Hickory Grove Baptist
Child Development Center
2710 Highway 905 Conway, SC 29526
(843) 365-1620

2022-2023 ENROLLMENT PACKET

Full Name of Child______________________________ Gender______________

Name by which child is called______________________________ Date of Birth______________

Father's Name______________________________ Cell Phone______________

Father's Employer______________________________ Business Phone______________

Mother's Name______________________________ Cell Phone______________

Mother's Employer______________________________ Business Phone______________

Number of children in family______ Boys________ Girls__________ E-mail Address:______________

Local church membership______________________________ If none, preference______________

Special interests of child______________________________

Special needs of child______________________________

Any serious health problems, allergies, illness, operation, or injury (age occurred)

____

______________________________. My child has had and can have (Y or N): Peanut Butter ☐ Eggs ☐

EMERGENCY: If parents cannot be located, in case of illness or accident, notify: (These individuals have the authority to obtain emergency medical treatment for child if parents cannot be reached)

Name______________________ Relationship______________ Phone Numbers______________

Name______________________ Relationship______________ Phone Numbers______________

If the contacts listed above cannot be located, I hereby give permission to our family physician (or doctor on call) to hospitalize, secure proper treatment, anesthesia, or surgery for my child.

Child's Physician & Address______________________________ Phone______________

Hospital Preference______________________________

The following individuals are authorized to pick up my child, include emergency contacts.

(These individuals will need to have proper identification on file to pick up):

____

____

____

(Parent) Signed______________________________ Date______________

(Parent) Signed______________________________ Date______________

Hickory Grove Child Development Center

General Information: (to be completed by parent or guardian)

Family Code Word(s)____________________________ Is child currently enrolled in school?____________________________

A. Medicine

I give permission for prescription and non-prescription medicine to be given to my child. Forms will be filled out individually by parents based on need. If you bring medicine to the CDC you must hand the medicine to a teacher and fill out a medication form for medicine to be administered.

Signature of Child's Mother Date

Signature of Child's Father Date

B. Emergency Medical Treatment

I give permission for Hickory Grove Baptist Child Development Center to obtain emergency medical treatment for my child.

Signature of Child's Mother Date

Signature of Child's Father Date

C. Transportation

I give permission for my child to be transported to and from Hickory Grove Baptist Child Development Center. I give permission for my child to be transported to and from field trips. Field trips will be announced in advance and permission slips distributed ahead of time.

Signature of Child's Mother Date

Signature of Child's Father Date

D. Swimming

I give permission for my child to participate in swimming activities through Hickory Grove Baptist Child Development Center. These events will be announced ahead of time and will be age-appropriate water play activities.

Signature of Child's Mother Date

Signature of Child's Father Date

E. Photo and Media

I understand that Hickory Grove Child Development Center will use my child's picture in many different forms including, but not limited to: classroom decorations, art and craft projects, cubbies, and classroom doors. I understand that my child's photos may also be used on Hickory Grove Child Development Center's Website where pictures of center events, classroom activities and special events may be posted.

Signature of Child's Mother Date

Signature of Child's Father Date

F. Student Handbook

I have received and read the Hickory Grove Child Development Center Student Handbook. I understand the policies and procedures listed in the handbook and agree to abide by said policies and procedures.

Signature of Child's Mother Date

Signature of Child's Father 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: ________ 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

DSS SOUTH CAROLINA DEPARTMENT of SOCIAL SERVICES

SOUTH CAROLINA DEPARTMENT OF SOCIAL SERVICES
CACFP MEAL BENEFIT INCOME ELIGIBILITY (CHILD CARE)

COMPLETE ONE APPLICATION PER HOUSEHOLD. PLEASE USE A PEN (NOT A PENCIL).

STEP 1 List ALL Household Members who are infants, children, and students up to and including grade 12. (If more spaces are required for additional names, attach another sheet of paper)

Definition of **Household Member**: "Anyone who is living with you and shares income and expenses, even if not related.
Children in Foster Care and children who meet the definition of **Homeless, Migrant or Runaway**, are eligible for free meals.

CHECK ALL THAT APPLY

CHILD'S FIRST NAME	MI	LAST NAME	ENROLLED IN CHILD CARE	FOSTER CHILD	HEAD START	HOMELESS/MIGRANT/RUNAWAY
			☐ YES ☐ NO	☐ YES ☐ NO	☐ YES ☐ NO	☐ YES ☐ NO
			☐ YES ☐ NO	☐ YES ☐ NO	☐ YES ☐ NO	☐ YES ☐ NO
			☐ YES ☐ NO	☐ YES ☐ NO	☐ YES ☐ NO	☐ YES ☐ NO
			☐ YES ☐ NO	☐ YES ☐ NO	☐ YES ☐ NO	☐ YES ☐ NO
			☐ YES ☐ NO	☐ YES ☐ NO	☐ YES ☐ NO	☐ YES ☐ NO

STEP 2 Do any household members (including you) currently participate in one or more of the following assistance programs: SNAP, TANF (FI), or FDPIR?

IF NO > Go to STEP 3
IF YES > Write case number here and proceed to STEP 4 (do not complete STEP 3)

CASE NUMBER:

Write only one case number in this space.

