



**NEW STUDENT Enrollment Form 2020-2021**

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 parents has custody of student, WCA requires a copy of guardianship papers. Likewise, WCA requires copy of custody agreements/court orders for divorced parents.**

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 \_\_\_\_\_

OFFICE USE ONLY	
Date received	_____
Payment \$	_____
Ck #	_____
Staff Initials	_____
*****	
___ Copy of Birth Certificate	
___ SC Immunization Record	
___ DSS Form	
___ Meds Form	
___ Transcript Requested	
___ Testing completed & testing fee paid	
___ W letter	

**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 health/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 \_\_\_\_\_ Please print Student's Name \_\_\_\_\_ 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:  Satisfactory:  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:**

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

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:  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

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. (individual 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 \_\_\_\_\_