



Emergency Care and Transfer Authorization

I authorize Camden Kids Academy LLC. To transport, authorize medical treatment and to administer medication.

I understand and accept the policies above.

Child's name: _____

Parent's name: _____

Date: _____

Transportation/Field Trips/Emergency Care

I give Camden Kids Academy LLC permission to have my child transport by EMS or to transport my child by bus for school pick up and field trips.

Sign: _____

Date: _____



Camden Kids Academy LLC

Emergency Care Information

Child's full names: _____ Date of Birth: _____

Date of last Tetanus shot: _____

Child is allergic to the following medications, insects, or food:

Child is taking the following medications (including over the counter medications)

List many chronic condition or major illness the child may have:

Name of family doctor: _____

Phone#: _____

Name of pediatrician: _____

Phone#: _____

Other doctors or therapist: _____

Phones#: _____

In event of an emergency, I desire my child to be transported to the following hospital:

In the event of an emergency, where can you be reached?

Print your full name, home address, medical insurer, and policy number.

Name: _____ Phones: _____

Address: _____

Insurer: _____ Policy Number: _____

Parent Signature: _____ Date: _____



Social Media Release

We love to put picture of our children on our Facebook, so that you can see them.

Camden Kids Academy has permission to put pictures of _____
on their Facebook page.

Signed _____ Date _____

Camden Kids Academy, LLC does NOT have permission to put pictures of _____
on their Facebook page.

Signed _____ Date _____



PARENT'S AUTHORIZATION FORM FOR CDCC & GDCH

Day Care Name Camden Kids Academy LLC

Child's Name _____

A. DISCIPLINE:

Do you understand the discipline policy for the day care? YES NO
Does this day care use corporal punishment? YES NO
If so, do you give permission for the staff to spank your child? YES NO N/A

_____ Signature _____ Date

B. MEDICINE:

I give permission for prescription and non-prescription medicine to be given to my child.

C. _____ Signature _____ Date

D. EMERGENCY MEDICAL TREATMENT:

I give permission to **Camden Kids Academy, LLC** to obtain emergency medical treatment.

_____ Signature _____ Date

D. AUTHORIZED PERSONS: The following person(s) are authorized to take my child from the daycare:

_____ Signature _____ Date

E. TRANSPORTATION: I give permission for my child to be transported to and from day care. I give permission for my child to be transported on field trips.

_____ Signature _____ Date

F. SWIMMING: I give permission for my child to participate in swimming activities.

_____ Signature _____ Date



Auto-debit Authorization

We will need your debit or charge card information for payment. This information is kept in a locked cabinet and will be shredded when it's no longer needed. Please fill out this information below:

I, _____ give **Camden Kids Academy, LLC** permission to use this information for my payment. \$_____ is to be deducted weekly on (select one):

Monday

Tuesday

Wednesday

Thursday

Friday

The card # is _____. The expiration date is _____.

_____ The billing zip code is _____.

CVC _____

Sign _____

Date _____

CAMDEN KIDS ACADEMY LLC.

PARENT/CHILD INFORMATION FORM



Please Print:

Fathers Name: _____ Driver's License# _____

Social Security # _____

Mothers Name: _____ Driver's License# _____

Social Security # _____

Home Address: _____ (Street) _____ (Apt #) _____ (City) _____ (State)

Second Home Address (if
parents live separately) _____ (Street) _____ (Apt #) _____ (City) _____ (State)

(H) Phone: _____

Father Employed By: _____

(W) Phone: _____ Cell #: _____ Email: _____

Receive text notifications on cell? Yes No Receive email notifications? Yes No

Mother Employed By: _____

(W) Phone: _____ Cell #: _____ Email: _____

Receive text notifications on cell? Yes No Receive email notifications? Yes No

Child's Name Date of Birth Social Security #

Emergency & Other Contacts

1. Name _____ Phone# _____

Address _____

2. Name _____

Address _____ Phone# _____

3. Name _____

Address _____ Phone# _____

Family Code Word: _____

Doctors Name: _____

Address: _____

Phone: _____

All Information Must Be Provided on This Form



Center Hours

Our center opens at 6:30 AM and closes at 6:00 PM.

The late charge is \$1.00 per minute per child that is picked up after 6:00 PM payable at time of pickup.

