



Love N Cherish Academy  
**STUDENT INFORMATION SHEET**

Start Date: \_\_\_\_\_

How did you hear about Love N Cherish Academy?  Newspaper  Website  Agency Referral (list): \_\_\_\_\_  
 LNCA Parent (please name): \_\_\_\_\_  
 Other: \_\_\_\_\_

Are you a SC ABC Child Voucher Recipient?  Yes  No If yes, please complete LNCA SC ABC Voucher Recipient Agreement  
 If no, have you applied for SC ABC Voucher?  Yes  No If yes, date of application: \_\_\_\_\_

**Program to be enrolled:**

**Start Date:** \_\_\_\_\_

- Teenie Turtles (6wks-12mon)
- Busy Bees (1 year)
- Awesome Ants (2 years)
- Chipper Chipmunks (3-4 years)
- Before School
- After School
- Before & After School
- Camp R.O.C.K. (Summer Camp)

Approximate drop-off time: \_\_\_\_\_ Approximate pick-up time: \_\_\_\_\_  
**Before/After School Children only**

Name of school: \_\_\_\_\_ Grade: \_\_\_\_\_ Start time: \_\_\_\_\_ End time: \_\_\_\_\_

**Student's Name:** \_\_\_\_\_ **Date of Birth:** \_\_\_\_\_

**Address:** \_\_\_\_\_

**Lives with:**  Mother  Father  Grandmother  Grandfather  Other: \_\_\_\_\_

**Primary Parent/Guardian:** \_\_\_\_\_ **Date of Birth:** \_\_\_\_\_

**Address:**  Same as child \_\_\_\_\_

**Relationship to child:**  Mother  Father  Grandmother  Grandfather  Other: \_\_\_\_\_

**Home phone:** \_\_\_\_\_ **Cell phone:** \_\_\_\_\_ **Cell Phone Carrier:** \_\_\_\_\_

**Work phone:** \_\_\_\_\_ **Email address:** \_\_\_\_\_

**Secondary Parent/Guardian:** \_\_\_\_\_ **Date of Birth:** \_\_\_\_\_

**Address:**  Same as child \_\_\_\_\_

**Relationship to child:**  Mother  Father  Grandmother  Grandfather  Other: \_\_\_\_\_

**Home phone:** \_\_\_\_\_ **Cell phone:** \_\_\_\_\_ **Cell Phone Carrier:** \_\_\_\_\_

**Work phone:** \_\_\_\_\_ **Email address:** \_\_\_\_\_

**FOR OFFICE USE ONLY**

- Immunization Record
- Student Information Sheet
- Emergency Treatment/Health Information
- Authorized Pick-/Emergency Contact
- DSS Form 2900
- General Policies

- Discipline & Behavior Management Policy
- Tuition & Enrollment Policies
- DSS Form 16160 USDA Food Program
- Parent Orientation Checklist
- Information

- BUSINESS OFFICE**
- Tuition & Enrollment Agreement w/ID
- Tuition Express Authorization Form
- OTHER**
- Educator Policy Agreement (if applicable)
- SC ABC Childcare Voucher Agreement (if applicable)

Notes: \_\_\_\_\_

Notes: _____ _____ _____ _____ _____		



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**EMERGENCY MEDICAL TREATMENT/HEALTH INFORMATION**

By signing below, I give my permission for my child, \_\_\_\_\_ DOB: \_\_\_\_\_ to have medical treatment if necessary by emergency medical professionals and agree that all information regarding my child's medical, health, and development are true.

**Mother's/Guardian's Information**

Name: \_\_\_\_\_  
Address: \_\_\_\_\_  
Home number: \_\_\_\_\_  
Cellular number: \_\_\_\_\_  
Work number: \_\_\_\_\_

**Father's/Guardian's Information**

Name: \_\_\_\_\_  
Address: \_\_\_\_\_  
Home number: \_\_\_\_\_  
Cellular number: \_\_\_\_\_  
Work number: \_\_\_\_\_

**Insurance Information**

Health Insurance Carrier	Name of insured	Group Number	Policy number
1.			
2.			
3.			

**Health**

Child medical conditions: \_\_\_\_\_  
Primary Care Physician: \_\_\_\_\_ Phone: \_\_\_\_\_  
Dentist: \_\_\_\_\_ Phone: \_\_\_\_\_  
Other Physician: \_\_\_\_\_ Phone: \_\_\_\_\_  
List physical disabilities, allergies, or therapies. \_\_\_\_\_  
List all medications taken on a regular basis \_\_\_\_\_

**Developmental History (Infants, Preschool & Kindergarten children only)**

My child began	Age	Does your child have any difficulties speaking? <input type="checkbox"/> Yes <input type="checkbox"/> No
Sitting		If yes, explain: _____
Crawling		Does your child have any special leaning needs? <input type="checkbox"/> Yes <input type="checkbox"/> No
Walking		If yes, explain: _____
Talking		Language spoken at home: <input type="checkbox"/> English <input type="checkbox"/> Spanish <input type="checkbox"/> Other: _____

List serious illnesses or hospitalizations: \_\_\_\_\_

**Eating**

Does your child have any eating problems?  Yes  No If yes, explain \_\_\_\_\_  
Does your child have any food allergies?  Yes  No If yes, explain \_\_\_\_\_  
Does your child have a favorite food?  Yes  No If yes, explain \_\_\_\_\_  
Does your child dislike a particular food?  Yes  No If yes, explain \_\_\_\_\_

Was your child carried to full term?  Yes  No  
Does your child eat with a spoon?  Yes  No  
Does your child eat with his/her hands?  Yes  No

