**NEW STUDENT** **Enrollment Form 2021-2022**

Date____________

# WESTSIDE CHRISTIAN ACADEMY

**554 Pinewood Road Sumter, SC 29154 803-775-4406**

Student's Name_______________________________________________
Last First Middle Goes By

Grade Entering ________ Any Grade Repeated? ___Yes ___No Age _____ Birth Date ____________ Gender ________

Student's Address ____________________________________________ Phone __________________
Street City/State/Zip Code

Church where student attends ______________________________________

**Student Lives With (check all that apply)**

__ Both parents
__ Father is deceased
__ Father has custody
__ Mother is deceased
__ Mother has custody
__ Other (please explain) _______________________________________
__ Parents are divorced
__ Student is adopted
__ Parents are separated
__ Student lives with grandparents
__Grandparents have custody

****If someone other than the parents have custody of student, WCA requires a copy of guardianship papers. Likewise, WCA requires copy of custody agreements/court orders for divorced parents.**

**OFFICE USE ONLY**

Date received ________________

Payment $__________________

Ck # ______________________

Staff Initials _________________

******************************

____ Copy of Birth Certificate

____SC Immunization Record

____DSS Form

____Meds Form

____Transcript Requested

____Testing fee paid

____Testing scheduled

____ W letter

**Father's Name** ____________________________________________
Last First Middle

Title_________ Email Address ___________________________ Cell # ____________
Mr./Rev./Dr. ***Required

Social Security # ______________________ Work Phone __________________
***Required

Employer ____________________________________________________

Address (if different from student) ______________________________________________
Street City/State/Zip Code

___ Allowed to pick up student ___ Emergency Contact Church ______________________________

**Mother's Name** ____________________________________________ Title ____________
Last First Middle Ms./Mrs./ Rev./Dr.

Social Security # _______________ Email Address ___________________________ Cell # ______________
***Required ***Required

Address (if different from student) ______________________________________________
Street City/State/ Zip Code

Employer _________________________________ Work Phone ____________________

___ Allowed to pick up student ___ Emergency Contact Church ______________________________

**Student Academic Information**

Last School Attended ______________________________________________ Grade __________

Address ______________________________________________ Phone ____________________
Street City/State/Zip Code

Fax ______________________ Contact Name ______________________________________________

Has student ever been referred for academic evaluation? ___ Yes ___ No If so, please provide WCA with a complete copy of evaluation.

Does student have any known learning disabilities or behavioral problems such as ADD or ADHD? ___ Yes ___ No
If so, please describe.

______________________________________________

______________________________________________

Has student ever been suspended or dismissed from school for academic, disciplinary or other reasons? ___ Yes ___ No If yes, please explain:

______________________________________________

______________________________________________

**Emergency/Medical Contact Information** (other than parents)

Name ______________________________________________ Relationship ____________________

Address______________________________________________ Phone ______________________
Street City/State/Zip Code
Cell # _________________________ Business Phone _________________________________

Name ______________________________________________ Relationship ____________________

Address______________________________________________ Phone ______________________
Street City/State/Zip Code
Cell # ______________________________ Business Phone _________________________________

Name ______________________________________________ Relationship ____________________

Address______________________________________________ Phone ______________________
Street City/State/Zip Code
Cell # ______________________________ Business Phone _________________________________

Name ______________________________________________ Relationship ____________________

Address______________________________________________ Phone ______________________
Street City/State/Zip Code
Cell # ______________________________ Business Phone _________________________________

**Authorized Pick Up/Contact Information** (the following people are authorized to pick my child from school)

Name ___________________________________________ Relationship ______________

Name ___________________________________________ Relationship ______________

Name ___________________________________________ Relationship ______________

Name ___________________________________________ Relationship ______________

Name ___________________________________________ Relationship ______________

Name ___________________________________________ Relationship ______________

Name ___________________________________________ Relationship ______________

Name ___________________________________________ Relationship ______________

**Permission to Photograph/Video**

WCA often uses student pictures in our various publications (i.e. Family Portal, WBC bulletin, yearbook and website). If you prefer that your child **NOT** be photographed or videotaped, please inform the school in writing of your wishes.

**Medical Information**

Allergies_______________________________________________________________

If student has an allergy that requires an *Epi-Pen* or any medications that need to be taken at school, you **MUST** see the health room attendant to complete the necessary forms.

Any physical health problems? ___Yes ___No If yes, please explain ______________________________

_________________________________________________________________________

Is student on any medication? ___Yes ___No Type and dosage: ______________________________

Physician ______________________________Phone #______________________________

Has student ever consulted, or been referred to a psychiatrist, psychologist, or psychiatric social worker for professional assistance?

