**NOTE: Please fill out this form ONLY if your child is in Nursery-4K or will be enrolled in Extended Care (Early Morning or Afternoon)

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: Westside Christian Academy County: Sumter

Address: 554 Pinewood Road Sumter, SC 29154

Street Address – no Post Office Boxes City, State, Zip

Child's Name:

Date of Birth: _____

Last First Middle Initial Nick Name

_____ 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: 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

DSS Form 2900 (MAR 10) Edition of OCT 07 is obsolete.