

****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: _____

Parent or Guardian

Date: _____