTIME 5K-5TH GRADE APPLICATION

Child's Name: _____ Grade: _____ for the school year_____

Street Address: _____

City: _____ State: _____ Zip Code: _____ Sex: ___M ___F Date of Birth: __/__/___

Please check the Warrior Overtime option below:

WARRIOR OVERTIME OPTION	Monthly	Daily
☐ Before School Care ONLY	$35	$5
☐ 5K-5th Grade	$250	$20

FOR OFFICE ONLY:

DSS Form 2900____

Registration Fee Billed _____

PLEASE CHECK PAYMENT PLAN:

☐ Bill Monthly Fee ☐ Bill Daily Fee *(as used)*

Emergency Phone Number: _____

Custodial Father's Name: _____ Phone Number: _____

Email Address: _____

Custodial Mother's Name: _____ Phone Number: _____

Email Address: _____

Who does the student live with? _____

Copy of Child Custody decree (if applicable) or any legal papers pertaining to parent restrictions must be on file in SCA front office.

CHILDREN WILL ONLY BE RELEASED TO CUSTODIAL PARENTS OR TO A PERSON DESIGNATED BY THE PARENTS ON THE WARRIOR OVERTIME APPLICATION.

Besides parents listed above, please list individuals that may pick up child (name and relationship to child):

(1) _____ Relationship: _____ Phone #:_____
(2) _____ Relationship: _____ Phone #:_____
(3) _____ Relationship: _____ Phone #:_____

WARRIOR OVERTIME MUST BE NOTIFIED IN WRITING OF ANY CHANGES TO THE PICK UP LIST.

List medication(s) taken regularly: _____

Are there any known Allergies? _____ if yes, please describe _____

Please list any other medical problems your child has _____

In the event of an emergency, SCA will obtain emergency medical treatment for your child. If necessary and 911 is contacted, your child will be transported to Spartanburg Regional Medical Center. 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____

Parent must be contacted BEFORE administering approved non-prescription medications listed above: □ YES □ NO

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