**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:

Address:

Street Address – no Post Office Boxes City, State, Zip

**Child’s Name:**

Date of Birth:

Enrollment Date:

Child’s Current Home Address:

Parent/Guardian’s Full Name:

Work Phone:

Other Phone:

Home Phone:

Parent/Guardian’s Full Name:

Work Phone:

Other Phone:

Home Phone:

Last First Middle Initial Nick Name

Street Address

City, State, Zip

**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:

Telephone Number(s):

Family Code Word(s):

Street Address

City, State, Zip

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

Full Name Relationship

Address:

Telephone Number(s):

Family Code Word(s):

Street Address

City, State, Zip

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  Emergency Care Provider: | City, State, Zip | Telephone |

Emergency Facility Name

Street Address City, State, Zip Telephone

DSS Form 2900 (MAR 10) Edition of OCT 07 is obsolete.

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

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