School A Child Learning Center
Enrollment Application

Child Introduction:

Child's Name: _____

Allergies: _____Long Term Medications: _____

Special Accommodations Necessary:_____

We want to get to know your child so that we can better assist him/her in our program. This information will only be used to help us be sensitive in certain areas and make special accommodations as necessary. We would also desire to partner with you in healthy habits & positive social interactions.

What are his/her routines, likes, dislikes…etc?

Eating:_____

Sleeping:_____

Fears:_____

Likes:_____

Dislikes:_____

Habits:_____

Favorites:_____

Social Interaction: _____

Where is your child at developmentally? Successful and struggling areas:

_____

What other information should we be made aware?

_____

Events at home often influence your child's behavior. We can better assist your child when we are informed of situations and/or events that might influence his/her overall behavior such as; divorce, separations for family or friends, death of relative, friend or pet. Knowing about these transitional times allows us to give your child special attention, understanding and care. We will be sensitive with this information and only utilize the information for the betterment of the child.

Are there events in the home that may be affecting behavior or mood? Has anything happened recently in your child's life that might have an effect on him/her?

Persons authorized to pick up child:

Mother's Name: _____ Cell:_____

E-mail: _____

Father's Name: _____ Cell:_____

E-mail: _____

If parents are divorced, who has legal custody: (Please circle) Mother Father

May the non-custodial parent pick up the child: (Please check) ____ Yes ____ No

If "No" is selected, you must provide court-issued custody papers that clearly describe the custody arrangements. Any person granted custody in such papers may pick up the child during the times that person has custody and may designate other persons who are authorized to pick up the child at such times, unless court papers state otherwise.

List the names (and attach a photocopy of their drivers license) of the people who have permission to pick up this child and their relationship.

Name Relationship Phone

1. _____

2. _____

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: School A Child Learning Center County: Horry

Address: 1639 Dunn Shortcut Rd, Conway, SC 29527
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

SOUTH CAROLINA DEPARTMENT OF SOCIAL SERVICES
CACFP MEAL BENEFIT INCOME ELIGIBILITY (CHILD CARE)

DSS SOUTH CAROLINA DEPARTMENT of SOCIAL SERVICES

COMPLETE ONE APPLICATION PER HOUSEHOLD. PLEASE USE A PEN (NOT A PENCIL).

STEP 1 List ALL Household Members who are infants, children, and students up to and including grade 12. (If more spaces are required for additional names, attach another sheet of paper)

Definition of **Household Member**: "Anyone who is living with you and shares income and expenses, even if not related.
Children in Foster Care and children who meet the definition of **Homeless, Migrant or Runaway**, are eligible for free meals.

CHECK ALL THAT APPLY

CHILD'S FIRST NAME	MI	LAST NAME	ENROLLED IN CHILD CARE	FOSTER CHILD	HEAD START	HOMELESS/MIGRANT/RUNAWAY
			☐ YES ☐ NO	☐ YES ☐ NO	☐ YES ☐ NO	☐ YES ☐ NO
			☐ YES ☐ NO	☐ YES ☐ NO	☐ YES ☐ NO	☐ YES ☐ NO
			☐ YES ☐ NO	☐ YES ☐ NO	☐ YES ☐ NO	☐ YES ☐ NO
			☐ YES ☐ NO	☐ YES ☐ NO	☐ YES ☐ NO	☐ YES ☐ NO
			☐ YES ☐ NO	☐ YES ☐ NO	☐ YES ☐ NO	☐ YES ☐ NO

STEP 2 Do any household members (including you) currently participate in one or more of the following assistance programs: **SNAP, TANF (FI),** or **FDPIR**?

IF NO > Go to STEP 3
IF YES > Write case number here and proceed to STEP 4 (do not complete STEP 3)

CASE NUMBER: ____________

Write only one case number in this space.

STEP 3 Total Household Gross Income

Are you unsure what income to include here? Turn to page 3 and review the charts titled, "Sources of Income" for more information.
The "**Sources of Income for Children**" chart will help you with the Child Income section. The "**Sources of Income for Adults**" chart will help you with All Adult Household Members section.

A. Child Income
Sometimes children in the household earn or receive income. Please include the TOTAL income received by all Household Members listed in STEP 1 here.

Child Income	How often? Weekly	Bi-Weekly	2x Month	Monthly
$	☐	☐	☐	☐

B. All Adult Household Members (including yourself)
List all Household Members not listed in STEP 1 (including yourself) even if they do not receive income. For each Household Member listed, if they do receive income, report total gross income (before taxes) for each source in whole dollars (no cents) only. If they do not receive income from any source, write "0" or leave any fields blank, you are certifiying (promising) that there is no income to report.

