WOODHAVEN BAPTIST CDC REGISTRATION FORM

Parent/Guardian Information **Registration Date:**________________

Child First & Last Name: ______________________ Nickname: __________

DOB: ______________ Age at Enrollment: _____ Gender: [ ] Male [ ] Female

Child's Address: ____

List any existing medical conditions, medication and/or special attention your child may require?

____

____

____

Allergies: ____

Pediatrician's Name: ______________________ Phone: ( ) ____________

Photographs: May we take photos of your child to display at the center? [ ] Yes [ ] No

Mother/Guardian

First & Last Name: ______________________ DOB: ____________

Address: ____

Occupation: ______________________ Home Phone: ( ) ____________

Employed By: ______________________ Office Phone: ( ) ____________

Work Hours: ______________________ Cell Phone: ( ) ____________

Email: ______________________ Church Member: ____________

Father/Guardian

First & Last Name: ______________________ DOB: ____________

Address: ____

Occupation: ______________________ Home Phone: ( ) ____________

Employed By: ______________________ Office Phone: ( ) ____________

Work Hours: ______________________ Cell Phone: ( ) ____________

Email: ______________________ Church Member: ____________

How did you hear about our Center or who referred you to us?____________________

____

WOODHAVEN BAPTIST CDC REGISTRATION FORM

Emergency Contacts & Authorized Pickup Persons:

1st Contact/Pick Up

Name: ______________________________ Phone: ______________

Relationship to the Child: ______________________________

[ ] Able to pick up all children in the family

[ ] Not able to pick up the following

children:______________________________

2nd Contact/Pick Up

Name: ______________________________ Phone: ______________

Relationship to the Child: ______________________________

[ ] Able to pick up all children in the family

[ ] Not able to pick up the following

children:______________________________

3rd Contact/Pick Up

Name: ______________________________ Phone: ______________

Relationship to the Child: ______________________________

[ ] Able to pick up all children in the family

[ ] Not able to pick up the following

children:______________________________

4th Contact/Pick Up

Name: ______________________________ Phone: ______________

Relationship to the Child: ______________________________

[ ] Able to pick up all children in the family

[ ] Not able to pick up the following

children:______________________________

Signatures:

Mother's Signature: ______________________________ Date: ______________

Father's Signature: ______________________________ Date: ______________

Office Staff's Signature: ______________________________ Date: ______________

Woodhaven Baptist CDC
Permission Form

Child's Name: ________________________________ Date: ________________

- I hereby (DO) (DO NOT) grant permission for my child to use all of the play equipment and participate in all activates at Woodhaven Baptist CDC.

- I hereby (DO) (DO NOT) grant permission for my child to be picked up by a Woodhaven CDC bus from ___________________ school for the after school program.

- I hereby (DO) (DO NOT) grant permission for my child to be included in evaluations and pictures connected with the program. Evaluations will be discussed with the parents upon request.

- I hereby (DO) (DO NOT) grant permission for my child to leave the Center's premises under proper supervision for walks or field trips in an authorized vehicle.

- I hereby (DO) (DO NOT) grant permission for the supervisor or acting supervisor to take whatever steps may be necessary to obtain emergency medical care if warranted. Medical conditions such as: Loss of consciousness, semi consciousness, severe breathing difficulties, severe bleeding, unequal pupils, seizures, neck or back injury, severe headache, a sick child who seems to be getting worse, repeated vomiting, abdominal pain cause severe discomfort, possible broken bone, or shock will require immediate medical care by a health care professional. Steps to obtain treatment for the child may include, but are not limited to the following:

    A) Attempt to contact a parent or guardian

    B) Attempt to contact the child's physician

    C) Attempt to contact you through any of the emergency numbers listed

    D) If we cannot contact you or your child's physician, the following steps will be taken:

        A) Call another physician

        B) Call an ambulance

        C) Have the child taken to ______________ hospital while being accompanied by a staff member who will stay with your child until you arrive.

Should your child need immediate emergency care an ambulance will be called and you will be notified immediately. When needed CPR/FIRST AID are always administered until emergency personnel arrive.

Woodhaven Baptist Child Development Center will not be responsible for anything that happens as a result of incorrect information given at the time of enrollment or failure to keep your child's file updated by the parent.

Mother's Signature:______________________ Father's Signature:_____________________

Woodhaven Baptist Child Development Center

Emergency Care & Evacuation Transportation Form

If a child is transported to a clinic, hospital or evacuated, this form will be taken to provide any necessary information.

Child's Full Name: ______________________________

Address: ______________________________

City: ____________________ State: ________ Zip: ____________

Drug Allergies: ______________________________

Blood Type: ____________ Health Concerns: ____________________

Physician's Name: ____________________ Phone: ______________

Dentist's Name: ____________________ Phone: ______________

Mother's Name: ______________________________

Place of Employment: ______________________________

Work Phone #: ________________ Cell Phone #: ______________

Father's Name: ______________________________

Place of Employment: ______________________________

Work Phone #: ________________ Cell Phone #: ______________

Emergency Contacts

Name	Address	Phone #	Relationship

Insurance Carrier: ________________ Policy #________________

*****I give permission for ______________________________ to be transported to ______________________________ hospital in the event of a medical emergency or to be taken to Neely's Creek ARP Church in the event of a Nuclear Evacuation.**

Parent's Signature: ________________________ Date: ____________

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: Woodhaven Baptist Child Development Center ____ County: ____ York

Address: 2060 Marett Blvd. ____ Rock Hill, SC 29732
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