APPLICATION PACKET

Veatrice Victoria Reid Academy

612 Gabriel Street
Columbia, SC 29203
803.735.9570 (P) | 803.754.0245 (F)
www.vvreid.org

REID TODAY... LEAD TOMORROW

Infants 6 weeks & up, Toddlers, Pre-School, Kindergarten, and 1st - 3rd Grade Students

PARENT ENROLLMENT CHECKLIST

V.V. Reid
612 Gabriel Street Columbia, SC 29203

- ❑ Birth Certificate (copy)
- ❑ Recent Photo
- ❑ Social Security Card (copy)
- ❑ SC Immunization Certificate (All students must have current immunization records on file.)
- ❑ DSS Form 2900
- ❑ Student Records (Elementary students ONLY, records must be received prior to enrollment)
- ❑ Emergency Medical Care Form
- ❑ Medication Authorization Form
- ❑ Photography/Video Permission Form
- ❑ Field Trip Authorization Form
- ❑ Allergy Information Sheet
- ❑ Discipline Policy
- ❑ Signed Financial Policy
- ❑ Acknowledgment of Receipt of Parent Handbook

STUDENT REGISTRATION FORM

V.V. Reid
612 Gabriel Street Columbia, SC 29203

Check one or both: Summer ☐ Fall ☐

_____ Boy ☐ Girl ☐

Child's Name: Last First Middle

Birth date: _____ **Birthplace:** _____

Class Desired: ***Infant/Toddler:*** ☐ 6 wks-1 year ☐ 1yr – 2 ½ ***Pre-K:*** ☐ Pre-K 2 ½ ☐ Pre-K 3 ☐ Pre-K 4

Elementary: ☐ Kindergarten ☐ 1st ☐ 2nd ☐ 3rd ☐ 4th ☐ 5th

Name of Last School Attended: _____

_____

Mother's Name: Last First Middle

_____

Address City State Zip Home Phone

_____

Occupation Employer Work Phone Cell Phone/Pager

E-mail address: _____

_____

Father's Name: Last First Middle

_____

Address (if different) City State Zip Home Phone

_____

Occupation Employer Work Phone Cell Phone/Pager

E-mail address: _____

Parent/Guardian Status: ☐ Married ☐ Single ☐ Divorced ☐ Separated ☐ Widowed

Who has custodial rights?: ☐ Both ☐ Father ☐ Mother ☐ Guardian

_____

Name of Guardian *(if applicable)*

_____

Address City State/Zip Home Phone Cell Phone

E-mail address: _____

Comment on eating habits/ food allergies:_____

_____

Comment on specific dislikes or fears :_____

_____

Comment on child's behavior/ discipline:_____

_____

Favorite toys or activities:_____

_____

Children must be toilet trained in order to enter preschool. Does your child take total responsibility for his/her toilet needs? ☐ Yes ☐ No

If no, please explain:_____

Previous preschool experience: _____

Has your child been tested for or diagnosed with any special needs? ☐ Yes ☐ No

If yes, please explain: _____

Any additional information that would help us to better understand and work with your child:

_____

MEDICAL INFORMATION

Pediatrician's/Doctor's Name: _____

Address:_____ Telephone: _____

Preferred Hospital (In Case of Emergency): _____

EMERGENCY CONTACT LIST

In the event of an emergency and parents cannot be reached, the following person(s) will be contacted:

Name	Telephone	Relationship

AUTHORIZED RELEASE

The child can be released to the following individuals only:

Name	Telephone	Relationship

Parent Signature: _____ Date _____

EMERGENCY CARE PERMISSION FORM

V.V. Reid
612 Gabriel Street Columbia, SC 29203

Name of Child: _____

I understand that every effort will be made to contact me in the event of an emergency requiring medical attention for my child. However, if I cannot be reached, I hereby authorize V.V. Reid Academy to transport my child to:

Select Preferred Hospital:

☐ Palmetto Richland Hospital

☐ Other _____

I also give permission to secure for my child the necessary medical treatment including anesthesia. I further understand the designated emergency officers at V.V. Reid Academy are trained in the basics of First Aid, and I authorize them to give my child First Aid when appropriate.

