**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: Creative Beginnings CDC County: Lexington

Address: 8023 Irmo Dr, Columbia, SC 29212

**------------------------------------------------------------------------------------------------------------**

**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:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Cell Phone:\_\_\_\_\_\_\_\_\_

Parent/Guardian's Full Name:

Home Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_Work Phone:\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Cell 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**

**Check** all meals Child will receive daily:

 **□ 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    \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Street Address \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_City, State, Zip\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Telephone \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_