

*Sky After School*  
432 East Boundary Street  
P.O. Box 158  
Chapin, SC 29036  
803-345-9428  
[www.skyafterschool.com](http://www.skyafterschool.com)



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2011-2012

*Parent Enrollment Checklist*

- Enrollment Application - Signed
- Policy and Permission Form Signed
- Transportation Permission Signed
- \$50 Registration Fee for 2011-2012 School Year
- Statement of Child's Health - DSS Form 2900

## Enrollment Application

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### I. Child's Information

Child's Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_  
Preferred Name: \_\_\_\_\_ Gender: \_\_\_\_\_  
Home Address: \_\_\_\_\_ SS#(Last 4 digits): \_\_\_\_\_  
City, State, Zip: \_\_\_\_\_  
Child's Physician: \_\_\_\_\_ Physician Phone: \_\_\_\_\_  
Allergies/Special Needs: \_\_\_\_\_  
(Please attach special instructions)

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### II. Parent's Information

Parent's Marital Status: Married  Single  Separated  Divorced  Widowed

If Divorced, who has legal custody: \_\_\_\_\_

Please list the persons in the household and the relationship to the child \_\_\_\_\_

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#### A. Mother/Guardian

Name: \_\_\_\_\_ Home Phone #: \_\_\_\_\_  
SS# (Last 4 digits): \_\_\_\_\_ Cell Phone #: \_\_\_\_\_  
Home Address: \_\_\_\_\_ Email Address: \_\_\_\_\_  
City, State, Zip: \_\_\_\_\_  
Employer: \_\_\_\_\_ Work Phone #: \_\_\_\_\_  
Work Address: \_\_\_\_\_ Work Hours: \_\_\_\_\_

#### B. Father/Guardian

Name: \_\_\_\_\_ Home Phone #: \_\_\_\_\_  
SS# (Last 4 digits): \_\_\_\_\_ Cell Phone #: \_\_\_\_\_  
Home Address: \_\_\_\_\_ Email Address: \_\_\_\_\_  
City, State, Zip: \_\_\_\_\_  
Employer: \_\_\_\_\_ Work Phone #: \_\_\_\_\_  
Work Address: \_\_\_\_\_ Work Hours: \_\_\_\_\_

*Enrollment Application Continued*

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**III. Emergency Contact Information (If parents cannot be reached)**

Name:

Work #:

Home #:

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Emergency Hospital Preference \_\_\_\_\_

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**IV. Persons Authorized to Pick Up Child**

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Family Code Word: \_\_\_\_\_

\* Family code word is used in emergency situations when parents can not contact the school to let us know someone different will pick up your child. If they give us the code word, we will know they are authorized to pick up your child.

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**V. Special Instructions**

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**Signature of Parent/Guardian:**

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**Date**

## **HOURS & DAYS OF OPERATION**

- Hours of operation are 2:30 p.m. - 6:15 p.m., Monday - Friday (during the school year)
- Hours of operation during holidays, in-service days, and summer break are 6:45 a.m. - 6:15 p.m., Monday - Friday.
- There is no additional charge for holidays and in-service days.
- The summer program, including special camps, begins the first week following the last day of the school year.
- Sky After School is closed the day following holidays are observed: New Year's Day, Good Friday, Memorial Day, July 4th, Labor Day, Thanksgiving Day, the Friday following Thanksgiving Day, Christmas Eve, Christmas Day, and the week between Christmas Day and New Year's Day. The Program may also close due to severe weather or conditions that prevent full operation.

## **TUITION**

A non-refundable registration fee \$50 is charged for each child when enrolling to reserve a space in our program. Tuition is payable on Monday, in advance, for each week with no deductions or credit for absence or holidays. Adjustments may be made for children absent if the director is notified in advance. A fee of \$20.00 will be charged for a returned check. To withdraw a child, two weeks notice or two weeks tuition payment is required.

## **TRANSPORTATION & PICK-UP**

Transportation is provided by the program from Chapin Elementary and Lake Murray Elementary schools. Please notify the program, in advance, of a change in the transportation schedule of a child. Children are signed into the program when picked-up at the school. A parent, legal guardian, or other adult authorized by the parent or guardian must pick up the child from Sky After School. Parents or authorized adults are required to enter the building and sign out their child each day.

## **CLOTHING**

Rubber-soled canvas or leather tennis shoes are recommended. Please, NO bare feet, flip-flops, or sharp pointed shoes, such as cowboy boots and cleats. A change of clothes may be kept at the facility. Please mark all personal items with the child's name. The program is not responsible for lost items.

## **ITEMS FROM HOME**

If the child must bring a personal item, please help the child understand the program will not be responsible for any item brought from home. We can put any projects or items that are sent home from school in a safe place until you pick up your child. Please do not send any toy guns, toys that can be swallowed, mouth toys, gum or candy. Food brought from home must be approved by the director.

## **FOOD**

Sky After School will serve a nutritious afternoon snack. Lunch will be served when children are in attendance for a full day. Food allergies/special needs will be observed as noted on the application.

## **DISCIPLINE**

The use of physical punishment is not permitted. Discipline consists of positive reinforcement, redirection and conflict resolution. Parents will be informed of behavioral problems. Efforts will be made to resolve any problem. Aggressive behavior, that is intended to cause injury and anxiety toward others, will not be allowed. The director reserves the right to ask parents to withdraw children from the program.

## **CONFIDENTIALITY OF RECORDS**

Children's records are open only to the Sky After School director(s) or director designee and the child's parent or legal guardian.

## **PARENT VISITS**

Sky After School has an "open door" policy. Parents are invited to visit and observe. Please reserve discussion of you child when the child is not present.

I have read the operating policies of Sky After School and understand that the management can determine, at its sole discretion, that a child should be withdrawn from the program.

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**Signature of Parent/Guardian:**

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**Date**

# Permission Form

## **PLAYGROUND/ACTIVITIES PERMISSION**

I hereby grant permission for my child to use all of Sky After School's play equipment and participate in all activities of the school.

## **MEDICAL ASSISTANCE PERMISSION**

I hereby grant permission for staff, or the director to take whatever steps necessary to obtain emergency medical care if warranted. These steps include, but are not limited to:

- 1) Attempt to contact parent or guardian.
- 2) Attempt to contact child's physician.
- 3) Attempt to contact parent or guardian through any persons listed in emergency information completed on Enrollment Application.
- 4) If unable to contact parent/guardian we may call another physician, call an ambulance, or transport the child to the hospital.
- 5) Any expenses incurred under #4 will be the responsibility of the child's family.
- 6) Sky After School will not assume any responsibility for anything that may happen if false information is given at any time.

## **MEDIA PERMISSION**

choose one

I hereby ( grant / do not grant ) Sky After School my permission to use my child's image in any media pertaining to the school but not limited to newsletter, website images, bulletins and news articles.

*I have read and agree to the policies and procedures of Sky After School.*

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<b>Child's Name</b>	<b>Parent's Name</b>	<b>Parent's Signature</b>	<b>Date</b>
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## **TRANSPORTATION PERMISSION**

I hereby grant permission for my child to be transported to and from \_\_\_\_\_ in an authorized vehicle driven by an authorized person of Sky After School, or ride a school bus operated by Lexington/Richland School District Five.

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<b>Child's Name</b>	<b>Parent's Name</b>	<b>Parent's Signature</b>	<b>Date</b>
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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: \_\_\_\_\_ County: \_\_\_\_\_

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