

# SouthEast Child Development Center Registration Package

1540 Elmtree Road  
Columbia, SC 29209  
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SC DSS License Number: 17,892



Child's First Name: \_\_\_\_\_

Child's Last Name: \_\_\_\_\_

Child's Birthday: \_\_\_\_\_

Start Date: \_\_\_\_\_

## Items Needed:

- Copy of child's birth certificate
- Copy of child's Social Security Card
- Copy of child's health insurance card
- Immunization Record (DHEC Form 1148)
- SCDC Handbook Acknowledgment Form
- Two sets of clothes (for children through 4 year old class)

## For Office Use Only

Date of Interview: \_\_\_\_ / \_\_\_\_ / \_\_\_\_

Interviewer: \_\_\_\_\_

Date of Enrollment: \_\_\_\_ / \_\_\_\_ / \_\_\_\_

Class Assignment: \_\_\_\_\_

## How did you hear about SCDC?

- Someone I know. Please give us their name: \_\_\_\_\_
- Web search
- Flyer. Please tell us where you saw our flyer: \_\_\_\_\_
- Other. Please give us some details: \_\_\_\_\_  
\_\_\_\_\_

Enrollment Agreement

1. This is an agreement between \_\_\_\_\_ (“the parent”) and SouthEast Child Development Center (“SCDC”). The parent agrees to enroll a child whose name is \_\_\_\_\_ (“the child”) in the SCDC program indicated in this enrollment form. The parent agrees to pay the following fees:

| Amount                        | Due Date                                   | Parent’s Initials |
|-------------------------------|--|-------------------|
| Weekly rate of: _____         | First school day of the week, in advance   |                   |
| Monthly rate of: _____        | First school day of the month , in advance |                   |
| Registration fee: \$50/family | At time of this registration               |                   |
| Other:                        |  |                   |

2. SCDC and the parent agree that the parent may change the payment option with a one week notification to SCDC
3. Should the parent use a third party to pay a portion of the SCDC fees, the parent agrees to pay any remainder due after the third party makes payment. The parent is responsible for establishing the relationship between SCDC and the third party and for assuring that the third party makes timely payments to SCDC. Should the third party fail to pay SCDC fees for any reason, the parent agrees to pay the balance due within 30 days of the due date agreed in paragraph 1 above.

The parent intends to use the following third party to pay part or all of the SCDC fees:

SC ABC             Veterans Administration     Other \_\_\_\_\_

4. The parent agrees that there are no other agreements, written or verbal, regarding this enrollment.

\_\_\_\_\_ (the parent) \_\_\_\_\_ (SCDC)

Date: \_\_\_\_\_

**Supplemental Information Required by SCDC**

Child's Name: \_\_\_\_\_

The following persons are authorized to pick up my child (we will require a photo ID until we recognize the person(s) picking up your child). We will record the person's fingerprint in our sign-in/sign-out system the first time he or she picks up your child.

| <i>First Name</i> | <i>Last Name</i> | <i>Relationship to Child</i> | <i>Cell phone</i> | <i>9-6 Land line(s), if any</i> |
|-------------------|------------------|------------------------------|-------------------|---------------------------------|
|                   |                  |                              |                   |                                 |
|                   |                  |                              |                   |                                 |
|                   |                  |                              |                   |                                 |
|                   |                  |                              |                   |                                 |

Church affiliation: \_\_\_\_\_

Child's special interests: \_\_\_\_\_

Any additional information that might be useful in working with your child:

**EMERGENCY MEDICAL CARE**

Child's Name: \_\_\_\_\_

In the event that I cannot be reached to make arrangements for emergency medical attention, I authorize SouthEast Child Development Center staff to take my child to an emergency room, or to the following physician or his or her associates, for medical care:

Dr: \_\_\_\_\_ Hospital: \_\_\_\_\_

Address: \_\_\_\_\_ Phone: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ ZIP: \_\_\_\_\_

Special instructions:

I consent for any and all treatment deemed necessary by the attending physician. (Attach a photocopy of your insurance card.)

Signature of parent or guardian \_\_\_\_\_

Date signed \_\_\_\_ / \_\_\_\_ / \_\_\_\_\_

**Affidavit/Jurat**

State of South Carolina  
County of Richland

Before me, the undersigned authority, personally appeared \_\_\_\_\_,  
who being duly sworn, testified under oath that the attached instrument is true and correct.

Signature of affiant: \_\_\_\_\_

Subscribed and sworn to (or affirmed) before me this \_\_\_\_ day of \_\_\_\_\_, \_\_\_\_\_

Signature of Notary: \_\_\_\_\_

Name of Notary: \_\_\_\_\_

My commission expires on: \_\_\_\_ / \_\_\_\_ / \_\_\_\_\_ (Seal)

**FIELD TRIP PERMISSION**

I give my permission for my child to go on any field trip that is to be taken while my child is enrolled at SCDC (applies only to elementary aged children)  Yes  No

I would be able to help by accompanying my child’s group as a helper when asked.  Yes  No

Parent’s or Guardian’s Signature \_\_\_\_\_

**PERMISSION TO PHOTOGRAPH (INCLUDING VIDEO) CHILD**

I give permission for my child to be photographed (including video) by SCDC staff for the following purposes:

Yes – documenting injuries or illnesses incurred prior to arriving at SCDC or while attending SCDC. These pictures will only be used to document the injury or illness and will be attached to the corresponding incident report. Parents must give permission for SCDC to take these photographs.

Yes,  No – Regular photographs of child activities at SCDC. These pictures will be used for advertising SCDC to prospective parents or for display within the SCDC facility or on the SCDC web sites. In the case of advertising photographs, the child will not be identified by name, age, address or any other personal information. Parents may request copies of these pictures, including digital copies, at no additional cost.

Parent’s or Guardian’s Signature \_\_\_\_\_

**PERMISSION FOR CHILD TO VIEW VIDEOS**

I give permission for my child to view videos at SCDC. SCDC staff will only select videos appropriate for the age of the child and will only show videos rated “G” or the equivalent and that have a theme and lesson consistent with a Christian world view. All staff-selected videos are approved by the Director prior to showing to the children.

Parent’s or Guardian’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: SouthEast Child Development Center County: Richland

Address: 1540 Elmtree Road Columbia, SC 29209  
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

\_\_\_\_\_  
SouthEast Child Development Center  
Name of Child Care Facility

Signature: \_\_\_\_\_ Date: \_\_\_\_\_  
Parent or Guardian

Signature: \_\_\_\_\_ Date: \_\_\_\_\_  
Director/Operator/Staff Designee

# SCDC Handbook Receipt

I acknowledge receipt of the SCDC Handbook for this year which includes the discipline, nutrition, and physical activity policies among other center procedures.

- I chose to download the Handbook from the SCDC Web Site
- I received the Handbook in hard copy

Signature \_\_\_\_\_

Printed Name: \_\_\_\_\_

Date: \_\_\_\_ / \_\_\_\_ / \_\_\_\_

Child's Name: \_\_\_\_\_