

Reg fee paid \_\_\_\_\_  
Est. rate \_\_\_\_\_



107 N. Main St Greer, SC 29650  
(864)244-0405 or 864-655-7402/ fax 469-2040  
Registration fee \$100 (non-refundable).  
Please provide latest DHEC Immunization Form.

**Child's Legal Name:** \_\_\_\_\_ **Date of Birth:** \_\_\_\_\_  
**Address:** \_\_\_\_\_ **Telephone:** \_\_\_\_\_  
**City:** \_\_\_\_\_ **State:** \_\_\_\_\_ **ZIP:** \_\_\_\_\_  
**Nickname:** \_\_\_\_\_ email address \_\_\_\_\_

**Mother's Full Name:** \_\_\_\_\_  
**Address:** \_\_\_\_\_  
**City:** \_\_\_\_\_ **State:** \_\_\_\_\_ **ZIP:** \_\_\_\_\_  
**Name of employer:** \_\_\_\_\_ **Occupation:** \_\_\_\_\_  
**Employer address:** \_\_\_\_\_ **City:** \_\_\_\_\_ **State:** \_\_\_\_\_  
**Home #:** \_\_\_\_\_ **Cell #:** \_\_\_\_\_ **Work#:** \_\_\_\_\_

**Father's Full Name:** \_\_\_\_\_  
**Address:** \_\_\_\_\_  
**City:** \_\_\_\_\_ **State:** \_\_\_\_\_ **ZIP:** \_\_\_\_\_  
**Name of employer:** \_\_\_\_\_ **Occupation:** \_\_\_\_\_  
**Employer address:** \_\_\_\_\_ **City:** \_\_\_\_\_ **State:** \_\_\_\_\_  
**Home #:** \_\_\_\_\_ **Cell #:** \_\_\_\_\_ **Work#:** \_\_\_\_\_

**Parent with legal custody:** \_\_\_\_\_

**Person(s) authorized to assume responsibility for your child in case of emergency:**  
**Name:** \_\_\_\_\_ **Relationship:** \_\_\_\_\_ **Telephone #:** \_\_\_\_\_  
**Address:** \_\_\_\_\_  
**Name:** \_\_\_\_\_ **Relationship:** \_\_\_\_\_ **Telephone #:** \_\_\_\_\_  
**Address:** \_\_\_\_\_

**Person(s) authorized to pick your child up from center:**  
**Name:** \_\_\_\_\_ **Relationship:** \_\_\_\_\_ **Telephone #:** \_\_\_\_\_  
**Address:** \_\_\_\_\_  
**Name:** \_\_\_\_\_ **Relationship:** \_\_\_\_\_ **Telephone #:** \_\_\_\_\_  
**Address:** \_\_\_\_\_

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



## First Aid & Transportation

I hereby give permission to Minds in Motion Learning Center staff to administer first aid treatment. I also give Minds in Motion V.P. permission to transport my child by car, bus or ambulance to an emergency facility for treatment, and agree to hold Minds in Motion V.P. harmless.

Parent/Legal Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_

## Medical Care & Treatment

In the event that I can not be contacted immediately, medical or surgical treatment can be administered to my child in the event of accident or emergency, as prescribed by a treating physician, and agree to hold Minds in Motion V.P. harmless.

Parent/Legal Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_

## Medical & Dental

I do hereby give consent for Minds in Motion V.P. to seek & authorize medical and or dental care for my child. I understand that i will be responsible for all medical and or dental fees that are incurred.

Parent/Legal Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_

## Photo Releases

I do hereby give consent for Minds in Motion V.P. to photograph and or video tape my child. I understand that these photos may be posted on Minds In Motion VP & LC website & used in conjunction with promotions, social media and advertising. I also release any rights to said photos.

Parent/Legal Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_

## Field Trips

My child has my permission to ride the Minds In Motion V.P. school bus to and from school and on field trips.

Parent/Legal Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_

# Health Information

Child's Name: \_\_\_\_\_ Nickname: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

Statement of Child's Present Health: \_\_\_\_\_

Name of Family Physician: \_\_\_\_\_ Telephone #: \_\_\_\_\_

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

Name of Dentist or Health Resource: \_\_\_\_\_

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

Hospital Reference: \_\_\_\_\_

**PLEASE INDICATE BELOW IF YOUR CHILD HAS HAD ANY OR HAS ANY OF THE FOLLOWING:**

Eye Trouble \_\_\_\_\_

Ear, Nose, Throat \_\_\_\_\_

Hearing Loss \_\_\_\_\_

Frequent or Severe Headaches \_\_\_\_\_

Dizziness or Fainting Spells \_\_\_\_\_

Head Injury \_\_\_\_\_

Epilepsy \_\_\_\_\_

Loss of Consciousness \_\_\_\_\_

Shortness of Breath or Lung Trouble \_\_\_\_\_

Spitting Up Blood \_\_\_\_\_

Tuberculosis \_\_\_\_\_

Skin Disease \_\_\_\_\_

Chest Pain \_\_\_\_\_

High Blood Pressure \_\_\_\_\_

Frequent Indigestion or Reflux \_\_\_\_\_

Stomach, Liver or Intestinal Problem \_\_\_\_\_

Rupture or Hernia \_\_\_\_\_

Piles or Rectal Problem \_\_\_\_\_

Sugar or Albumen In Urine \_\_\_\_\_

Jaundice \_\_\_\_\_

Diabetes \_\_\_\_\_

Heart Trouble \_\_\_\_\_

Bone, Joint or Other Deformity \_\_\_\_\_

Back Trouble \_\_\_\_\_

Tumor, Growth, or Cancer \_\_\_\_\_

Nervous Trouble of Any Sort \_\_\_\_\_

Mental Incapacity \_\_\_\_\_

Frequent Nose Bleeds \_\_\_\_\_

Any Adverse Reaction To Drugs or Medicine \_\_\_\_\_

Any Illness or Injury Not Mentioned Above \_\_\_\_\_

Allergies or Additional Concerns: \_\_\_\_\_

\_\_\_\_\_

*If your child is not attending school, please attach a copy of the most recent immunization record.*

Parent/Legal Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_

# Discipline Policy

At Minds in Motion V.P., our goal is to help cultivate the positive qualities in which your child possesses. We also want to foster ways of helping children learn self control, self confidence and to respect others.

If a child is having problems in the areas mention above, the teacher will calmly ask the child questions about this behavior.. (ex. Are you making good choices) The teacher will also reinforce our motto - " Think before we speak and before we act". This will allow the child to use their own thought process in a calm manner to make good decisions. The teacher will also encourage the child to use their words when expressing themselves to their classmates. (ex. I didn't like that when you took my toy, may I have it back please).

We will redirect, use conflict resolution, and the thinking area as disciplinary measures. We do not in any way advocate corporal punishment.

If a child bites, uses profanity, or tries to cause bodily harm to another child or staff member the parents will be contacted for a parent conference to see if there are problem areas we can work on as a team.

If the behavior continues, we will have no choice but to terminate child care services.

I have read this policy and understand it fully, by signing I agree to this policy.

Parent Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Parent Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Parent Signature: \_\_\_\_\_ Date: \_\_\_\_\_

\*\*\*\*\*STAFF USE ONLY\*\*\*\*\*

DATE ENROLLED \_\_\_\_\_ DATE STARTED \_\_\_\_\_

LAST DATE ATTENDED \_\_\_\_\_

REASON FOR LEAVING \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

STAFF NOTES \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_