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

2017 SUMMER CAMP REGISTRATION

$30.00 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 <u>if parents cannot be reached</u>. 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 <u>fully</u> 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