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: Shanklin county: Beaufort

Address:

a) street Address:121 Morrall Dr

b) City, state, Zip: Beaufort, SC 29906

Child's Name:

a) Last: child l name

b) First: child f name

C) Midde Initial:child m name

b) Nick Name:

Date of Birth: Enrollment Date:

Child's Current Home Address:

a) street Address: USA

b) City, state, Zip: ciy, GA, 1212

Parent/Guardian's Full Name: parent f name parent l name

Phone: (111) 111-1111 Work Phone: Other Phone:

Parent/Guardian's Full Name:

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:

a) Full Name:

b) Relationship:

C) street Address:

D) City, state, Zip :

E) Telephone Number(s):

F) Family Code Word(s):

2. Person responsible if parent/guardian unavailable for emergency medical services:

a) Full Name:

b) Relationship:

C) street Address:

D) City, state, Zip :

E) Telephone Number(s):

F) Family Code Word(s):

Is Child currently enrolled in school? (5K up to 6 years old): No

My Child will regularly attend this facility FROM 7 am am/pm TO 2:45 pm 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

Check all days Child will regularly attend this facility:

Breakfast Morning Snack Lunch

Afternoon 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 : Full Name
street Address:
City, state, Zip:
Telephone:

Dental Care Provider

Name :
street Address:
City, state, Zip:
Telephone:

Health Care Provider

Name :

Certificate of immunization: Yes

My child has the following health conditions such as allergies, asthma, diabetes, epliepsy, etc. and or take the following medications on a regular basis.

Aditional comments:

I certify to the best of my knowledge:

Child Name:child f name child m name child l name

is in good mental and physical health and able to participate in the child care program at

Name of the child care facility: Shanklin

parent f name parent l name
Parent Signature

06-01-2020
Date

Yes, I confirm that I have read and understand this form. By checking this box, I am electronically signing this form.

Director/operator/staff designee

06-01-2020
Date