Youth and Teen Program Application

PRIMARY PARENT/GUARDIAN

Name____ Relationship to Child_________________

Physical Address____City_______________ State____ Zip________

Mailing Address (if different)________________________________ City ______________ State ____ Zip _______

Home Phone # _____________ Cell # ________________ Work # ______________ Email: ___________________

Employer ____

SECONDARY PARENT/GUARDIAN

Name ____ Relationship to Child __________________________

Physical Address _______________________________________ City _________________ State _____ Zip ______

Mailing Address (if different) ______________________________ City _________________ State _____ Zip _____

Home Phone # __________________ Cell # ______________ Work # _______________ Email: ________________

Allowed to Pick -Up: Yes__________ No_________
*Person(s) responsible for payment of fees: ____

STUDENT INFORMATION

Child's Name ____ Date of Birth _________________ Age ___
School ____ Grade __________
Sex of Child: Male _____________ Female ___________

Child's Name ____ Date of Birth _____________ Age ______
School ____ Grade __________
Sex of Child Male _____________ Female ___________

Child's Name ____ Date of Birth ____________ Age _______
School ____ Grade ___________
Sex of Child Male ____________ Female ____________

MEDICAL INFORMATION

Does the child have known allergies, dietary restrictions, or medical conditions? If yes, list:

Child's name, allergy, restrictions, conditions, and treatment. **Note:** This center is not authorized to administer medications to children.

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____
____

MEDICAL AUTHORIZATION

Insurance Company ________________________________ Policy Number: _________________________
Doctor's Name ______________________________ Address _________________ Office # ____________
Preferred Hospital: GHS _______ St. Francis__________

Please provide any additional information about your child's history, behavior, physical, emotional, or mental health which staff should be aware____
____
____

ADDITIONAL EMERGENCY CONTACTS & AUTHORIZED PICK-UP LIST

Please list the names of individuals who may be contacted in an emergency if the primary parent/guardian cannot be reached. Anyone **NOT** listed below **WILL NOT** be allowed to pick up your child. A picture ID will be required at pick up. Must list at least two contacts.

Contact/Pick-Up #1: ______________________ Relationship to Child ___________ Phone #__________

Contact/Pick-Up #2: ______________________ Relationship to Child ___________ Phone # __________

Contact/Pick-Up #3: ______________________ Relationship to Child ___________ Phone # __________

Contact/Pick-Up #4: ______________________ Relationship to Child ___________ Phone # __________

PROGRAM AGREEMENTS AND CONSENT

I understand that I am responsible for paying for every week that my child is enrolled in the program. I understand that I must give Pleasant Valley Connection a two week notice before removing my child from the program. I also understand fees and deposits are non-refundable. I also give consent for my child to be transported by Pleasant Valley Connection staff in Pleasant Valley Connection vehicles for pick-up and field trips (if applicable). In the event of an emergency in which I cannot be reached, I authorize medical personnel to provide the necessary first aid and/or hospitalization of my child. I understand that I am responsible for the payment of any medical expenses. I understand that the Summer Day Camp hours are 7:30am-5:30pm and that a $ 1.00 per minute late fee will be assessed for every minute after 5:30pm that my child is not picked up.

Parent/Guardian Signature ___________________________________Date _________________

PROGRAM AGREEMENTS AND CONSENT

Consent to Release of Academic Records, such as MAP & PASS tests and other related information:

I grant consent to my child's school, _________________________________(name of school) for the release of my child's, _____________________________________(student's name) academic records, MAP and PASS scores, attendance records and any disciplinary incidents (i.e. referrals, detentions, etc.) to PLEASANT VALLEY CONNECTION staff; and furthermore, I grant permission to employees of PLEASANT VALLEY CONNECTION to facilitate meetings with teachers, guidance counselors, and other school officials as necessary to share and receive information regarding my child's progress at the school named above and at PLEASANT VALLEY CONNECTION.

Parent/Guardian Signature _____________________________________ Date ___________

WAIVER AND RELEASE FORM

I, ______________________________, The parent/guardian of __________________________
Parent/Guardian Student's Name

Give permission for him/her to participate in the 2021 Pleasant Valley Connection Summer Day Camp program. I understand that program activities involve outdoor games, travel to and from special activities, and other physical activities which can cause bodily injury. I, _____________________________ (parent/guardian) hereby release and hold harmless PLEASANT VALLEY CONNECTION, its agents, and employees from any liability for any injuries or damages resulting from _______________________________ participation in the 2021
Student's Name

Summer Day Camp Program.

Parent/Guardian Signature ___________________________________ Date ______________

PHOTO/MOVIE RELEASE

I understand that photographs of participants may be taken during programs, and I give permission for Pleasant Valley Connection to use those photographs in publicity materials.

Parent/Guardian Signature _____________________________________ Date ____________

PG Movie Release

My Child(ren) ____ has permission to view rated G-PG movies.

Parent/Guardian Signature ____ Date __________

OFF- SITE ACTIVITY CONSENT

I, ________________________________ give permission for my child(ren) __________________________
Parent Name (printed) Child(ren)'s Name(s) Printed

__________________________________ to participate in off-site activities, including swimming, as a participant in The Pleasant Valley Connection, Inc. 2021 Summer Camp.

_____________________________________ ______________________________
Parent Signature Date

TRANSPORTATION CONSENT

I, _______________________________________ give permission to Pleasant Valley Connection to
Parent Name Printed

Transport my child(ren) ____ in Pleasant Valley Connection vehicles to activities as a participant in the 2021 Summer Camp.

____ _______________________________
Parent Signature Date

Consent for Access/Release of Educational Records

Greenville County Schools

I understand that a student's education records are confidential and may only be disclosed as allowed by the Family Educational Rights and Privacy Act of 1974 or with the written permission of the student's parent, legal guardian, or eligible student (who has reached 18 years of age or attends a postsecondary school).

I request that Greenville County Schools provide copies of / or access (verbal and/or written) to education records as specified below:

Student Information

Student's full name (as it appears on the education records):

Last_________________________ First__________________ Middle________________

Date of Birth ___________________

Provide: (check all that apply)

☐ Access to the following records (verbal and/or written) ☐ Copies of records

(If you do not identify specific records, GSC will provide access to the entire educational record)

____

____

____

Person having access to (verbal and/or written), or copies of:

Last _________________________ First__________________ Middle________________

Position or Agency ____

Access Purpose ____

Consent for release of information

I authorize the above named person to have access to (verbal and/or written), or copies of the above specified records for the listed purpose. I understand that this authorization can only be revoked by **my written request**.

Release Authorization (print name)____________________________________ Date__________

Signature: ________________________________

I am: ☐ parent of the named student ☐ legal guardian of the named student ☐ eligible student

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Withdrawing consent for release of information

I am revoking all rights of the above named person's access to (verbal and/or written), or copies of the above specified records for the listed purpose.

Withdrawal Authorization (print name)__________________________________ Date__________

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: ______________________ 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