Weekly Rates**

\$30 registration fee per family

\$145 weekly for infants

\$140 weekly for one-year olds

\$135 weekly for two-year olds

\$130 weekly for three-year olds

\$125 weekly for four years and up

\$60 after schoolers

\$125* weekly for after schooler summer program

** there may be additional activity fees*

*** we reserve the right to re-assess the fees on a monthly basis to address changes to operating costs; you will be notified at least 2 weeks in advance of any changes.*

Automatic Draft is required for payment

Center Closings

We have 8 paid holidays without a deduction in weekly rate. Not all of these holidays will fall during the week. If a holiday falls on Saturday, we close on Friday. If a holiday falls on Sunday, we close on Monday. Our Holidays are: New Year's Day, Memorial Day, Fourth of July, Labor Day, Thanks Giving (Thurs. and Friday), Christmas Eve and Christmas Day.



CKA Child Care Contract

This contract is made between the parent(s)/guardians:

_____ name of parent or primary payer

_____ address of parent or primary payer

and **Camden Kids Academy LLC** (center) for the care of the following child
(*separate contracts will be completed for each child to be enrolled*):

_____ child's name and date of birth _____

The payment for care shall be \$_____ per week (exceptions to be noted

below) and reflects a schedule as follows:

arrival time 6:30 AM and pick up time 6:00 PM pm on Monday - Friday.

Exceptions:

- 1) Center does not operate on scheduled center holidays and payment terms will remain the same for scheduled center holidays
- 2) Weekly payment terms may in cases be waived on case to case basis. Any changes to the weekly payment terms will be stated here -

The above times and days are flexible but a doctors note should be provided for any drop offs after 10:30 AM Monday - Friday .

If parent is going to be late picking up the child, every effort must be made to contact the center. A late pick up fee of \$1/minute will be charged.

Payment is due to the center in advance of care and paid on the following day of the week: _____. Accepted methods of payment include cash, personal check, credit card, or money order. If a personal check is returned due to a lack of funds, the parent/guardian must pay applicable returned check fee charged by the bank. If a check is returned more than one time, only cash or money orders will be accepted as payment. If a payment is not made on time, the following fee will apply: \$_____

**Overtime rates are as follows:**

For the purpose of this contract, overtime rates are considered any amount of time that care occurs prior to the scheduled drop off time or after the scheduled pick up time.

With advance notice by the parent and approval by the center, the center agrees to provide overtime care at a rate of \$1.00 per minute.

Without advance notice by the parent and approval by the center, the overtime rate will be \$1.00 per minute.

Payments during Holidays, Vacations, and Other absences:

The center will not be open for business on the following Holidays:

We have 8 paid holidays without a deduction in weekly rate. Not all of these holidays will fall during the week. If a holiday falls on Saturday, we close on Friday. If a holiday falls on Sunday, we close on Monday. Our Holidays are: New Year's Day, Memorial Day, Fourth of July, Labor Day, Thanks Giving (Thurs. and Friday), Christmas Eve and Christmas Day.

Parents are expected to pay for care on those Holidays.

The parents can avail of 8 vacation days (available on pro rata basis) in a calendar year (i.e depending on when the child(ren) is enrolled into a program)

If a parent plans on taking a vacation and the child will not be in care, the center must be given at least 2 weeks notice. Parents are not expected to pay during their scheduled vacations.



When a child is ill, the parents are expected to make every effort to give the center as much notice as possible. Parents can use scheduled vacation days with a doctors note or is expected to pay on child sick days.

If a child does not arrive for the day and no notice has been given to the center, parents are still expected to pay.

Additional charges:

The center will charge additional fees as follows: (i.e. for supplies, special trips, damaged property, etc).

Termination Procedures:

"This contract may be terminated by the parent(s) or the center. A 2 - week notice prior to the last date of care is required. After the 2-week notice is provided, any past due payments should be cleared and payment for the 2-weeks will need to be made on the first day of each week.

The center may immediately terminate this contract without any notice if payment is not made on time."

Other:

The Center will take every action to recover outstanding payments owed to the Center including (and not limited to) filing claims with the Magistrate court, reporting to the credit bureau(s) and providing information debt/ outstanding payments to other parties who may be assigned the authority to share delinquency information and/or collect outstanding payments on behalf of the center. What the center considers as delinquent accounts/ bad debt is at the discretion of the Center.

- *If the center chooses not to enforce any portion of the contract, it does not give up the center's right to enforce any other portion of the contract.*
- *The contract can be revised at any time by the center, if necessary.*



I understand if I have an unpaid balance to Camden Kids Academy LLC and do not make satisfactory payment arrangements, my account may be placed with an external collection agency. I will be responsible for reimbursement of any fees from the collection agency, including all costs and expenses incurred collecting my account, and possibly including reasonable attorney's fees if so, incurred during collection efforts.

In order for Camden Kids Academy LLC or their designated external collection agency to service my account, and where not prohibited by applicable law, I agree that Camden Kids Academy LLC and the designated external collection agency are authorized to (i) contact me by telephone at the telephone number(s) I am providing, including wireless telephone numbers, which could result in charges to me, (ii) contact me by sending text messages (message and data rates may apply) or emails, using any email address I provide and (iii) methods of contact may include using pre-recorded/artificial voice message and/or use of an automatic dialing device, as applicable.

