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: Holy Trinity Episcopal Day School County: Pickens

Address: 193 Old Greenville Highway Clemson, SC 29631
Street Address – no Post Office Boxes City, State, Zip

Child's Name: _____
Last First Middle Initial Nick Name

Date of Birth: _____ Enrollment Date: August 20, 2019

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** N/A am/pm **TO** N/A 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 Telephone

Emergency Care Provider: _____
Emergency Facility Name

_____
Street Address City, State, Zip Telephone

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

Holy Trinity Episcopal Day School
Name of Child Care Facility

Signature: _____ Date: _____
Parent or Guardian

Signature: _____ Date: _____
Director/Operator/Staff Designee