



MCCS CYTP
 Hourly Care Facility
 P.O. BOX 51008
 BEAUFORT, SC 29904

Start Date: _____

DROP-IN REGISTRATION FORM

Child's	
Name: _____ (Last) (First) (MI)	Birthdate: _____
Home Address: _____ (Street)	Home Phone #: _____
_____ (City) (State) (Zip)	Nickname: _____ (if any)
Sponsor's	
Name: _____ (Last) (First) (MI)	S.S. #: _____
Work Place: _____	Work / Cell Phone #: _____ / _____
Work Address: _____ (Street or Command)	Rank/Grade: _____
_____ (City) (State) (Zip)	
Spouse's	
Name: _____ (Last) (First) (MI)	S.S. #: _____
Work Place: _____	Work / Cell Phone #: _____ / _____
Work Address: _____ (Street or Command)	Rank/Grade: _____
_____ (City) (State) (Zip)	

EMERGENCY CONTACT/PICK-UP PERSON: (Person to contact if a parent cannot be reached)	
Name: _____ (Last) (First) (MI)	Home Phone #: _____
Person may pick-up child? <input type="checkbox"/> Yes <input type="checkbox"/> No	Work / Cell Phone #: _____ / _____
Relation to child: _____	Phone #: _____ / _____

MEDICAL HISTORY **A copy of the Child's shot record must be attached to this form**	
I certify that to the best of my knowledge and belief that my child is in good and normal health and has no contagious or infectious diseases.	
Parent's Initials: _____	
Describe any chronic illness', conditions, disabilities or allergies: _____	
Identify any medications child is receiving and for what reason: _____	

Parent Signature: _____ Date: _____

PRIVACY ACT STATEMENT: Under the authority of Title 5, U.S. Code 301, Departmental regulations information regarding registration of authorized dependents is required to provide customer service for authorized personnel to utilize the facilities. The information provided will be used to notify parents when situations concerning their children occur. The information is voluntary, but failure to provide the information will result in the inability of the child care personnel to allow the individual to take advantage of the services.

MCCS-SC BEAUFORT
CHILD CARE RESOURCE & REFERRAL PROGRAM
STATEMENT OF SPECIAL NEEDS

MCCS-SC Beaufort is committed to including children with special needs in regional Child Development Programs. Special needs may require smaller group size, a teacher or provider with special skills or training, or physical changes to a classroom or FCC home. Completing this statement will help us identify any accommodation your child may need. Please check items below that apply to your child:

- 1 Asthma
- 2 Apnea
- 3 Autism (to include PDD non-specific, Asperger's Syndrome, or any Pervasive Developmental Disorder)
- 4 Allergies - severe allergies to bee stings, severe environmental allergies or severe food allergies - severe means "life threatening reaction occurs on contact with allergen"
- 5 Chromosomal disorder such as Down Syndrome, Velo-Cardio Facial Syndrome, X-Chromosome Disorders or a mutation of any chromosome.
- 6 Seizure Disorder
- 7 Diabetes
- 8 Premature birth - born before 36 weeks gestation
- 9 Developmental Disability (mental Retardation)
- 10 Developmental Delay to include communication/speech delay, social/emotional delay, motor/physical skill delay
- 11 Attention Deficit Hyperactivity disorder with or without Hyperactivity (ADHD)
- 12 Severe Behavior disorder (SBI)
- 13 Obsessive compulsive Disorder (OCD)
- 14 Other mental health conditions such as Paranoia or Schizophrenia
- 15 Hearing loss or deafness
- 16 Vision loss, or blindness
- 17 Inability to walk, to include children using a wheel chair (children 18+ months)
- 18 Suffered severe physical trauma, due to incidents such as, auto accident, severe fall, physical abuse, etc.
- 19 Suffered severe emotional trauma, due to incidents such as, auto accident, severe fall, physical abuse, death in family, chronic illness, etc.
- 20 Digestive Disorder, Specify _____
- 21 Respiratory, disorder, specify _____
- 22 Chronic Heart condition
- 23 Disorder of the spine or skeletal system such as scoliosis
- 24 Missing limb
- 25 Blood disorder such as Hemophilia
- 26 Other condition not listed, specify _____
- 27 Member of Exceptional Family Member (EFM) Program
- 28 NONE

NOTE: If your child is HIV positive, do not indicate on this form. To safeguard your child's confidentiality, please reveal your child's HIV status only to the program director.

Child's Name: _____ DOB: _____
(Please Print)

Parent's Signature: _____ Date: _____