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:	Facility: County:				
Address:					
	ss – no Post Office Boxes	City, Stat	e, Zip		
Child's Name:Last		Middle Initial	Nick Name		
	Enro	Ilment 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:			
	s who have the authority to ob guardian unavailable for emergen		itment for the child.		
Addross:	III Name	Relationship			
	Street Address	City, State, Zip			
Telephone Number(s): Family Code Word(s):					
2. Person responsible if parent/g	guardian unavailable for emergen	cy medical services:			
	III Name	Relationship			
Address:	Street Address	City, State, Zip			
Telephone Number(s):		Family Code Word(s):			
Is Child currently enrolled in sch	ool? (5K up to 6 years old) \Box `	Yes 🛛 No			
My Child will regularly attend thi	s facility FROM am	/pm TO am/pm			
If Child is a drop-in, indicate hou	am/pm TO am/p	m			
Check all days Child will regular	rly attend this facility: 🛛 Mon 🔅	🗆 Tue 🛛 Wed 🖓 Thurs	🗆 Fri 🛛 Sat 🖓 Sun		
Check all meals Child will receive	ve daily: 🛛 Meals are not offe	red 🛛 Breakfast 🖓 Mori	ning Snack 🛛 Lunch		
Afternoon Snack Dinner	er 🛛 Evening Snack				
HEALTH INFORMATION: (to be	e completed by Parent or Guardia	an)			
Family Physician or Health Reso	ource:	Name			
Street Address Emergency Care Provider:	City, State, Z	ip	Telephone		
	E	Emergency Facility Name			
Street Address	City, State, Z	ip	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 following medications on a	health c a regular	onditior basis:	ns such as allergies, asthma, d	liabetes, epilepsy, etc., and/or takes the	
Additional Comments:					
I certify that to the best of m	y knowled	dge			
	Child's Name				
is in good mental and physic	ai nealth	and able	e to participate in the child care p	program at	
Name of Child Care Facility					
Signature:		Parent	or Guardian	Date:	
Signature:	Dire	ctor/Opera	ator/Staff Designee	Date:	