Name of Adult Household Members (First and Last)	Earnings from Work	How often? Weekly	Bi-Weekly	2x Month	Monthly	Public Assistance Child Support Alimony	How often? Weekly	Bi-Weekly	2x Month	Monthly	Pensions/Retirement Social Security/SSI/ VA Benefits/Other	How often? Weekly	Bi-Weekly	2x Month	Monthly
	$	☐	☐	☐	☐	$	☐	☐	☐	☐	$	☐	☐	☐	☐
	$	☐	☐	☐	☐	$	☐	☐	☐	☐	$	☐	☐	☐	☐
	$	☐	☐	☐	☐	$	☐	☐	☐	☐	$	☐	☐	☐	☐
	$	☐	☐	☐	☐	$	☐	☐	☐	☐	$	☐	☐	☐	☐
	$	☐	☐	☐	☐	$	☐	☐	☐	☐	$	☐	☐	☐	☐

Total Household Members (Children and Adults) ☐

Last Four Digits of Social Security Number (SSN) of Primary Wage Earner or Other Adult Household Member X X X X X X ☐☐☐☐

Check if No SSN ☐

STEP 4 Contact Information and adult signature.

"I certify (promise) that all information on this application is true and that all income is reported. I understand that this information is given in connection with the receipt of Federal funds, and that CACFP officials may verify (check) the information. I am aware that if I purposely give false information, the participant/center may lose meal benefits, and I may be prosecuted under applicable State and Federal laws."

PRINT NAME OF ADULT SIGNING FORM	SIGNATURE OF ADULT			DATE
ADDRESS	CITY	STATE	ZIP	PHONE/EMAIL

DSS
SOUTH CAROLINA
DEPARTMENT of SOCIAL SERVICES

SOUTH CAROLINA DEPARTMENT OF SOCIAL SERVICES
CACFP MEAL BENEFIT INCOME ELIGIBILITY (CHILD CARE)

OPTIONAL Children's Ethnic and Racial Identities (Optional)

We are required to ask for information about your children's race and ethnicity. This information is important and helps to make sure we are fully serving our community. Responding to this section is optional and does not affect your children's eligibility for receiving meals during care.

Ethnicity (check one): ☐ Hispanic or Latino ☐ Not Hispanic or Latino

Race (check one or more): ☐ American Indian or Alaskan Native ☐ Asian ☐ Black or African American ☐ Native Hawaiian or Other Pacific Islander ☐ White

The **Richard B. Russell National School Lunch Act** requires the information on this application. You do not have to give the information, but if you do not, the funds your child care center/provider receives may be impacted. You must include the last four digits of the social security number of the adult household member who signs the application. The last four digits of the social security number is not required when you apply on behalf of a foster child or you list a Supplemental Nutrition Assistance Program (SNAP), Temporary Assistance for Needy Families (TANF) Program or Food Distribution Program on Indian Reservations (FDPIR) case number or other FDPIR identifier for your child or when you indicate that the adult household member signing the application does not have a social security number. We will use your information to determine the meal reimbursement for your child care center/provider. We MAY share your eligibility information with education, health, and nutrition programs to help them evaluate, fund, or determine benefits for their programs, auditors for program reviews, and law enforcement officials to help them look into violations of program rules.

In accordance with Federal civil rights law and U.S. Department of Agriculture (USDA) civil rights regulations and policies, the USDA, its Agencies, offices, and employees, and institutions participating in or administering USDA programs are prohibited from discriminating based on race, color, national origin, sex, disability, age, or reprisal or retaliation for prior civil rights activity in any program or activity conducted or funded by USDA. Persons with disabilities who require alternative means of communication for program information (e.g. Braille, large print, audiotape, American Sign Language, etc.), should contact the Agency (State or local) where they applied for benefits. Individuals who are deaf, hard of hearing or have speech disabilities may contact USDA through the Federal Relay Service at (800) 877-8339. Additionally, program information may be made available in languages other than English.

To file a program complaint of discrimination, complete the USDA Program Discrimination Complaint Form, (AD-3027) found online at: http://www.ascr.usda.gov/complaint_filing_cust.html, and at any USDA office, or write a letter addressed to USDA and provide in the letter all of the information requested in the form. To request a copy of the complaint form, call (866) 632-9992. Submit your completed form or letter to USDA by:

MAIL*: U.S. Department of Agriculture
Office of the Assistant Secretary for Civil Rights
1400 Independence Avenue, SW
Washington, D.C. 20250-9410

FAX: (202) 690-7442; or
EMAIL: program.intake@usda.gov.

***Only use this address if you are filing a complaint of discrimination.**
This institution is an equal opportunity provider.

