

This form is to be completed for each child at the time of enrollment with the Spartanburg Day School, updated by the guardian as needed when changes occur, and maintained on file at Spartanburg Day School.

Student Name _____ Grade: _____ Age: _____

AUTHORIZATION OF MEDICAL TREATMENT: In the event of an illness or accident, I hereby give permission to a representative of the Spartanburg Day School to act for me in my behalf as the parent or other person having the legal authority to act for the student named above in the securing of medical, surgical, and/or dental treatment. In the event of an emergency, I hereby give permission to the physician selected by Spartanburg Day School to hospitalize, secure proper treatment for, and to order injections, anesthesia, or surgery for the student name. I certify that I am the parent and have the legal ability to sign these authorizations on behalf of the student named above. I consent to the release of information to Spartanburg Day School and to the insurance company. **I understand that every effort will be made to contact me prior to treatment.**

_____ (Signature of Legal Guardian) _____ (Date)

PERTINENT INFORMATION: As the parent or legal guardian of the student listed above, I give my permission for the nurse to divulge pertinent information to selected persons in charge of student care regarding any health concerns pertaining to my child.

_____ (Signature of Legal Guardian) _____ (Date)

PLEASE provide further information. (Check if the condition applies to the student)

____ Seizures? Epilepsy?
 • Type: Grand mal ____ Focal ____ Petite mal ____ Febrile ____ Occurance: once ____ occasional ____ frequent ____
 • Treatment: Controlled with medication ____ Medicated only when needed ____
 Medication _____
 ____ Concussion? ____ Date: _____
 ____ Fainting? Specify: _____
 ____ Frequent headaches? Migraines? (Circle) suggested treatment _____
 ____ Asthma? Specify triggers for attacks _____
 • Does student carry a rescue inhaler? ____ Does student use a nebulizer? ____
 ____ Gastro-intestinal or urinary conditions? Specify: _____

Allergies:

____ Food Allergy? To: _____ Reaction: _____
 To: _____ Reaction: _____
 PLEASE SEE Food Allergy letter and Treatment Form included in Health Forms
 ____ Hay fever (seasonal or environmental) Specify allergen: _____
 • Treatment: _____
 ____ Animal (bee, cat, horse, feathers, dander) Specify: _____
 ____ Medicinal (penicillin, sulfa) Specify: _____
 Does your child carry an EpiPen? ____ (yes or no)

Please list daily medications (dosage and time of day) that is administered at home:

Medication: _____ Dosage: _____ Time: _____
 Medication: _____ Dosage: _____ Time: _____
 Medication: _____ Dosage: _____ Time: _____
 Medication: _____ Dosage: _____ Time: _____

Please provide any other pertinent health information concerning your child that the nurse needs to be made aware.

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Student Name: _____

Family Member Signature: _____

In order for us to safely dismiss your child, we would like to ask for names of individuals that are permitted to pick up your child. Please provide us with a photo ID of anyone that will pick up your child other than parents.

Please list the individuals, phone numbers and their relationship to your child. Please let us know throughout the year if there are any changes to this information.

| Individuals Name | Phone Number(s) | Relationship |
|------------------|-----------------|--------------|
| _____ | | |
| _____ | | |
| _____ | | |
| _____ | | |
| _____ | | |
| _____ | | |

**Please list the individual(s) who may NOT pick up your child:

| Individuals Name | Relationship |
|------------------|--------------|
| _____ | |
| _____ | |

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: _____ Select 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

Spartanburg Day School Lower School – 3K and 4K

Policies and Procedures 2018-2019

Name of Student: _____

1. Release of Student

- Parents must notify the school if someone who does not regularly pick up their child will be picking up their child. Parents must provide the school with accurate contact information for this person if the parents will not be reachable. The names of all adults authorized to pick up a child must be on file with the school along with a copy of the persons photo ID. When an adult who does not routinely pick up a child comes to the school, a photo ID must be presented to the administrator or front office personnel before the person enters the child's classroom or before the child enters the car.

