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: Mommy's Time Out, LLC ______ County: Orangeburg

Address: 1151 Henley Street ______ Orangeburg, South Carolina 29115
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 ______ 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

____
Name of Child Care Facility

Signature: ______________________________ Date: ______________
Parent or Guardian

Signature: ______________________________ Date: ______________
Director/Operator/Staff Designee

CHILDCARE ENROLLMENT

PLEASE PRINT LEGIBLY & FILL OUT ALL SECTIONS OF THIS FORM

STUDENT INFORMATION

FULL NAME (LAST, MIDDLE, FIRST): ______________________

DATE OF BIRTH: ______________ SEX: ________ AGE: ______________

NICKNAME ______________________ ENROLLMENT DATE: ______________

FAMILY INFORMATION

CHILD LIVES WITH ______________________

MOTHER'S NAME ______________________ ☐ PARENT ☐ LEGAL GUARDIAN

PLACE EMPLOYED ______________ WORK PHONE ______________

HOME ADDRESS ______________________

HOME PHONE ______________ CELL PHONE ______________

FATHER'S NAME ______________________ ☐ PARENT ☐ LEGAL GUARDIAN

PLACE EMPLOYED ______________ WORK PHONE ______________

HOME ADDRESS ______________________

HOME PHONE ______________ CELL PHONE ______________

CUSTODY ☐ MOTHER ☐ FATHER ☐ BOTH ☐ OTHER ______________

MEDICAL INFORMATION

I hereby grant permission for the staff of this facility to contact the following medical personnel to obtain emergency medical care if warranted.

CHILD'S DOCTOR ______________ DOCTOR'S PHONE ______________

ADDRESS ______________________

CHILD'S DENTIST ______________ DENTIST'S PHONE ______________

ADDRESS ______________________

HOSPITAL PREFERENCE ______________________

PLEASE LIST ALLERGIES, SPECIAL MEDICAL OR DIETARY NEEDS, OR OTHER AREAS OF CONCERN ______________

____

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AUTHORIZATIONS

Child will be released only to the custodial parent or legal guardian and the persons listed below. The following people will also be contacted and are authorized to remove the child from the facility in case of illness, accident or emergency if for some reason the custodial parent or legal guardian cannot be reached.

NAME	ADDRESS	WORK#	HOME#
NAME	ADDRESS	WORK#	HOME#
NAME	ADDRESS	WORK#	HOME#
NAME	ADDRESS	WORK#	HOME#

HELPFUL INFORMATION ABOUT CHILD

Your signature below indicates that you have received the above items and that the information on this enrollment form is complete and accurate.

PARENT/GUARDIAN SIGNATURE: ______________________ DATE: __________

EMERGENCY CONTACT LIST

CHILD'S NAME: ______________________ DATE: __________

PLEASE FILL OUT AND SIGN A NEW EMERGENCY CONTACT LIST EACH YEAR

MY NAME: ______________________ I AM CHILD'S ☐ PARENT ☐ LEGAL GUARDIAN

PLEASE PRINT FULL NAME

AND ______________________ IS CHILD'S SECOND ☐ PARENT ☐ LEGAL GUARDIAN

PLEASE PRINT FULL NAME

YOU CAN REACH ME AT THESE NUMBERS/THIS STREET ADDRESS:

HOME: .... ☐ N/A NO LANDLINE

MOBILE: ....

WORK: ....

ADDRESS: ....

....

....

IF YOU CAN'T REACH ME, PLEASE CONTACT ONE OF THESE INDIVIDUALS:

NAME: ....

RELATIONSHIP: ....

PHONE: ....

ADDRESS: ....

....

NAME: ....

RELATIONSHIP: ....

PHONE: ....

ADDRESS: ....

....

ALLERGIES:

☐ LIFE THREATENING

....

....

CHILD'S DOCTOR'S INFORMATION:

NAME: ....

TEL: ....

MY CHILD IS CURRENTLY TAKING THESE MEDICATIONS

By signing I authorize the childcare facility or its agents to call 911 on behalf of my child in an emergency.

SIGNATURE: ______________________ DATE: __________

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