DO NOT FILL OUT For official use only

Annual Income Conversion: Weekly x 52, Every 2 Weeks x 26, Twice a Month x 24, Monthly x 12

Total Income	How often? Weekly	Bi-Weekly	2x Month	Monthly	Household Size	Categorial Eligibility	Eligibility FREE	REDUCED	PAID	For Child Care Homes Only:
	☐	☐	☐	☐		☐	☐	☐	☐	Tier I_____ Tier II_____

Determining Official's Signature	Date	Confirming Official's Signature	Date

School A Child Learning Center
A Ministry of Missions for the Nations Ministry | 1639 Dunn Shortcut Rd Conway, SC 29527
843.236.5683 | contact@missionsfornations.com

Financial Agreement

- Registration fee is:
  ☐$50 (Launch After School Program) ☐$100 (SAC Learning Center) ☐ $110 (Launch Summer Camp)
  FEE IS NON-REFUNDABLE
  Parent Initial _____

- The tuition fee for _____is $_____ per week for the first child and $_____ per week for each additional child, *within the same* family.
  Parent Initial _____

- Summer Camp Program – tuition is due each Monday one week in advance.
  Other Programs - tuition is due each Friday for the following week. If payment is not received in full by Monday 6:00 PM, your child will not be able to attend until payment is received in full.
  I understand that the tuition fee agreed upon is due whether or not my child is in attendance each day.
  Parent Initial _____

- Additional spending money for your child may be required depending on planned field trips/ activities.
  Parent initial _____

- PICK UP late fee of $1.00 **per minute** will be assessed for any child picked up after 6:00PM and $5 **per minute** after 6:20PM which will be due with the next tuition payment. (For example: if your child is picked up at 6:30PM your late pick up fee will be $70 ($20+$50=$70).
  Parent initial _____

- NON-PAYMENT late fee of $5.00 **per day** will be assessed for each child if payment is received later than Monday at 6:00 PM. This Late Fee will be added to the tuition payment which is due ASAP. Your child will not be able to attend until payment is received in full.
  Parent initial _____

- Debit/Credit and cash payments are acceptable forms of payment.
  Parent Initial_____

Please return the signed registration and financial agreement form to the above address. Your child will not be considered registered until the required forms and fees have been received. I have carefully read and understand all the information.
My signature below confirms my financial commitment to this program.

Child's Name: _____ Parent/Guardian Signature: _____

Date: _____

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Parent / Guardian Agreement

Please read carefully and initial each place where you agree.

Failure to complete this form in its entirety will prohibit your child(ren)'s enrollment.

___ I have read (or have had it read to me) and understand the Parent Handbook in its entirety.
___ I am comfortable abiding by the enrollment information policies & procedures, financial information, curriculum guide, discipline & termination, learning approach method that is within this handbook.
___ I understand that this facility does not use corporal punishment as discipline, and I do NOT give permission to any of the staff to spank my child.
___ I give permission for my child to be transported on organized/planned field trips.
___ I give permission for my child to have their photo taken or video recorded for promotional services or class projects.
___ Any concerns or question I have had, I have asked the director of this program and I am comfortable with the answers I have received.
___ I have toured the facility area that is designated for the use of School A Child Learning Center and feel comfortable with its safety, sanitation, layout & materials.
___ Any concern that may arise after my child (ren)'s enrollment, I will respectfully bring those concerns to the directors attention and look to find a peaceful resolve.
___ I feel that my child(ren) & I will have a great experience here, and if things should not go as expected, I will make sure that I withdrawal peacefully after all my debts are paid in full.
___ I will be sure to do my best to pay on time, arrive on time & communicate with staff members as clearly & considerately as I can.
___ I understand that there is no "perfect" facility, and I will try to be patient with any changes that may occur. Example: new additions/amendments to the program, new staff...etc.
___ I understand that all learning & development accomplishments & successes are a conglomeration of parent, teacher, student & encouragers along the journey in each child's life. I choose to participate in the team of my child (ren)'s learning & development.
___ I give permission for my child to use the following sprays& ointments and be assisted as needed by staff. (Please check)
__Sunscreen __Bug repellant __Antiseptic __Anti-Itch __Diaper Rash __Hand Cream

Medical Consent & Release
___ I give permission for prescription and non-prescription medicine to be given to my child.
___ I give permission for SAC staff to administer simple first aid procedures.
___ I give permission for SAC staff to call 911 in an emergency situation prior to calling me.
___ I consent to any x-ray, examination, anesthetic, medical or surgical supervision and on the advice of any physician or surgeon license to practice in the state of treatment, when the need for such treatment is immediate, and when efforts to contact me, the parent/guardian are unsuccessful.
___ I agree to pay for said treatment and will hold Missions For The Nations, its affiliates and members harmless from liability.

By signing below, I am agreeing to each statement:

Child's Name: _____ Date: _____

Sign: _____ Name: _____
Signature of Parent/Guardian *Name of Parent/Guardian*

THIS FORM MUST BE INITIALED, SIGNED COMPLETELY & RETURNED PRIOR TO YOUR CHILD'S FIRST DAY