___Yes ___ No If yes, please explain______________________________________________

_________________________________________________________________________

**Please provide the health room attendant and teacher with any additional information regarding the health and well-being that will assist WCA in caring for your child. Any known fears/phobias, i.e. closed spaces, spiders, heights, etc.**

**Medical Consent**

In the event of an emergency, and parents cannot be contacted or contact persons cannot be reached, I authorize and direct Westside Christian Academy staff to seek emergency treatment for my child and send my child by ambulance, (properly accompanied) to the hospital, doctor or medical facility deemed necessary.

___Yes ___No Parent's Signature___________________________________________________ Date_______________

Parent's Name ________________________________________ Student's Name _________________________________________
Please print Please print

How did you hear about WCA: ____Radio ____ Sumter Living ____ The Item ____Shaw News ____Friend/Acquaintance

____Other: ___________________________________________________________________________________________________

Referred to WCA by: ____________________________________________________________________

**Statement of Nondiscrimination**

WCA admits students of any race, color, national or ethnic origin to all rights, privileges, programs, and activities generally accorded or made available to students at Westside Christian Academy. It does not discriminate based on race, color, national or ethnic origin in administration of its educational policies, admission policies, athletics, and other administered programs, particularly in regard to employment and student admission policies, procedures, and practices.

**Please refer to cover letter for fees and documents that must accompany student's enrollment form.**

# Physical Examination

**Student:** ______________________________

**Grade:** ______________ **Date:** ______________

**Code:** ✓ **Statisfactory: X Needs Observation: XX Needs Immediate Attention: C Correction of Defect**

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**Nutrition:**____________________ **Posture:**__________________________

**Gate:**______________________ **Musculature:**_____________________

**Skin:**_______________________ **Scalp:**____________________________

**Eyes:**_________**Ears:**________ **Nose:**______________________________

**Mouth, Gums:**______________ **Speech:**_________**Teeth:**___________

**Throat:**______________________ **Lymph Nodes:**________**Thyroid:**________

**Heart:**________________________ **Lungs:**__________ **Abdomen:**__________

**Bones & Joints:**____________ **Feet:**_____________________________

**Hemoglobin:**________________ **Urinalysis:**__________________________

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**Should Physical Activity Be Restricted?** _________________________________________

_______________________________________________________________

**Parent Present:**_______________________________________________________

_______________________________________________________________

______________________________
**Examining Physician**

**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: ______________________ County: ______________________

Address: ____________________________________________

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) ④ Yes ④ 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: ④ **Mon** ④ **Tue** ④ **Wed** ④ **Thurs** ④ **Fri** ④ **Sat** ④ **Sun**

**Check** all meals Child will receive daily: ④ **Meals are not offered** ④ **Breakfast**
④ **Morning Snack** ④ **Lunch** ④ **Afternoon Snack** ④ **Dinner** ④ **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

DSS Form 2900 (MAR 10) Edition of OCT 07 is obsolete.

Dental Care Provider:

______________________

Name

______________________

Street Address City, State, Zip Telephone

Health Insurance Provider: ______________________

Certificate of Immunization: ④ Yes ④ No ④ 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

Director/Operator/Staff Designee

**Westside Christian Academy**
**Permission for Over-the Counter Medications School Year_______________**

Student: ____________________________________ Grade:________________

The non-prescription medications listed below are available from the school Health Room Assistant. Please read this list and indicate which medications you are willing for your child to receive by placing a check mark next to those medications. If you wish your child to receive any other over the counter medication you will need to fill out a Medication Authorization form. These forms are available from the Health Room Assistant.

**Acetaminophen (Tylenol):** For simple headache, minor muscular aches or cold discomfort.

[ ] 500 mg Regular Strength Tablets (dosage according to age)
[ ] Oral Suspension Liquid (dosage according to weight or age)

**Ibuprofen (Motrin):**

For menstrual cramps, simple headache, or minor muscular aches.

[ ] 200 mg. Regular Strength Tablets (dosage according to age)
[ ] Oral Suspension Liquid (dosage according to weight or age)

**Menthol Cough Drops:**

[ ] One or two during the school day for bronchial congestion and cough due to cold.

**Antibacterial Ointment:** [ ] Topically for minor cuts and skin abrasions.

**Calamine Lotion:** [ ] Topically for insect bites, poison ivy, etc.

**Orajel:** [ ] Topically on gums for relief of minor toothache.

**Lip Balm (Blistex):** [ ] Topically for relief of chapped lips. (indiviual applicators)

**Tums:**

[ ] One or two chewable tablets for relief of heartburn, sour stomach, indigestion, or upset stomach associated with these symptoms (First grade and up.)

Signature of Parent/ Guardian_________________________________________ Date_______________