Signatures:

The signatures below indicate agreement with this contract and with the written policies of the provider (contained in a separate document). The provider may change policies as needed with advance written notice.

Signature of Parent/Primary Payer:

Date: _____

Name of Parent/Primary Payer

Summer Manuel

Date: 1/1/2020

Center Director
Camden Kids Academy LLC

If the parent or legal guardian is under the age of 18, a co-signer must sign this agreement and act as guarantor to the contract and agree to be bound by all financial terms.

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

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 children in day care (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.

Child's First Name	MI	Child's Last Name	Foster Child	Migrant	Runaway	Homeless	Head Start
			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Check all that apply

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

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 (List only household members with income)

Are you unsure what income to include here? Flip the page 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 Monthly Bi-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'. If you enter '0' or leave any fields blank, you are certifying (promising) that there is no income to report.

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

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

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 the Form

Signature of Adult

Today's Date

Address

City

State

Zip

Phone/Email

Source of Income for Children	
Sources of Child Income	Examples
Earnings from work	<ul style="list-style-type: none"> A child has a regular full or part-time job where they earn a salary or wages
Social Security - Disability Payments - Survivors Benefits	<ul style="list-style-type: none"> 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	<ul style="list-style-type: none"> A friend or extended family member regularly gives a child spending money
Income from any other source	<ul style="list-style-type: none"> 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
<ul style="list-style-type: none"> Salary, wages, cash bonuses Net income from self-employment (farm or business) <p>If you are in the U.S. Military:</p> <ul style="list-style-type: none"> Basic pay and cash bonuses (do NOT include combat pay, FSSA, or privatized housing allowances) Allowances for off-base housing, food, and clothing 	<ul style="list-style-type: none"> Unemployment benefits Workers compensation Supplemental Security Income (SSI) Cash assistance from State or local government Alimony payments Child support payments Veterans benefits Strike benefits 	<ul style="list-style-type: none"> 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

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.

This institution is an equal opportunity provider.

***Only use this address if you are filing a complaint of discrimination.**

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?	Household size	Eligibility	For Child Care Homes Only: Tier I _____ Tier II _____
<input type="text"/>	<input type="radio"/> Weekly <input type="radio"/> Bi-Weekly <input type="radio"/> Monthly <input type="radio"/> 2x Month	<input type="text"/>	<input type="radio"/> Free <input type="radio"/> Reduced <input type="radio"/> Paid	
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	
Determining Official's Signature	Date	Confirming Official's Signature	Date	

South Carolina Department of Social Services
INFANT STATEMENT

From: Child Care Center/Provider: _____
Sponsoring Organization: _____

To: Parent/Guardian of Infant(s) in Child Care

I am required by the Child and Adult Day Care Food Program to **offer** a CACFP meal to all enrolled infants in my care. A CACFP meal includes iron fortified infant cereal and baby food when appropriate for the child's age, at no additional charge.

I am required to **offer** an infant formula, which meets program requirements to all enrolled infants in my care. The formula that I am providing is iron fortified _____. There will be no additional charge to you, if you would like your infant to receive the formula and/or age appropriate food that I am offering.

I understand that not all infants need the same formula, and that the formula served to your infant should be the one recommended by your physician. If you choose, you may continue to provide your infant's formula or other food items.

Parent/Guardian, please check the following statement that applies to you. Then sign and date below:

Name of Infant: _____ **Birth Date:** _____

- ☐ I would like the child care provider to serve my infant the iron fortified infant formula listed above. When my child is developmentally ready, I understand that besides the formula, the caregiver will offer my infant other food items, approved by the CACFP meal pattern guidelines, at no additional charge to me.
- ☐ I will supply the breast milk/infant formula to the child care provider to serve to my infant. The name of the formula I will provide is: _____. I understand that the caregiver will offer other food items, approved by the CACFP meal pattern guidelines, to my child when developmentally ready.
- ☐ I will supply the breast milk on site or express. I understand that the caregiver will offer other food items, approved by the CACFP meal pattern guidelines, to my child to my child when developmentally ready.
- ☐ I will provide breast milk/infant formula and all other meal items to my child care provider to serve to my infant. The name of the formula I will provide is _____.

Note: You will need to provide a medical statement for exempt formulas such as Nutramigen, NeoSure or Alimentum.

If there are any changes from your above selection, a new form is required.

Signature of Parent/Guardian: _____ Date: _____
Signature of Provider: _____ Date: _____