Date_____

NEW STUDENT Enrollment Form 2019-2020

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 _____

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

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? If so, please describe.
___ Yes ___ No

_____

_____

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. ParentsWeb, 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 _____ 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:**_____

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) ❑ 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

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_____