

STUDENT INFORMATION SHEET

ALLERGY/FOOD RESTRICTION NO PHOTO NON-AUTHORIZED PICKUP

STUDENT

Full Name: _____
First Middle Last Prefers to be Called

Main Home Address: _____
Street City State Zip Code

Birthdate: _____ Gender: _____ Ethnicity/Race: _____

PARENT / GUARDIANS

First Last Relationship:

Cell Phone: _____ Work Phone: _____ Employer: _____

Email: _____

Drivers License #: _____ Lives with Student Yes No Emergency Contact Yes No

First Last Relationship:

Cell Phone: _____ Work Phone: _____ Employer: _____

Email: _____

Drivers License #: _____ Lives with Student Yes No Emergency Contact Yes No

EMERGENCY CONTACTS

First Last Relationship:

Cell Phone: _____ Alt Phone: _____ Drivers License #: _____
 Authorized Pickup Yes No

First Last Relationship:

Cell Phone: _____ Alt Phone: _____ Drivers License #: _____
 Authorized Pickup Yes No

LIFE THREATING ALLERGIES / MEDICAL CONDITIONS

Allergies: _____ EpiPen Provided Yes No

Medical Conditions: _____

PARENTAL PERMISSIONS

Yes No I give permission for my child to participate in all routine daycare activities, including athletics, and be transported in daycare-approved transportation in the event of an emergency.

Yes No I give permission for my child to be included in any pictures and/or videos taken that

 Parent Signature

 Date

AUTHORIZED PICKUP LIST

Please list anyone other than previously listed Parents/Guardians authorized to pick up your child. Phone Number and Drivers License number must be provided.

Name: _____ Drivers License # _____

Cell Phone: _____ Work/Alternative Phone: _____

Relationship to Student: _____ Emergency Contact Yes No

Name: _____ Drivers License # _____

Cell Phone: _____ Work/Alternative Phone: _____

Relationship to Student: _____ Emergency Contact Yes No

Name: _____ Drivers License # _____

Cell Phone: _____ Work/Alternative Phone: _____

Relationship to Student: _____ Emergency Contact Yes No

Name: _____ Drivers License # _____

Cell Phone: _____ Work/Alternative Phone: _____

Relationship to Student: _____ Emergency Contact Yes No

Name: _____ Drivers License # _____

Cell Phone: _____ Work/Alternative Phone: _____

Relationship to Student: _____ Emergency Contact Yes No

NON - AUTHORIZED PICKUP LIST

Please indicate anyone who is barred from picking up the student. If the person is one of the child's parents or legal guardians, The Diamond must have a copy of court papers on file in order to enforce.

Name: _____ Relationship: _____ Court Papers on File Yes No

Name: _____ Relationship: _____ Court Papers on File Yes No

Name: _____ Relationship: _____ Court Papers on File Yes No

Student Name: _____

Student's Doctor: _____ Phone# _____

Student's Dentist: _____ Phone# _____

CURRENT MEDICAL CONDITION

Please indicate all that apply to the student:

- | | | |
|---|---|--|
| <input type="checkbox"/> Glasses/Contacts | <input type="checkbox"/> Hearing Loss | <input type="checkbox"/> Speech Defects |
| <input type="checkbox"/> Migraines | <input type="checkbox"/> Severe Headaches | <input type="checkbox"/> Epilepsy |
| <input type="checkbox"/> Bladder or Urinary Problems | <input type="checkbox"/> Heart Condition/Murmur | <input type="checkbox"/> Kidney Disorder |
| <input type="checkbox"/> ADD/ADHD (Taking Medication <input type="checkbox"/> Yes <input type="checkbox"/> No) Medication: _____ | | |
| <input type="checkbox"/> Asthma (Medication/Inhaler <input type="checkbox"/> Yes <input type="checkbox"/> No) Medication: _____ | | |
| <input type="checkbox"/> Diabetes (Medication/Insulin <input type="checkbox"/> Yes <input type="checkbox"/> No) Medication: _____ | | |
| <input type="checkbox"/> Seizures - Describe _____ Medication: _____ | | |
| <input type="checkbox"/> Life Threatening Allergies: _____ Medication: _____ | | |

MEDICATIONS

Only medications prescribed by a Doctor can be given by our Staff to your Child. All medicines must be in the original container with the Prescription and Dosage information. If any other medications are needed you must come to the Daycare and administer them to your child. Please read the Handbook for all Medical Policies and Procedures.

I have read and understand the Medication Procedures in the Student Handbook.

 Parent Signature

 Date

EMERGENCY CARE

In the event of an emergency, please FIRST contact _____ at the following number _____, if unable to reach, then call listed Emergency Contact in order listed. If unable to reach the emergency contact, I hereby give my permission for my child, as needed, to be transported by ambulance or daycare approved transportation to a medical facility and for a doctor and/or attending physician to hospitalize and/or provide proper treatment for my child. I also give my permission for daycare personnel to administer medication and provide and/or obtain emergency care as needed.

 Permission to Transport/Dispense Emergency Care – Parent Signature

 Date

Student Name: _____

Name: _____ Relationship to Student: _____

I hear by agree to make prompt payment in full of all Tuition, Fees and costs associated with the care provided by the Diamond Child Development Center.

Agreement to Pay – Financially Responsible Party Signature

Date

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: The Diamond Child Development Center County: Cherokee

Address: 115 D Macedonia Road Gaffney, SC 29341
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

The Diamond Child Development Center

Name of Child Care Facility

Signature: _____ Date: _____
Parent or Guardian

Signature: _____ Date: _____
Director/Operator/Staff Designee

Student Name: _____

I have read , understand, and agree with the expectations of The Diamond Child Development. I understand that I will be held accountable for knowing and following the guidelines, policies, and expectations contained in this handbook.

Parent Signature: _____ Date _____

I have read and understand the and agree to follow the Discipline Policy of The Diamond Child Development.

Parent Signature: _____ Date _____

I have read and understand the procedure of evacuating the premises in case of an emergency have a clear understanding as to how the procedure would be carried out.

Parent Signature: _____ Date _____