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: Bethel Cares County: Kershaw

Address: 814 Fair Street, PO BOX 581(29021) Camden, SC 29020
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

PERMISSION FORM

****

EMERGENCY MEDICAL TREATMENT

I hereby give permission that my child,_____, may be given emergency treatment by a staff member at the daycare center. I also give permission for my child to be transported by car or ambulance to an emergency center for treatment. In the event that I cannot be contacted immediately, medical treatment can be administered to my child in the case of an accident or emergency, as prescribed by the physician.

Child's Physician_____Address_____Phone#_____

Child's Dentist_____Address_____Phone#_____

Child's Insurance Provider_____Address_____Phone#_____

Please list below the name, address, telephone # and relationship of at least 2 individuals who may be contacted in an emergency if you can not be reached and who have the authority to obtain emergency medical treatment for the child.

Name_____Address_____Phone#_____Relationship

Name_____Address_____Phone#_____Relationship

****

TRANSPORTATION, FIELD TRIPS AND SWIMMING

I hereby give permission that my child,_____, may be transported to and from school. I understand that special field trips, including swimming, will require separate and individual permission slips. My child will not be allowed to participate unless individual permission slips are completed for EACH trip.

****

MEDICATION

If any medication is to be given to my child_____, it must be brought in it's original container and clearly labeled. Individual medication sheets must be filled out daily in order for medication to be given. Information will be logged immediately following the administration of the medication, and a copy will be provided to the child's parent or guardian. If there is an error in administering the medication, parents/guardians will be notified immediately, and it will be documented in writing.

****

PICK-UP AUTHORIZATION

The following people are authorized to pick up my child,_____.

1)_____Address_____Phone#

2)_____Address_____Phone#

3)_____Address_____Phone#

****

I understand and agree to accept the above policies regarding emergency medical treatment, transportation, field trips, medication, and child pick-up.

PARENT'S SIGNATURE_____DATE_____

REQUIRED POLICIES

Confidentiality of Records (DSS Regulation # 114-503 I (1)

Children's records are open only to the particular child's teacher, the director(s) or director designee, authorized employees of the Department of Social Services, and the child's parent or legal guardian.

Staff/personnel records are open only to that staff member, the director(s) or director designee, and authorized employees of the Department of Social Services.

All files will be kept locked up in the director's office.

Right of Parents to Free and Full Access to Their Child (DSS Regulation # 114-503 F(3) (a)

The center shall permit the parent of a child to free and full access to his or her child without prior notice unless there is a court order limiting parental access. This free access must not disrupt instructional activities and classroom routines.

Emergency Medical Plan (DSS Regulation #114-505 C (1)

In the case of a medical emergency in which emergency care and treatment is warranted, the following steps will be followed:

911 and the parent/guardian will immediately be called. If CPR or First Aid is necessary, trained staff will administer treatment until the ambulance arrives. Emergency information for the child will be taken with the child to the hospital or emergency room. A staff person will remain with the child at the hospital or emergency room location until the parent/guardian arrives.

I have read and understand all policies relating to the operation of the facility.

Signature_____**Date**_____

DISCIPLINE POLICY

I understand that inappropriate behavior (such as biting, spitting, slapping or kicking) which may be harmful to other children or the teachers will be handled in the following manner:

First Offense: Time Out with a note sent home to parents will be used for children over two years of age. Redirection will be used for those under the age of two. The length of time-out will be according to the age of the child. Approximately one minute of time-out will be used per yearly age of the child. For example, three year olds will have a three minute time out period; four year old children will have a four minute time out period; etc.

Second Offense: Parents will be called to pick up child.

Third Offense: Immediate expulsion (removal) of child from daycare

Note: We do not participate in any form of corporal punishment, not even when authorized by the parent.

Signature:_____ **Date:**_____

Signature:_____ **Date:**_____

Signature:_____ **Date:**_____

Signature:_____ **Date:**_____

Signature:_____ **Date:**_____

Signature:_____ **Date:**_____

***************This form must be signed and dated yearly.**