

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



POLICIES AND REGULATIONS

Welcome to **Our Children Learning Center**, when your child or children are away from home, Come join us ***"Where a Home makes a World of Difference."*** These policies have been developed for the purpose of maintaining a safe, healthy, and happy environment for your child. Please read these carefully and return them signed. You will receive a copy for your records.

- **SECURITY:** Client records are safeguarded in a locked file cabinet in a secure area, to maintain confidentiality of names, address and other information, to include the identity of the child and family members. Only authorized personnel will have access to records, to include DSS, Parents, and Caregivers.
- **IMMUNIZATION:** A current shot record must accompany your child's registration form. This is in accordance with latest information from DHEC. Please provide a replacement copy every time the child's shots are updated. Failure to provide a current shot record in thirty (30) days may result in disenrollment.
- **ATTENDANCE TRACKING:** A parent or authorized person must sign the child in each day; drop-off and pick-up times must be documented. Appointment pick-up and return times must also be documented.
- **RELEASE OF CHILD:** Your child will only be released to you, or an authorized person that you have informed us about in writing. Their driver's license or other identification will be required as verification in order for your child/children to be released. So, please ensure the responsible person has these documents.
- **THE PARENT WHO HAS CONTRACTED WITH THE CENTER WILL TAKE PRECEDENT AS THE LEGAL GUARDIAN IN DECISION MAKING FOR THE CHILD WHILE AT THE CENTER.**
PLEASE NOTE: if a parent, not living with you, is on the authorized pick-up list, they are then authorized to pick the child up from the center. Update pickup records accordingly, because the center will not be held liable for the child's release.
- **PARENTAL FREE AND FULL ACCESS TO CHILDREN:** Parent(s) are permitted access to their child(ren) in our care without prior notice, unless there is a court order limiting parental access.
- **INCLEMENT WEATHER CLOSURES:** Generally, if the local schools are closed because of inclement conditions, the center will be closed also; or closing if local authorities call closure after childcare has begun.

OUR CHILDREN LEARNING CENTER

15 Stanley Road | Beaufort, SC 29906 | Phone: (843) 846-9676 | ourchildrenlearningcenter@gmail.com
www.ourchildrenlearningcenter.com



- **ADMINISTRATION OF MEDICATION:** The center does not administer medications. If medication is required for your child during the time he or she is at the center, a parent or guardian are welcome to the center to administer medication to their child.
- **MILDLY ILL CHILDREN:** Parents are required to pick up child if symptoms are:
 1. child's temperature reaches 100 degrees or above
 2. vomits two or more times
 3. frequent diarrhea
 4. excessive green/yellow mucus in nose/sneezing
 5. untreated ringworm
 6. or, any infectious illness/condition which poses harm to the child or others
 7. Child must be fever-free for twenty-four (24) hours without taking a fever reducer and have a doctor's clearance before returning to childcare center.
- **AS A FORM OF DISCIPLINE, WE USE THE TIME-OUT METHOD.** We prefer using verbal and example guidance techniques to redirect cognitive and behavioral choices. We believe children should be encouraged to want to do the right/appropriate thing, which becomes a life-long lesson.

We do not:

 - Administer corporal punishment.
 - Withhold food or snacks.

Parents are notified promptly if their assistance is needed.
- **WE OFFER A CURRICULUM FOR CHILDREN AGES 2-5.** Our curriculum is designed to allow for individual differences and does not put pressure on a child to learn. We offer encouragement and guidance, as well as demonstrate examples for learning. Play, creative activities, and music are a big part of our program.
- **EMERGENCY PLANS AND EVACUATION PLANS** are posted in the attendance log, on the wall by the door in the center, and included in enrollment packet. Please read and observe the procedures.
- **TRANSPORTATION IS NOT PROVIDED AT THIS TIME.**

I have read the Policies and Regulations of **Our Children Learning Center** and agree to the terms aforementioned.

Parent Signature: _____ Date: _____

Daycare Director: _____ Date: _____

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MEDICAL RELEASE FORM

MEDICAL AUTHORIZATION: It is unfortunate that accidents may occur, and because we want to be prepared to give your child the best and most immediate medical care possible, please read and supply the requested information.

