



# Bundle of Joy Academy

Successful Beginnings Start with Education

A STEM BASED AFTER SCHOOL PROGRAM



<b>STUDENT INFORMATION</b>	
Child's Name: _____ Grade _____ Location: Simpsonville/Greenville	
Date of Birth _____ School _____	
Mailing Address _____ City _____ Zip _____	
Home Phone ____-____-____ Male ____ Female ____	
<b>PERSONS AUTHORIZED TO PICK UP CHILD</b>	
Father's Name _____	Mother's Name _____
Work Phone _____	Work Phone _____
Phone number most easily contacted on _____	Phone number most easily contacted on _____
Responsible party? Yes _____ No _____	Responsible party? Yes _____ No _____
Employer _____	Employer _____
Email _____	Email _____
<b>OTHER PERSONS AUTHORIZED TO PICK UP CHILD OR TO CALL IN AN EMERGENCY</b>	
Name: _____ Work Phone _____ Home Phone _____	
Pager/Mobile _____ Phone number most easily contacted on _____	
Name: _____ Work Phone _____ Home Phone _____	
Pager/Mobile _____ Phone number most easily contacted on _____	

### ENROLLMENT AGREEMENT

I hereby authorize the Bundle of Joy Academy to provide academic after school care and tutoring to \_\_\_\_\_.

**It has been explained to me that the tuition of \$ 65 is for each week for nine months of the calendar school year and as a result tuition will also be due when schools are closed. Christmas and Spring break and any holiday that Greenville County Schools are closed.** Also, Bundle of Joy Academy reserves the right to withhold transportation on any day that the administrator deems travel to be unsafe. A late fee in the amount of **\$35** will be assessed in the event that there are insufficient funds and the tuition cannot be paid in full on the scheduled date. The late fee will be added to the tuition due and a second attempt will be made to withdraw the tuition plus the late fee the next business day. I have been made aware and understand that if my child is absent for whatever reason, I am still responsible for the weekly tuition. When schools are closed, if I choose for my child to attend the vacation camp provided by the Bundle of Joy Academy, I have been informed and I understand that I am responsible for paying the **additional** daily tuition of **\$20**, for each of the days that \_\_\_\_\_ needs full day vacation care. In the event that I decide to withdraw my child/children from the program, I must give the Director a written Bundle of Joy Academy two-week notice and I would be responsible for the tuition due until the last day. Failure to provide the two-week notice or to pay tuition up to the last day will result in my account being forwarded to Transworld systems a collection agency working on behalf of Bundle of Joy Academy. In like manner, should the Bundle of Joy Academy determine it necessary to have my child removed from the program; I will be given a written two-week notice and will not hold the Learning Center liable for the dismissal.

Parent/Guardian Signature..... Date.....

### RELEASE OF LIABILITY

In the event that an accident occurs, I am aware that Bundle of Joy Academy does not provide accident insurance and I will not hold Bundle of Joy Academy responsible for any injury.

Parent/Guardian Signature..... Date.....

### TRANSPORTATION RELEASE

I give parental consent for my child to be transported by staff for school pick up (if applicable Bundle of Joy Academy).

Parent/Guardian Signature..... Date.....

**EMERGENCY CARE RELEASE**

In the event of an emergency in which I am cannot be reached, I hereby authorize emergency medical personnel to provide the necessary first aid and/or hospitalization.

Parent/Guardian Signature..... Date.....

**PARENT/GUARDIAN PACKET**

I have received a copy of the Child Care Parent/Guardian packet, which outlines policies, holiday schedule, and other aspects of my child’s participation in the program. Particularly, I have read and understand the Bundle of Joy Academy Staff Code of Conduct, Positive Discipline Policies and Procedures, Medication, and Transportation Policies.

Parent/Guardian Signature..... Date.....

**CELLPHONE, IPOD, CAMERAS AND OTHER ELECTRONICS POLICY**

These electronic gadgets whether for listening, or imagining are not permitted at the center. The students will be required to keep any electronics that they have in their bags until they leave. If the students are found using these electronic gadgets, the student will be required to give the gadget to a Staff of Bundle of Joy Academy until it is time to go home.

Parent/Guardian Signature..... Date.....

**LATE PICK UP POLICY**

I have been made aware that all children should be picked up before 6:00pm. There will be a late pick-up fee of \$1.00/minute after 6:00pm. In the event that I am late picking up

\_\_\_\_\_, I will be expected to pay this late fee at the time of pick up or it will be charged to my tuition account.

Parent/Guardian Signature..... Date.....

**PHOTOGRAPHY RELEASE**

*I understand that my child may be photographed, videotaped, and/or interviewed for the purpose of promotional use.*

Parent/Guardian Signature..... Date.....

**HOW DID YOU HEAR ABOUT OUR AFTER SCHOOL?**

From Child’s School       Advertisement       Signage       Friend Referral Name: \_\_\_\_\_

**PREVIOUS AFTERSCHOOL PROGRAM:** \_\_\_\_\_ **DATES ATTENDED:** \_\_\_\_\_

**MEDICAL INFORMATION:**

**Physical illnesses:** \_\_\_\_\_

**Allergies:** \_\_\_\_\_

**Name of medication** \_\_\_\_\_ **Dosage** \_\_\_\_\_

**Name of medication** \_\_\_\_\_ **Dosage** \_\_\_\_\_

**Name of medication** \_\_\_\_\_ **Dosage** \_\_\_\_\_

**Time(s) of med. Administration** \_\_\_\_\_

All prescriptions must be in the original prescription container. If new medications are prescribed, please see the Director immediately in order to update the medical file.

Physician's Name: \_\_\_\_\_

Phone Number \_\_\_\_\_

Dentist's Name: \_\_\_\_\_

Phone Number \_\_\_\_\_

**Please list any additional information about your child's health history, behavior and physical, emotional or mental health about which the staff should be aware.**

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Parent/guardian signature: ..... 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 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