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 or Jasper

Address:

a) street Address - no Post Office Boxes:

b) City, state, Zip:

Child's Name:

a) Last:

b) First:

C) Midde Initial:

b) Nick Name:

Date of Birth: 05-12-2020Enrollment Date:

Child's Current Home Address:

a) street Address: USA

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

Parent/Guardian's Full Name: kamruzzaman

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:

Check all days Child will regularly attend this facility:

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

Dental Care Provider

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

Health Care Provider

Name :

Certificate of immunization: No

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:sarder

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

Name of the child care facility: Shanklin

Kamruzzaman	05-29-2020
Parent or guardian	**Date**

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

	05-29-2020
Director/operator/staff designee	**Date**