

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 annually thereafter, and maintained on file at the facility.

GENERAL INFORMATION: *(to be completed by Parent or Guardian)*

Name of Facility: _____ 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) (Phone)

Emergency Care Provider: _____
(Emergency Facility Name)

(Street Address) (City, State, Zip) (Phone)

Dental Care Provider: _____
(Name)

(Street Address) (City, State, Zip) (Phone)

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)

Parent's Authorization Form For CCC and GCCH

Child Care Name _____

Child's Name _____

Do you understand the discipline policy of this child care facility? Yes _____ No _____

Does this child care use corporal punishment? Yes _____ No _____

If yes, have you given permission for your child to be spanked? Yes _____ No _____

If yes, in what manner? _____

Have you read, and do you understand, all policies of this child care? Yes _____ No _____

Signature _____ Date _____

I give permission for prescription and non-prescription medicine to be given to my child.

Signature _____ Date _____

The following persons are authorized to pick up my child:

Signature _____ Date _____

I give permission for the child care to transport my child to and from the center and/or on field trips.

Signature _____ Date _____

I give permission for my child to participate in swimming activities.

Signature _____ Date _____

I give permission for _____ child care center to obtain emergency medical treatment for my child.

Signature _____ Date _____