Name of Child's Doctor: _____
Phone Number: _____
Hospital: **BEAUFORT MEMORIAL HOSPITAL**
Insurance Number: _____
Medicaid Number: _____

PLEASE READ

The Staff at **Our Children Learning Center** are certified in First Aid and CPR, and I am requesting now, your permission to give immediate first aid or CPR treatment to your child/children, if ever deemed necessary. You, the parent(s), and the Emergency Medical Persons will be called to the center, or, hospital per our Emergency Notification Procedure.

CONSENT TO EMERGENCY FIRST AID AND TRANSPORTATION

*I hereby give permission that my child, _____ may be given emergency treatment by Paramedics. I also, give permission for my child to be transported by ambulance to an emergency center for treatment. I agree to pay all cost and fees contingent on any emergency medical care and or treatment for my child as secured and authorized under this consent that is not covered by the provider's insurance.

Parent Signature: _____ **Date:** _____

ALTERNATE PERSON TO GIVE CONSENT FOR MEDICAL CARE AND TREATMENT:

In the event, that you cannot be contacted at a critical time for your child's **medical care, as **prescribed by a treating physician**, The persons listed below have your permission to give consent for treatment.*

Contingent upon **Exhausted attempts to contact Parents, or, designated contact persons above.*

List Persons whom you authorize to make Medical Decisions for you, the Parent(s)

Parent Signature: _____ Date: _____

Daycare Director: _____ Date: _____

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DAYCARE PICK-UP RELEASE FORM

RELEASE OF CHILD: Your child will only be released to you, or an authorized person that you have informed us about in writing. Driver's license or other identification will be required as verification. So, please update the list below as needed.

The Parent who has contracted with the center, will take precedent as the legal guardian, in decision making for the child while at the center.

PLEASE NOTE

If a parent, not living with you, is on the authorized pick-up list, they are then, authorized to pick the child up from the center. Update for records accordingly because the center will not be held liable for the child's release.

EMERGENCY/PICKUP PERSONS

List people in order of whom to contact first. Please initial and date updates.

#	NAME	PHONE/CELL	EMAIL	INT.	DATE
1					
2					
3					
4					
5					
6					
7					
8					
9					
10					

**YOU MAY REMOVE PERSONS BY DRAWING A LINE THROUGH,
AND INITIALING THE CORRECTION AND DATE**

PLEASE REQUEST THIS FORM FROM THE DIRECTOR AS NEEDED.

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FINANCIAL AGREEMENT FORM

CHILD CARE FEES	WEEKLY FEE	REGISTRATION FEE
Ages 1 - 3	\$250.00	\$125.00
Ages 4 - 5	\$225.00	\$125.00
Ages 5-12	\$125.00	\$100.00
Half Time Care <i>After School Weekly</i>	\$125.00	\$125.00

- **Fees are due each Monday by the end of the day.**
 - Childcare services are Monday through Friday; from 7:00 a.m. to 5:00 p.m.
 - After-school services Monday through Friday; from 2:00 p.m. to 5:00 p.m.
 - A Late pick-up charge of \$1.00 per minute, past 5:00 p.m, will be enforced.
 - Partial payments are not accepted and will result in termination of care.
 - Non- payment of childcare fee will result in immediate termination.
- **Enrollment of your child constitutes "Full time space"**, regardless of whether the child attends one (1) day or five (5) days a week. Full fee is required weekly on a regular basis. We do not provide part time care on a regular basis; exceptions are made for enrollee's school age siblings during school breaks.
- **For any other absences, the full fee is due and payable whether the child attends care or not.** (Example vacation/absences, minor illnesses, parent days off, transportation problems, inclement weather, etc.)
- **Parents must give two (2) week notice if this agreement is to be terminated.** Full payment must be rendered upon termination, including the two (2) week notice, even if the child is not in attendance.

I am the Parent or Legal Guardian of: _____

I have read and agree to the above terms and hold this agreement legally binding.

Parent Signature _____ Date: _____

Daycare Director: _____ Date: _____

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2025-2026 OUR CHILDREN LEARNING CENTER CALENDAR