STEP 3 Total Household Gross Income

Are you unsure what income to include here? Turn to page 3 and review the charts titled, "Sources of Income" for more information.
The "**Sources of Income for Children**" chart will help you with the Child Income section. The "**Sources of Income for Adults**" chart will help you with All Adult Household Members section.

A. Child Income
Sometimes children in the household earn or receive income. Please include the TOTAL income received by all Household Members listed in STEP 1 here.

Child Income	How often? Weekly	Bi-Weekly	2x Month	Monthly
$	☐	☐	☐	☐

B. All Adult Household Members (including yourself)
List all Household Members not listed in STEP 1 (including yourself) even if they do not receive income. For each Household Member listed, if they do receive income, report total gross income (before taxes) for each source in whole dollars (no cents) only. If they do not receive income from any source, write "0" or leave any fields blank, you are certifiying (promising) that there is no income to report.

Name of Adult Household Members (First and Last)	Earnings from Work	How often? Weekly	Bi-Weekly	2x Month	Monthly	Public Assistance Child Support Alimony	How often? Weekly	Bi-Weekly	2x Month	Monthly	Pensions/Retirement Social Security/SSI/ VA Benefits/Other	How often? Weekly	Bi-Weekly	2x Month	Monthly
	$	☐	☐	☐	☐	$	☐	☐	☐	☐	$	☐	☐	☐	☐
	$	☐	☐	☐	☐	$	☐	☐	☐	☐	$	☐	☐	☐	☐
	$	☐	☐	☐	☐	$	☐	☐	☐	☐	$	☐	☐	☐	☐
	$	☐	☐	☐	☐	$	☐	☐	☐	☐	$	☐	☐	☐	☐
	$	☐	☐	☐	☐	$	☐	☐	☐	☐	$	☐	☐	☐	☐

Total Household Members (Children and Adults) ☐

Last Four Digits of Social Security Number (SSN) of Primary Wage Earner or Other Adult Household Member X X X X X X _ _ _ _

Check if No SSN ☐

STEP 4 Contact Information and adult signature.

"I certify (promise) that all information on this application is true and that all income is reported. I understand that this information is given in connection with the receipt of Federal funds, and that CACFP officials may verify (check) the information. I am aware that if I purposely give false information, the participant/center may lose meal benefits, and I may be prosecuted under applicable State and Federal laws."

PRINT NAME OF ADULT SIGNING FORM	SIGNATURE OF ADULT	DATE

ADDRESS	CITY	STATE	ZIP	PHONE/EMAIL

SOUTH CAROLINA DEPARTMENT of SOCIAL SERVICES

SOUTH CAROLINA DEPARTMENT OF SOCIAL SERVICES
CACFP MEAL BENEFIT INCOME ELIGIBILITY (CHILD CARE)

OPTIONAL Children's Ethnic and Racial Identities (Optional)

We are required to ask for information about your children's race and ethnicity. This information is important and helps to make sure we are fully serving our community. Responding to this section is optional and does not affect your children's eligibility for receiving meals during care.

Ethnicity (check one): ☐ Hispanic or Latino ☐ Not Hispanic or Latino

Race (check one or more): ☐ American Indian or Alaskan Native ☐ Asian ☐ Black or African American ☐ Native Hawaiian or Other Pacific Islander ☐ White

The **Richard B. Russell National School Lunch Act** requires the information on this application. You do not have to give the information, but if you do not, the funds your child care center/provider receives may be impacted. You must include the last four digits of the social security number of the adult household member who signs the application. The last four digits of the social security number is not required when you apply on behalf of a foster child or you list a Supplemental Nutrition Assistance Program (SNAP), Temporary Assistance for Needy Families (TANF) Program or Food Distribution Program on Indian Reservations (FDPIR) case number or other FDPIR identifier for your child or when you indicate that the adult household member signing the application does not have a social security number. We will use your information to determine the meal reimbursement for your child care center/provider. We MAY share your eligibility information with education, health, and nutrition programs to help them evaluate, fund, or determine benefits for their programs, auditors for program reviews, and law enforcement officials to help them look into violations of program rules.

In accordance with Federal civil rights law and U.S. Department of Agriculture (USDA) civil rights regulations and policies, the USDA, its Agencies, offices, and employees, and institutions participating in or administering USDA programs are prohibited from discriminating based on race, color, national origin, sex, disability, age, or reprisal or retaliation for prior civil rights activity in any program or activity conducted or funded by USDA. Persons with disabilities who require alternative means of communication for program information (e.g. Braille, large print, audiotape, American Sign Language, etc.), should contact the Agency (State or local) where they applied for benefits. Individuals who are deaf, hard of hearing or have speech disabilities may contact USDA through the Federal Relay Service at (800) 877-8339. Additionally, program information may be made available in languages other than English.