2. Illness

- If a child has a temperature of 100 degrees or more, is vomiting, has diarrhea or any symptoms of contagion, the child will be separated from the other children and the parents will be contacted to come for the child immediately. **A child must be symptom free for 24 hours, without medication, before returning to school.**

Parent Initials _____

3. Administration of Medications

- The only time a medication can be given to your child at school by the school nurse is when a parent writes a signed note stating that your child needs the medication.
- Medications have to be in the original prescription bottle with the label of how to administer.

4. Potty Training

- Children enrolled in 3K and beyond must be potty trained before attending school. Potty-trained preschool children:
 - no longer wear diapers (disposable or cloth) or disposable underwear (pull-ups)
 - can tell the teacher when they need to use the restroom, and
 - can attend to his/her own hygiene (wipe on his/her own).
- If your child is not completely potty trained as described above when school begins, and has more than an occasional accident, your child will be asked not to return until fully potty trained. **Parent initials** _____

5. Discipline and Behavior Management

- Corporal punishment is NOT allowed at Spartanburg Day School. Classroom management is handled in a positive nature where students learn from their mistakes.

6. Behavior Management Plan

- I understand that if my child does not adhere to school policies, he or she may be placed on a behavior management plan. If the behavior does not improve within the specified time deemed by the Head of Lower School, my child may be dismissed from the school. **Parent initials** _____

7. Confidentiality

- All student records and testing of students are kept in a locked cabinet in the Lower School Office for security and confidentiality purposes.

8. Tracking of Students

- In the morning, parents of 3K and 4K children must park and walk their children into the school and take them to their classroom where they will be greeted by their teacher. If students are moving to another special activity or anywhere in the building, they are escorted by a teacher. Children may not move about the building alone. Teachers will take tracking sheets with them as they move around the building, keeping count of each student.

9. Emergency Medical Form

- All parents will fill out an Emergency Medical Form. This plan addresses conditions under which emergency medical care or treatment is warranted and steps that will be followed.

10. Evacuation Plan / Emergency Preparedness

- We have a written plan for removing children from the building in case of fire, a natural disaster, or threatening situation that may post a health or safety hazard.

Parent Signature Required:

I have read and understand all the procedures and policies on this form along with the Lower School Handbook for my child at Spartanburg Day School.

(Parent Signature)

(Date)

South Carolina Department of Social Services
Child Care Licensing
**AUTHORIZATION FOR INTERVENTION, THERAPY AND
EXTRACURRICULAR ACTIVITIES**

I authorize Spartanburg Day School non DSS Staff to remove
Name of Person/Entity Providing Activity

Name of Child / _____
Child's Date of Birth

from Spartanburg Day School and/or its programs from
Name of Child Care Facility

8:00 a.m. to 6:00 p.m. on Aug 2018 - August 2019
Time Time Dates/Period of Service (See instructions below)
for the purpose of participating in Auxiliary Prog. Dir, Guidance, Nurse, LS Assist, Carpool Staff, IB Coordinator, Art, Music, PE, Spanish, Library, Tech I am aware that
Type of Activity

while participating in same as listed above, my child will not be supervised
Type of Activity

by a qualified staff person employed by Spartanburg Day School
Name of Child Care Facility

I am also aware that Spartanburg Day School non DSS Staff and its employees
Name of Person/Entity Providing Activity

are not required to adhere to laws governing Spartanburg Day School
Name of Child Care Facility

including, but not limited to laws governing staff to child ratios, supervision, background checks, and educational training.

Parent/Guardian's Signature Aug 2018-2019
Date

Rachel L. Deems
Child Care Facility Director's Signature Aug 2018-2019
Date

Theresa Holland, Kate Clayton, Stella Furrell
Person Providing Activity's Signature Aug 2018-2019
Date

Ed Allmon, Ciro Ofun, Ewa Wals
Person Providing Activity's Signature Aug 2018-2019
Date

Instructions:

This form must be completed and signed by all parties before providing services or activities. Beginning and ending dates should be used to show when the service or activity is being provided. If the service or activity continues for more than a year from the date it is signed, the form must be renewed.