

# Edwards Road Baptist WEEKDAY

## 2018 2019

Office use
Class: _____
Date: _____

1050 Edwards Road \* Greenville, SC \* 29615 \* (864-292-0194)

[www.edwardsroadpreschool.org](http://www.edwardsroadpreschool.org)

[facebook.com/erbcpreschool](https://facebook.com/erbcpreschool)

[rblackwelder@erbc-sc.org](mailto:rblackwelder@erbc-sc.org)

### Registration / Emergency Form

DSS registration #266

Year begins **September 4, 2018** thru **May 22, 2019**

\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_(\_\_\_\_)\_\_\_\_-\_\_\_\_-\_\_\_\_  
**Child's** last name First Name Middle Name Sex Child's Date of birth

Edwards Road Baptist Church Weekday admits students of any race, color and national or ethnic origin

**Circle program and days child will attend:**

<p><b>MDO 9am – 2pm</b></p> <p>Registration = \$100 ( \$200 max)                  Classes operate September thru May  <b>Registration fees non refundable</b></p> <p>Circle choices</p> <p>M\$100mo T\$100mo R\$100mo F\$100mo</p>	<p><b>Kindergarten 9am – 12pm</b></p> <p>Registration = 1 month tuition                  Classes operate September thru May  <b>Registration fees non refundable</b></p> <p>K3MWF \$190 * K3Tu / Th \$135                  K4 (5 day) \$270 * K4MWF\$190 * K4TRF\$190 *                  K5 (5day) \$330</p>	<p><b>Late Stay</b></p> <p>12pm – 2pm \$9 daily</p> <p>Circle choices</p> <p>M Tu W Th F</p>
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other children in family –list additional siblings on back

Child's name _____ Sex (____) _____ - ____ - ____ Date of birth	Child's name _____ Sex (____) _____ - ____ - ____ Date of birth
Child's name _____ Sex (____) _____ - ____ - ____ Date of birth	Child's name _____ Sex (____) _____ - ____ - ____ Date of birth

### Parent Information

<b>MOM:</b> _____ date of birth ____-____-____	<b>DAD:</b> _____ date of birth ____-____-____
Mom's e-mail _____	Dad's e-mail _____
Mom's cell # _____ carrier for texting : ATT, T-Mobile, Sprint, Verizon, other _____	Dad's cell # _____ carrier for texting : ATT, T-Mobile, Sprint, Verizon, other _____
Mom's occupation _____	Dad's occupation _____
Mom's employer _____	Dad's employer _____
Mom's Driver's license# _____	Dad's Driver's license# _____
Member of any church? <b>YES NO</b>	Member of any church? <b>YES NO</b>
Name of church mother attends _____	Name of church father attends _____

Authorized pick-up #1 / Emergency contact– <b>other than parent</b> Name _____ Phone _____ Relationship to child _____ Drivers License # _____	Authorized pick-up #2 / Emergency contact – <b>other than parent</b> Name _____ Phone _____ Relationship to child _____ Drivers License # _____
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date \_\_\_\_-\_\_\_\_-\_\_\_\_ Comments \_\_\_\_\_

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: EDWARDS ROAD BAPTIST WEEKDAY County: Greenville

Address: 1050 Edwards Road Greenville, SC 29615  
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:

\_\_\_\_\_ **Authorized pick-up**  
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:

\_\_\_\_\_ **authorized pick-up**  
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** 9am am/pm **TO** 12pm or 2pm 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

EDWARDS ROAD BAPTIST WEEKDAY  
Name of Child Care Facility

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

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

# Parent Agreement / Release Form (to be notarized)



## Medical Release – (for each registered child)

I hereby authorize Edwards Road Baptist Church Weekday Early Education program staff to secure medical attention for my child, \_\_\_\_\_ in case of serious illness or accident. I will assume full cost of said medical treatment and will not hold Edwards Road Baptist Church or the Weekday Early Education Program financially responsible for these costs. I do hereby release Edwards Road Baptist Church, Weekday Early Education Program, their staff and/or volunteers from any and all claim and liabilities of whatsoever nature both individually and collectively, that may arise from my child participating in activities at the Weekday Program of Edwards Road Baptist Church.

## Field Trip Release **K4 & K5 CHILDREN ONLY**



I UNDERSTAND THAT SPECIAL TRIPS ARE PLANNED FOR THE CHILDREN AWAY FROM THE CENTER THROUGHOUT THE SCHOOL YEAR. I AM AWARE THAT I WILL BE SIGNING A PERMISSION FOR EACH EXCURSION AS IT IS TO OCCUR AND THAT EACH TRIP WILL BE CAREFULLY ARRANGED AND SUPERVISED BY AN ADEQUATE NUMBER OF ADULTS. I AM WILLING TO ASSUME THE RESPONSIBILITY FOR MY CHILD, \_\_\_\_\_ TO PARTICIPATE WITH THE EDWARDS ROAD BAPTIST CHURCH WEEKDAY EARLY EDUCATION PROGRAM ON THESE TRIPS.

**NO YES**

PHOTOGRAPHS taken of my child at Edwards Road Baptist WEEKDAY may be published in any of the WEEKDAY or Church literature, newsletters, WEBSITE, etc...



**\_ NO YES**

You have my permission to publish for classmate parents (e-mail / phone)



Share e-mail? **NO YES** e-mail address \_\_\_\_\_



share Phone #? **NO YES** phone # \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

**EDWARDS ROAD BAPTIST CHURCH WEEKDAY PROGRAM ADMITS STUDENTS OF ANY RACE, COLOR, AND NATIONAL OR ETHNIC ORIGIN. DSS REGISTRATION #266**

Parent Signature \_\_\_\_\_ Date \_\_\_\_\_

Subscribed and sworn to before me this \_\_\_\_\_ day of \_\_\_\_\_ 20\_\_\_\_  
State of South Carolina County of Greenville

Notary Public \_\_\_\_\_ My commission expires \_\_\_\_\_

# DHEC SC CERTIFICATE OF IMMUNIZATION

**This is required before your child can attend**

**Submit an up to date DHEC 2740 certificate  
from your Doctor or SC Health Department**

**DHEC Department of Immunization 864-372-3270**

(Check with Renee, there may be an up to date form in your child's file.)

you may have your doctor send forms via fax to 864-770-0304 attn: Renee

This must be updated during the year as children get new vaccines.

<b>2018-2019 DHEC routine of scheduled immunizations. Day care - K5</b>	Birth	2 months	4 months	6 months	12 months	15 months	18 months	4-6 years
Hep B	HepB	HepB			HepB			
IPV		IPV	IPV				IPV	IPV
DTaP		DTaP	DTaP		DTaP	DTAP		DTaP
Hib		Hib	Hib	Hib	Hib			
MMR					MMR	MMR		MMR
Var					Var	Var		Var
PCV prevnar		PCV	PCV	PCV	PCV			