To file a program complaint of discrimination, complete the USDA Program Discrimination Complaint Form, (AD-3027) found online at: http://www.ascr.usda.gov/complaint_filing_cust.html, and at any USDA office, or write a letter addressed to USDA and provide in the letter all of the information requested in the form. To request a copy of the complaint form, call (866) 632-9992. Submit your completed form or letter to USDA by:

MAIL*: U.S. Department of Agriculture
Office of the Assistant Secretary for Civil Rights
1400 Independence Avenue, SW
Washington, D.C. 20250-9410

FAX: (202) 690-7442; or
EMAIL: program.intake@usda.gov.

***Only use this address if you are filing a complaint of discrimination.**
This institution is an equal opportunity provider.

DO NOT FILL OUT For official use only

Annual Income Conversion: Weekly x 52, Every 2 Weeks x 26, Twice a Month x 24, Monthly x 12

Total Income ____

How often? ☐ Weekly ☐ Bi-Weekly ☐ 2x Month ☐ Monthly

Household Size ____

Categorial Eligibility ☐

Eligibility ☐ FREE ☐ REDUCED ☐ PAID

For Child Care Homes Only: Tier I________ Tier II________

Determining Official's Signature ____ Date ____

Confirming Official's Signature ____ Date ____

INSTRUCTIONS FOR DSS FORM 16160

To apply for free and reduced-price meals, complete this application using the instructions below, sign your name and return the application to the center.

Step 1—List ALL Household Members who are infants, children, and students up to and including grade 12. Check if the child is enrolled in the Child Care facility, Foster Child, is in Head Start or is Homeless, Migrant or a Runaway. Check all that apply

Step 2—Households Getting SNAP, Participating in the Family Independence (FI) Program or Participating in the Food Distribution Program on Indian Reservations (FDPIR): List current SNAP, Family Independence or FDPIR case number. Complete steps 1 and 4. Do not complete step 3.

Step 3—If you did not provide a SNAP, FI or FDPIR case and you do not have an eligibility statement for Head Start or Even Start, complete this step and step 1.

A. Child Income

Sometimes children in the household earn or receive income. Please include the TOTAL income received by all Household Members listed in step 1.

B. All Adult Household Members (including yourself)

List all Household Members not listed in step 1 (including yourself) even if they do not receive income. For each Household Member listed, if they do receive income, report the total gross income (before taxes).for each source in whole dollars (no cents) only. If they do not receive income from any source, write "0" . If you enter "0" or leave any fields blank, you are certifiying (promising) that there is no income to report.. The applicant must also enter the Total Household Members, the Last Four Digits of Social Security Number (SSN) of the primary wage earner or other adult household member or check the box if the applicant does not have a SSN.

Source of Income for Children	
Sources of Child Income	**Examples**
Earnings from work	• A child has a regular full or part-time job where they earn a salary or wages
Social Security – Disability Payments – Survivors Benefits	• A child is blind or disabled and receives Social Security benefits • A parent is disabled, retired, or deceased, and their child receives Social Security benefits
Income from person outside of household	• A friend or extended family member reguarly gives a child spending money
Income from any other source	• A child receives regular income from a private pension fund, annuity, or trust

Source of Income for Adults		
Earnings from Work	**Public Assistance/Alimony/ Child Support**	**Pensions/Retirement/ All other sources of income**
• Salary, wages, cash bonuses • Net income from self-employment (farm or business) **If you are in the U.S. Military:** • Basic pay and cash bonuses (do NOT include combat pay, FSSA, or privatized housing allowances) • Allowances for off-base housing, food, and clothing	• Unemployment benefits • Workers compensation • Supplemental Security Income (SSI) • Cash assistance from State or local government • Alimony payments • Child support payments • Veterans benefits • Strike benefits	• Social Security (including railroad retirement and black lung benefits) • Private Pensions or disability benefits • Income from trusts or estates • Annuities • Investment income • Earned interest • Rental income • Regular cash payments from outside household

Step 4—Applicants must have the adult household member sign, print name, date and complete all other boxes in this step.

OPTIONAL—Ethnic/Racial Identity: Put a check (☑) next to the ethnicity you identify with. Put a check (☑) next to the race or races you identify with. We need the information to be sure everyone gets benefits on a fair basis. You do not have to answer these questions to get free or reduced price meals. USDA is an equal opportunity provider and employer.

Ethnicity:

1. *Hispanic or Latino.* A person of Cuban, Mexican, Puerto Rican, South or Central American, or other Spanish culture or origin, regardless of race. The term "Spanish origin" can be used in addition to "Hispanic or Latino."
2. *Not Hispanic or Latino.*

Race:

1. *American Indian or Alaskan Native*. A person having origins in any of the original peoples of North and South America (including Central America), and who maintains tribal affiliation or community attachment.
2. *Asian.* A person having origins in any of the original peoples of the Far East, Southeast Asia, or the Indian subcontinent, including, for example: Cambodia, China, India, Japan, Korea, Malaysia, Pakistan, the Philippine Islands, Thailand, and Vietnam.
3. *Black or African American*. A person having origins in any of the black racial groups of Africa. Terms such as "Haitian" or "Negro" can be used in addition to "Black or African American."
4. *Native Hawaiian or Other Pacific Islander*. A person having any origins in any of the original peoples of Hawaii, Guam, Samoa, or other Pacific Islands.
5. *White.* A person having origins in any of the original peoples of Europe, the Middle East, or North Africa.