If child was pre-mature. What was the due date \_\_\_\_\_  
Does your child eat with a fork?  Yes  No  
Does your child drink  breast milk  formula  whole milk

**Toileting Habits**

Does your child indicate his/her toileting needs?  Yes  No  
Does your child remain dry during naps?  Yes  No  
Does your child have a fear of the restroom?  Yes  No  
Does your child have frequent accidents?  Yes  No  
Does your child remain dry overnight?  Yes  No  
Family words for Urination: \_\_\_\_\_  
If yes, how? \_\_\_\_\_  
Is yes, what is the fear? \_\_\_\_\_  
Bowel movement: \_\_\_\_\_

Parent/guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_  
Parent/guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_



Love N Cherish Academy  
**AUTHORIZED PICK-UP/EMERGENCY CONTACT**

Student's Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Family code word: \_\_\_\_\_

My child can be dropped off and/or released to the following people whom will show ID and register in the ProCare Check-In System with fingerprint when picking up my child. **When dropping off for the first time please, allow 10 minutes for initial registration into the system.**

Name	Contact Number	Relationship	Check all that apply
1.	Home: _____ Cell: _____	<input type="checkbox"/> Grandmother <input type="checkbox"/> Grandfather <input type="checkbox"/> Other:	<input type="checkbox"/> Pick-up <input type="checkbox"/> Emergency pick-up
2.	Home: _____ Cell: _____	<input type="checkbox"/> Grandmother <input type="checkbox"/> Grandfather <input type="checkbox"/> Other:	<input type="checkbox"/> Pick-up <input type="checkbox"/> Emergency pick-up
3.	Home: _____ Cell: _____	<input type="checkbox"/> Grandmother <input type="checkbox"/> Grandfather <input type="checkbox"/> Other:	<input type="checkbox"/> Pick-up <input type="checkbox"/> Emergency pick-up
4.	Home: _____ Cell: _____	<input type="checkbox"/> Grandmother <input type="checkbox"/> Grandfather <input type="checkbox"/> Other:	<input type="checkbox"/> Pick-up <input type="checkbox"/> Emergency pick-up
5.	Home: _____ Cell: _____	<input type="checkbox"/> Grandmother <input type="checkbox"/> Grandfather <input type="checkbox"/> Other:	<input type="checkbox"/> Pick-up <input type="checkbox"/> Emergency pick-up
6.	Home: _____ Cell: _____	<input type="checkbox"/> Grandmother <input type="checkbox"/> Grandfather <input type="checkbox"/> Other:	<input type="checkbox"/> Pick-up <input type="checkbox"/> Emergency pick-up
7.	Home: _____ Cell: _____	<input type="checkbox"/> Grandmother <input type="checkbox"/> Grandfather <input type="checkbox"/> Other:	<input type="checkbox"/> Pick-up <input type="checkbox"/> Emergency pick-up
8.	Home: _____	<input type="checkbox"/> Grandmother <input type="checkbox"/> Grandfather <input type="checkbox"/> Other:	<input type="checkbox"/> Pick-up <input type="checkbox"/> Emergency pick-up
9.	Home: _____ Cell: _____	<input type="checkbox"/> Grandmother <input type="checkbox"/> Grandfather <input type="checkbox"/> Other:	<input type="checkbox"/> Pick-up <input type="checkbox"/> Emergency pick-up
10.	Home: _____ Cell: _____	<input type="checkbox"/> Grandmother <input type="checkbox"/> Grandfather <input type="checkbox"/> Other:	<input type="checkbox"/> Pick-up <input type="checkbox"/> Emergency pick-up
11.	Home: _____ Cell: _____	<input type="checkbox"/> Grandmother <input type="checkbox"/> Grandfather <input type="checkbox"/> Other:	<input type="checkbox"/> Pick-up <input type="checkbox"/> Emergency pick-up
12.	Home: _____ Cell: _____	<input type="checkbox"/> Grandmother <input type="checkbox"/> Grandfather <input type="checkbox"/> Other:	<input type="checkbox"/> Pick-up <input type="checkbox"/> Emergency pick-up
13.	Home: _____ Cell: _____	<input type="checkbox"/> Grandmother <input type="checkbox"/> Grandfather <input type="checkbox"/> Other:	<input type="checkbox"/> Pick-up <input type="checkbox"/> Emergency pick-up
14.	Home: _____ Cell: _____	<input type="checkbox"/> Grandmother <input type="checkbox"/> Grandfather <input type="checkbox"/> Other:	<input type="checkbox"/> Pick-up <input type="checkbox"/> Emergency pick-up
15.	Home: _____ Cell: _____	<input type="checkbox"/> Grandmother <input type="checkbox"/> Grandfather <input type="checkbox"/> Other:	<input type="checkbox"/> Pick-up <input type="checkbox"/> Emergency pick-up

Parent/guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Parent/guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Updates		
Date	Line #	Signature

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: Love N Cherish Academy County: York

Address: 2199 Mt. Holly Road Rock Hill, SC 29730  
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:

	<small>Full Name</small>	<small>Relationship</small>
Address: _____		
<small>Street Address</small>	<small>City, State, Zip</small>	
Telephone Number(s): _____		Family Code Word(s): _____

2. Person responsible if parent/guardian unavailable for emergency medical services:

	<small>Full Name</small>	<small>Relationship</small>
Address: _____		
<small>Street Address</small>	<small>City, State, Zip</small>	
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

	<small>City, State, Zip</small>	<small>Telephone</small>
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Emergency Care Provider: \_\_\_\_\_  
Emergency Facility Name

	<small>City, State, Zip</small>	<small>Telephone</small>
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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