



St. Joseph Catholic Church & School

1200 Cornelia Road
Anderson, SC 29621

K-4 Registration Form for 2011-2012

Application Fee \$25.00 (new families)

Today's Date

Child's Full Name Preferred Name

Date of Birth

Please Check: Full Day (7:30-2:30) Half Day (7:30-11:45)
Registered and contributing parishioners at St. Joseph Parish
Catholic family desiring non-parishioner rate
Parishioner at another Catholic Church
Non-parishioner (name of church)
Male
Female

Student's Ethnic Background: White Black Hispanic Asian American Indian Multi-Racial

Address Street City Zip

Home Telephone # Father's Mobile #

Email Address Mother's Mobile #

Parent's Marital Status married divorced single separated

Father's Name Work Phone #

Occupation Employer

Mother's Name Work Phone #

Occupation Employer

Other siblings and ages

With whom does child live?

Has your child been dismissed from another center? Yes No

Has your child been asked to withdraw from another center Yes No

If yes, why?

Please list all centers your child has attended

Child's Physician _____ Phone _____ Address _____
Child's Dentist _____ Phone _____ Address _____

Please explain any diseases, illnesses, or handicaps your child had had or now has:

Please list any allergies your child has had or now has (food/medicine): _____

How would you describe your child? (quiet, active, shy, outgoing, assertive, etc) _____

IN CASE OF EMERGENCY:

Neighbor/Friend/Family member to be called in case of emergency:

1st name _____ Relationship _____ Phone _____

Address _____

2nd name _____ Relationship _____ Phone _____

Address _____

PLEASE LIST THOSE AUTHORIZED TO PICK UP YOUR CHILD: (Picture ID and Family Code Word will be required)

Copy of Health Insurance Card yes no

Please Check:

In an emergency situation, do we have permission to take your child to the hospital in the event we cannot reach you or our emergency contact? yes no

I give permission for my child to participate in field trips, take walks, or use wading pools or sprinklers (weather permitting) under strict adult supervision. yes no

I give permission for my child to be included in pictures or videos taken at school which might appear in the newspaper, school newsletters, journal books, www.sjccs.net, or otherwise be used to promote SJCCS. yes no

I give permission for my child's name, phone number, and address to be given to other parents in my child's classroom. This information is valuable to parents who are trying to plan birthdays, and also for a parent who volunteers in the classroom to contact parents regarding events. yes no

BY LAW, ALL CHILDREN MUST HAVE A SC STATE CERTIFICATE OF IMMUNIZATION. This certificate must be on a special state form which can be obtained from your doctor's office or the Anderson County HEALTH DEPARTMENT.

Signed _____

Date _____

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 annually thereafter, 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