

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: \_\_\_\_\_ Select 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

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