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)

DSS Form 2900 (SEPT 06) Edition of DEC 05 is obsolete.