Greenwood Baptist WEE Center

Whosoever receives one such child in my name receives me.

2401 Claussen Road-Florence, SC 29505

OFFICE USE ONLY

☐ all day _______

☐ kindergarten only

☐ kindergarten + lunch

☐ after school

☐Mclaurin

☐Greenwood

☐DLC

Date of enrollment ___________

Child's legal name ___________________________________

Birthday _ _ / _ _ / _ _ Sex _____

Current home address ___________________________________

____

Home telephone number __________________________________

Mother's name ____________________________ Occupation _________________________

Business number ____________________ Cell number ___________________________

Cell Provider _______________________ (Needed for our call system)

Email address _____________________________________

Father's name _____________________________ Occupation ________________________

Business number ____________________ Cell number ___________________________

Cell Provider _______________________ (Needed for our call system)

Email address _____________________________________

Child lives with ☐ both parents ☐ mother ☐ father ☐other _________________

Please list names and birthdates of all children in your home.

_______________________ _______________________ _______________________

Please list any other persons living with the child and their relationship to the child. (if any)

_______________________ _______________________ _______________________

Are parents Christians? ___________

What church do you attend? ____

Has child had previous child care experience? ____________

If so, where and when? ____

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: Greenwood Baptist WEE Center County: Florence

Address: 2401 Claussen Road Florence, SC 29505
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

Parents Authorization Form

Child's Name ___________________________

A. Discipline

Do you understand the discipline policy of our daycare? ☐ Yes ☐ No

Does this daycare use corporal punishment as discipline?☐Yes ☐ No

_____________________________ _____________
Signature *Date*

B. Medicine

I give permission for prescription and non-prescription medicine to be given to my child.

_____________________________ _____________
Signature *Date*

C. Emergency Medical Treatment

I give permission to Greenwood WEE Center to obtain emergency medical treatment.

_____________________________ _____________
Signature *Date*

D. Persons authorized to take my child from Greenwood WEE Center

________________ ________________ ________________

________________ ________________ ________________

_____________________________ _____________
Signature *Date*

E. I give permission for my child to be transported to and from the day care. I give permission for my child to be transported on field trips. I give permission for my child to participate in swimming activities.

_____________________________ _____________
Signature *Date*

WEE Center Specific Information

- We will process the automatic payments/credit cards each Friday.
- If we are not notified in advance of a vacation week, we will charge the full amount that week and the half rate credit will be reflected in the next week's ACH charge/credit card.
- You will have online access to your balance and charges as soon as you register at the online site.
- Kindergarten only fees will be charged the beginning of the month.
- Drop-ins must be paid the day of the drop-in (cash or check will be accepted for these).
- There will be a $25 fee on any payments presented to the bank that are not paid.

Parental Consent Form (Photography and Websites)

I hereby authorize Greenwood Baptist WEE Center to allow my child to be

(check all that apply):

______ Photographed

______ Website usage (WEE Center facebook page, etc.)

Name of participant(s): ____

Name of parent or legal guardian: ____________________________________

Signature of parent or legal guardian: ________________________________

Automated Payment Processing
Safe – Convenient – Easy

We are excited to offer the safety, convenience and ease of Tuition Express®–a payment processing system that allows secure, on-time tuition and fee payments to be made from either your bank account or credit card.

ELECTRONIC FUNDS TRANSFER AUTHORIZATION FOR BANK ACCOUNT and CREDIT CARD

I (we) hereby authorize (business name) ________________________________ to initiate credit card charges to the below-referenced credit card account **(Section A)** OR, initiate debit entries to my (our) checking or savings account, indicated below **(Section B).** To properly affect the cancellation of this agreement, I (we) are required to give 10 days written notice. Credit union members: please contact your credit union to verify account and routing numbers for automatic payments. Check with the center for accepted credit card types.

COMPLETE ONE SECTION ONLY

SECTION A (Credit Card)

Cardholder Name ____________ Phone # ____________

Cardholder Address ____________ City ____________ State ____ Zip ____

Account Number ____________ Expiration Date ____________

Cardholder Signature ____________ Date ____________

SECTION B (Bank Account)

Your Name ____________ Phone # ____________

Address ____________ City ____________ State ____ Zip ____

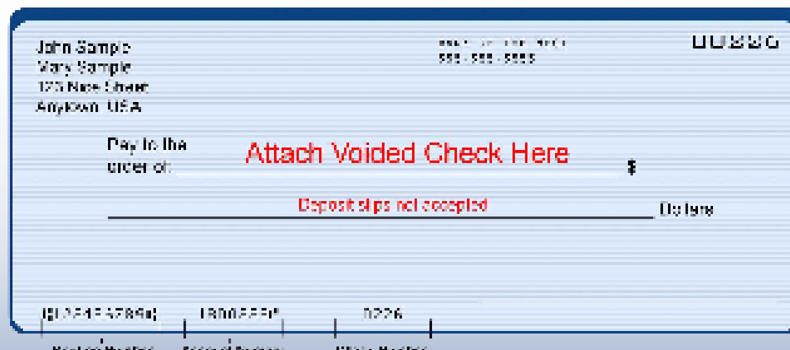
Bank or Credit Union Name ____________ Bank or Credit Union Address ____________ City ____________ State ____ Zip ____

Routing Transit Number (see sample below) ____________ Account Number (see sample below) ____________ ☐ Checking ☐ Savings

Authorized Signature ____________ Date ____________

For Official Use Only

Date Received
Employee Signature



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