



# 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)	<input type="checkbox"/> Checking	<input type="checkbox"/> Savings	
Authorized Signature	Date			

#### For Official Use Only

Date Received
Employee Signature



A service of

