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:				
Child's Name:	- no Post Office Boxes		City, State, Zip	
	First	Middle Initial	Nick Name	
		rollment 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 1. Person responsible if parent/gu	-		cal treatment for the child.	
Full	Name	Relationship		
Address:s	treet Address	City, State, Zip		
Telephone Number(s):		Family Code V	Family Code Word(s):	
2. Person responsible if parent/gu	ardian unavailable for emerge	ency medical services:		
	Name	Rela	tionship	
Address:s	treet Address	City, State, Zip		
		Family Code Word(s):		
Is Child currently enrolled in scho	ol? (5K up to 6 years old)] Yes 🛛 No		
My Child will regularly attend this	facility FROM a	.m/pm TO a	am/pm	
If Child is a drop-in, indicate hour	s of care: FROM	_ am/pm TO	am/pm	
Check all days Child will regularly	v attend this facility: D Mon	□ Tue □ Wed □ T	hurs 🛛 Fri 🗆 Sat 🗆 Sun	
Check all meals Child will receive	e daily: 🛛 Meals are not off	fered 🛛 Breakfast	Morning Snack Lunch	
□ Afternoon Snack □ Dinner	Evening Snack			
HEALTH INFORMATION: (to be	completed by Parent or Guard	dian)		
Family Physician or Health Resou	Irce:	Name		
			-	
Street Address Emergency Care Provider:	City, State,	μ∠ip	Telephone	
	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:			
following medications on a	a regular	basis:		diabetes, epilepsy, etc., and/or takes the		
Additional Comments:						
I certify that to the best of m	y knowled	lge				
-	Child's Name					
is in good mental and physic	al health	and able	e to participate in the child care	program at		
			Name of Child Care Facility			
Signature:				Date:		
		Parent	or Guardian			
Signature:				Date:		
	Direc	ctor/Opera	ator/Staff Designee			