MAY						
S	M	T	W	T	F	S
				1	2	3
4	5	6	7	8	9	10
11	12	13	14	15	16	17
18	19	20	21	22	23	24
25	26	27	28	29	30	31

JUNE						
S	M	T	W	T	F	S
1	2	3	4	5	6	7
8	9	10	11	12	13	14
15	16	17	18	19	20	21
22	23	24	25	26	27	28
29	30					

JULY						
S	M	T	W	T	F	S
		1	2	3	4	5
6	7	8	9	10	11	12
13	14	15	16	17	18	19
20	21	22	23	24	25	26
27	28	29	30	31		

AUGUST						
S	M	T	W	T	F	S
					1	2
3	4	5	6	7	8	9
10	11	12	13	14	15	16
17	18	19	20	21	22	23
24	25	26	27	28	29	30
31						

SEPTEMBER						
S	M	T	W	T	F	S
	1	2	3	4	5	6
7	8	9	10	11	12	13
14	15	16	17	18	19	20
21	22	23	24	25	26	27
28	29	30				

OCTOBER						
S	M	T	W	T	F	S
			1	2	3	4
5	6	7	8	9	10	11
12	13	14	15	16	17	18
19	20	21	22	23	24	25
26	27	28	29	30	31	

NOVEMBER						
S	M	T	W	T	F	S
						1
2	3	4	5	6	7	8
9	10	11	12	13	14	15
16	17	18	19	20	21	22
23	24	25	26	27	28	29
30						

DECEMBER						
S	M	T	W	T	F	S
	1	2	3	4	5	6
7	8	9	10	11	12	13
14	15	16	17	18	19	20
21	22	23	24	25	26	27
28	29	30	31			

JANUARY 2026						
S	M	T	W	T	F	S
				1	2	3
4	5	6	7	8	9	10
11	12	13	14	15	16	17
18	19	20	21	22	23	24
25	26	27	28	29	30	31

FEBRUARY						
S	M	T	W	T	F	S
1	2	3	4	5	6	7
8	9	10	11	12	13	14
15	16	17	18	19	20	21
22	23	24	25	26	27	28

MARCH						
S	M	T	W	T	F	S
1	2	3	4	5	6	7
8	9	10	11	12	13	14
15	16	17	18	19	20	21
22	23	24	25	26	27	28
29	30	31				

APRIL						
S	M	T	W	T	F	S
			1	2	3	4
5	6	7	8	9	10	11
12	13	14	15	16	17	18
19	20	21	22	23	24	25
26	27	28	29	30		

SCHOOL CLOSINGS AND FEDERAL HOLIDAYS

Memorial Day
Juneteenth
Independence Day
Labor Day
Election Day

May 26
June 19
July 4
Sept 1
Nov. 4

Veterans Day
Thanksgiving Break
Christmas Break
New Years Break
Dr. Martin Luther King, Jr. Day

Nov. 11
Nov. 26-28
Dec. 24-26
Dec. 31-Jan. 2
Jan. 19

President's Day
Good Friday Holiday
Spring Break

Feb. 16
April 3
April 13-17



FEED YOUR
FUTURE
SOUTH CAROLINA

WIC has the answers to all of these questions:

- What kind of food should your children be eating?
- Where can your children get immunizations (shots)?
- How can you learn more about breastfeeding?

WIC Helps:

- **Women:** Pregnant, recently pregnant, breastfeeding, or who have a new baby
- **Infants:** Newborn to age 1
- **Children:** Ages 1 to 5

WIC INCOME ELIGIBILITY GUIDELINES

Effective July 1, 2024 to June 30, 2025

FAMILY SIZE	INCOME (185% POVERTY)		
	YEARLY	MONTHLY	WEEKLY
1	\$27,861	\$2,322	\$536
2	\$37,814	\$3,152	\$728
3	\$47,767	\$3,981	\$919
4	\$57,720	\$4,810	\$1,110
5	\$67,673	\$5,640	\$1,302
6	\$77,626	\$6,469	\$1,493
7	\$87,579	\$7,299	\$1,685
8	\$97,532	\$8,128	\$1,876
For each additional family member add:	\$9,953	\$830	\$192

Even if you are working, you might be eligible for healthy foods and personalized nutrition information.

- **To apply for WIC or make an appointment, call 1-855-472-3432.**
- **Visit dph.sc.gov/wic.**



**Scan here
for Pre-application!**

In accordance with federal civil rights law and U.S. Department of Agriculture (USDA) civil rights regulations and policies, this institution is prohibited from discriminating on the basis of race, color, national origin, sex (including gender identity and sexual orientation), disability, age, or reprisal or retaliation for prior civil rights activity.

Program information may be made available in languages other than English. Persons with disabilities who require alternative means of communication to obtain program information (e.g., Braille, large print, audiotope, American Sign Language), should contact the responsible state or local agency that administers the program or USDA's TARGET Center at (202) 720-2600 (voice and TTY) or contact USDA through the Federal Relay Service at (800) 877-8339.