I further understand that the school is in no way liable for medical expenses incurred from illness and/or accidental injury while in attendance during the regular school day and attendance or participation in any of the school-sponsored activities.

Is your child allergic to any medications? If so, please indicate:

Allergy	Reaction

Parent/Guardian: _____
Printed Name

_____
Signature

_____
Date

Medical Insurance Information

Policy Holder:_____

Policy Number: _____ Doctor's Name: _____

Doctor's Address: _____

Telephone:_____

MEDICATION AUTHORIZATION FORM

V.V. Reid
612 Gabriel Street Columbia, SC 29203

Instructions:
This form shall be completed and signed by the parent or guardian before any medication is administered.

Name of child:_____ Birth date: _____

MEDICATIONS

Name of Medication	Dosage	Time of Day to Administer		How to Administer	Dates/Time Period	
					Begin	End
		AM	PM			
		AM	PM			
		AM	PM			
		AM	PM			
		AM	PM			
		AM	PM			

- If an over-the-counter (OTC) medicine, does the label indicate that the child's physician should be consulted? ☐ YES ☐ NO
- If YES:

I have consulted with my child's physician and I _____ am authorizing a dosage consistent with the physician's recommendation.
Parent/Guardian

OTC Medication Name: _____ Parent/Guardian Initials: _____

Authorization:
I hereby authorize administration of the above medication(s) to my child by the designated Medical Emergency staff of V.V. Reid Academy.

_____ _____ _____
Print Name of Parent or Guardian Signature Date

PHOTOGRAPHY & VIDEO TAPING PERMISSION FORM

V.V. Reid
612 Gabriel Street Columbia, SC 29203

I hereby grant permission to V.V. Reid Academy to photograph or videotape my child for the use in newsletters, posters, scrapbooks, presentations, class work, websites, brochures and other media forms that will be used for the promotion of V.V. Reid Academy.

Child's name:_____

Parent/Guardian Signature: _____

FIELD TRIP INFORMATION SHEET

V.V. Reid
612 Gabriel Street Columbia, SC 29203

Please complete this form that will accompany your child on the field trip. This information is necessary should we need to contact you while we are away from the school. No student will be allowed to participate without this form being completed and signed by the parent or guardian. The information on this form is considered confidential and will accompany the school trip leader/nurse on the trip.

Student Name: _____

Mother's Name:_____

Cell Number: _____

Work Number: _____

Father's Name: _____

Cell Number: _____

Work Number: _____

ALTERNATE EMERGENCY CONTACT PERSONS

Name	Telephone

Signature:_____ Date:_____

(Parent/Guardian)

FOOD ALLERGY INFORMATION SHEET

V.V. Reid
612 Gabriel Street Columbia, SC 29203

Parents, if your child is allergic to any type of food or drink, please list them below. If there are any medical conditions that we should be aware of, please list them below as well.

Student Name: _____

Food Allergies and/or Medical Conditions:

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

Please complete document, sign and date: _____
Signature

_____
Date

DISCIPLINE & BEHAVIOR MANAGEMENT POLICY

V.V. Reid
612 Gabriel Street Columbia, SC 29203

I _____, have received and understand the Discipline
Parent/Guardian
& Behavior Management Policy. The policy outlines methods of guidance appropriate to the ages of the children and include, but not limited to the following:

- Positive, non-violent, non-abusive methods for managing behavior shall be implemented
- Corporal punishment shall not be used in this facility
- Emotional abuse is also prohibited, including but not limited to: profane, harsh, demeaning or humiliating language in the presence of children
- Threatening, humiliating, ignoring, corrupting, terrorizing or rejecting a child is prohibited
- Withholding, forcing or threatening to withhold for of force food, sleep or toileting is prohibited
- Unsupervised isolation of a child shall not be allowed
- The use of children to discipline other children is prohibited
- Children shall not be restrained through drugs or mechanical restraints

Please sign and date:

Printed Name: _____

Signature: _____ Date _____

FINANCIAL POLICY STATEMENT

V.V. Reid
612 Gabriel Street Columbia, SC 29203

V.V. Reid Academy is a Christ-centered, faith-based ministry. As such, it meets its financial responsibilities solely through the financial faithfulness of its students' families, augmented by financial contributions from concerned individuals or Reid Chapel A.M.E. Church. V.V. Reid Academy does not receive any government or public funds; therefore, the timely fulfillment of each family's commitment is of the utmost importance. Accordingly, parents agree to the following:

1. I/We understand that the school's tuition is a weekly financial commitment, and payments are due every Monday. I/We understand that weekly tuition is to be paid in full by 10:00 AM on Monday. If not, a $15.00 late fee will be a charged your account. If payment is not received by the close of the business on Monday, I/we will not be permitted to bring my/our child(ren) to school the next day, and our child(ren) will not be permitted to return to school until ALL fees are current.
2. I/We understand that a $55.00 charge will be assessed for returned checks. In addition, a $15.00 weekly late fee will be charged to unpaid returned check balance for a total of $70.00 in addition to the current tuition payment. After two (2) returned checks, all future payments must be cash, money order or certified check.
3. I/We understand monthly statements are NOT sent; however, they are available upon request and for tax purposes.
4. I/We understand that all past due accounts must be made current to maintain priority registration for the following school year.
5. I/We understand that if my/our child(ren) transfer to another school all accounts must be paid in full before transcripts will be released.
6. I/We understand and agree that I am/we are responsible to give the school a two weeks notice prior to withdrawing my/our child(ren) from the school and that I/we am/are responsible to satisfy all tuition obligations during the child(ren)'s time of enrollment.

I have read the above policy and agree to comply with the terms as stated.

Signature_____

Printed name_____

Child's Name_____

Business Office Use Only

Date Received_____ Applicant Term & Year_____

RECURRING ACH AUTHORIZATION FORM

V.V. Reid
612 Gabriel Street Columbia, SC 29203

All payments for tuition will be received through ACH draft. Payments can be made from a checking or savings account or a credit card or debit card. **If this form is not completed, your student(s) will not be accepted.**

You authorize regularly scheduled charges to your checking/savings account. You will be charged the amount indicated below each billing period. A receipt for each payment will be provided to you and the charge will appear on your bank statement as an "ACH Debit". You agree that no prior notification will be provided unless the date or amount changes, in which case you will receive notice from us at least 10 days prior to the payment being collected.

I, _____, authorize V.V. Reid Academy to charge my bank account

indicated below for $_____ on the Monday of each week. This payment is for school tuition.

Billing Information

Billing Address _____ Phone # _____

City, State, Zip _____

Email _____

Checking/Savings Account

☐ Checking ☐ Savings

Name on Acct _____

Bank Name _____

Account Number _____

Routing Number _____

Bank City/State _____

Credit/Debit Card

☐ Visa ☐ MasterCard
☐ American Express ☐ Discover

Cardholder Name _____

Account Number_____

Exp. Date _____

CVV _____

I understand that this authorization will remain in effect until I cancel it in writing, and I agree to notify V.V. Reid Academy in writing of any changes in my account information or termination of this authorization at least 15 days prior to the next billing date.

For ACH debits to my checking/savings account, I understand that because these are electronic transactions, these funds may be withdrawn from my account as soon as the above noted periodic transaction dates. In the case of an ACH Transaction being rejected for Non-Sufficient Funds (NSF)

I understand that V.V. Reid Academy may at its discretion attempt to process the charge again within 7 days, and agree to an additional $55.00 charge for each attempt returned NSF which will be initiated as a separate transaction from the authorized recurring payment. I acknowledge that the origination of ACH transactions to my account must comply with the provisions of U.S. law.

I certify that I am an authorized user of this bank account and will not dispute these scheduled transactions with my bank; so long as the transactions correspond to the terms indicated in this authorization form.

Student Name: _____

Student Name: _____

Student Name: _____

SIGNATURE _____ DATE _____
(Account Holder's 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: V. V. Reid Academy County: Richland

Address: 612 Gabriel Street (Street Address – no Post Office Boxes) Columbia, South Carolina 29203 (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