To file a program discrimination complaint, a Complainant should complete a Form AD-3027, USDA Program Discrimination Complaint Form which can be obtained online at: <https://www.usda.gov/sites/default/files/documents/ad-3027.pdf>, from any USDA office, by calling (866) 632-9992, or by writing a letter addressed to USDA. The letter must contain the complainant's name, address, telephone number, and a written description of the alleged discriminatory action in sufficient detail to inform the Assistant Secretary for Civil Rights (ASCR) about the nature and date of an alleged civil rights violation. The completed AD-3027 form or letter must be submitted 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; or

fax:
(833) 256-1665 or (202) 690-7442; or

email:
Program.Intake@usda.gov

This institution is an equal opportunity provider.



FEED YOUR
FUTURE
SOUTH CAROLINA

WIC tiene las respuestas a todas estas preguntas:

- ¿Qué tipo de alimentos deberían comer sus hijos?
- ¿Dónde pueden obtener inmunizaciones (vacunas) sus hijos?
- ¿Cómo puede aprender más acerca de la lactancia materna?

WIC ayuda a:

- **Mujeres:** Embarazadas, en primeros meses de gestación, lactantes o con bebés recién nacidos.
- **Bebés:** desde su nacimiento hasta la edad de 1 año.
- **Niños:** de 1 a 5 años de edad.

PAUTAS DE ELEGIBILIDAD POR INGRESOS PARA WIC

Vigentes desde julio 1 de 2023 hasta junio 30 de 2025

NÚMERO DE PERSONAS EN LA FAMILIA	INGRESOS (185% DEL NIVEL DE POBREZA)		
	ANUAL	MENSUAL	SEMANAL
1	\$27,861	\$2,322	\$536
2	\$37,814	\$3,152	\$728
3	\$47,767	\$3,981	\$919
4	\$57,720	\$4,810	\$1,110
5	\$67,673	\$5,640	\$1,302
6	\$77,626	\$6,469	\$1,493
7	\$87,579	\$7,299	\$1,685
8	\$97,532	\$8,128	\$1,876
Para cada miembro adicional de la familia, agregue:	\$9,953	\$830	\$192

Aunque esté trabajando, usted puede ser elegible para recibir alimentación saludable e información personalizada sobre nutrición.

- **Para aplicar a WIC o solicitar una cita, llame al 1-855-472-3432.**
- **Visite dph.sc.gov/wic.**



¡Escanee aquí para la solicitud previa!

De acuerdo con la ley federal de derechos civiles y las normas y políticas de derechos civiles del Departamento de Agricultura de los Estados Unidos (USDA), esta entidad está prohibida de discriminar por motivos de raza, color, origen nacional, sexo (incluyendo identidad de género y orientación sexual), discapacidad, edad, o represalia o retorsión por actividades previas de derechos civiles.

La información sobre el programa puede estar disponible en otros idiomas que no sean el inglés. Las personas con discapacidades que requieren medios alternos de comunicación para obtener la información del programa (por ejemplo, Braille, letra grande, cinta de audio, lenguaje de señas americano (ASL), etc.) deben comunicarse con la agencia local o estatal responsable de administrar el programa o con el Centro TARGET del USDA al (202) 720-2600 (voz y TTY) o comuníquese con el USDA a través del Servicio Federal de Retransmisión al (800) 877-8339.

Para presentar una queja por discriminación en el programa, el reclamante debe llenar un formulario AD-3027, formulario de queja por discriminación en el programa del USDA, el cual puede obtenerse en línea en: <https://www.usda.gov/sites/default/files/documents/ad-3027s.pdf>, de cualquier oficina de USDA, llamando al (866) 632-9992, o escribiendo una carta dirigida a USDA. La carta debe contener el nombre del demandante, la dirección, el número de teléfono y una descripción escrita de la acción discriminatoria alegada con suficiente detalle para informar al Subsecretario de Derechos Civiles (ASCR) sobre la naturaleza y fecha de una presunta violación de derechos civiles. El formulario AD-3027 completado o la carta debe presentarse a USDA por:

(1) correo:
U.S. Department of Agriculture
Office of the Assistant Secretary for Civil Rights
1400 Independence Avenue, SW
Washington, D.C. 20250-9410; o

(2) fax:
(833) 256-1665 o (202) 690-7442; o

(3) correo electrónico:
program.intake@usda.gov

Esta institución es un proveedor que ofrece igualdad de oportunidades.