SPRINGS CHRISTIAN DAY SCHOOL

A MINISTRY OF BOILING SPRINGS FIRST BAPTIST CHURCH

SUMMER 2018 ENROLLMENT APPLICATION

Date of Application__________________________

Student Name____ Preferred Name____________________________
Last First Middle

Please note that this application alone will not secure a place for your child. **This application must be accompanied by the non-refundable registration and activity fee.** Please see attached letter for a list of fees and policies. PLEASE PRINT NEATLY. Applications must be completed in full and submitted before your child will be considered for admission.

☐ 2 Year Old	☐ **2 Day Tuesday/Thursday**
☐ 3 Year Old	☐ **3 Day Monday/Wednesday/Friday**
☐ 4 Year Old	☐ **5 Day Monday--Friday**

GENERAL STUDENT INFORMATION

Gender______________________ DOB_________/__________/___________ Present Age______________

Street Address____ City___________________________________

State________ Zip____________ Home Phone ______________________ Parents' Names__________________________

Siblings attending SCDS ____

____

I give/do not give (Circle One) Springs Christian Day School permission for my child to appear in photographs, CD's, DVD's or videotapes while participating in the program for the purposes of publicity, staff training, and/or promotion.

***Parent/Guardian Signature*____ *Date*_________________**

In consideration of Springs Christian Day School accepting my/our child as a student, I/we will accept full financial responsibility for my/our child's tuition, fees, costs assessed for damage to books or school property. It is also understood that failure to pay all tuition and fees may result in dismissal until all financial obligations have been met.

***Parent/Guardian Signature*____ *Date*_________________**

Office Use Only

Registration Fee paid________ Date_______________ Check or Cash Ck#_______

Activity Fee paid____________ Date_______________ Check or Cash Ck#_______

3600 Boiling Springs Road, Boiling Springs, SC 29316 (864) 578-2148 FAX (864) 578-1583
www.scdssaints.com
DSS#924

FAMILY INFORMATION

Father'*s/Guardian's Full Name* ____
Last First Middle Preferred Name

Phone and address (if different from student): Permission to Publish Home Phone and Address: ☐ Yes ☐ No

Street_______________________City_____________State__________Zip___________

Home Phone ______________ Cell Phone ______________Work Phone ______________

Employer______________________ Occupation______________________

Business Address____
Street City State Zip

Work Hours__________ Email Address ______________________________

*Custody: ☐ Primary ☐ Joint ☐ No Lives in home with student? ☐ Yes ☐ No

Permission to Pick-Up: ☐ Yes ☐ No Contact in case of emergency: ☐ Yes ☐ No

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Mother's/Guardian's Full Name ____
Last First Middle Preferred Name

Phone and address (if different from student): Permission to Publish Home Phone and Address: ☐ Yes ☐ No

Street_______________________City_____________State__________Zip___________

Home Phone ______________ Cell Phone ______________Work Phone ______________

Employer______________________ Occupation______________________

Business Address____
Street City State Zip

Work Hours__________ Email Address ______________________________

*Custody: ☐ Primary ☐ Joint ☐ No Lives in home with student? ☐ Yes ☐ No

Permission to Pick-Up: ☐ Yes ☐ No Contact in case of emergency: ☐ Yes ☐ No

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Please list others who live in the home:

Name______________________ Relation to child______________________

Name______________________ Relation to child______________________

Name______________________ Relation to child______________________

Name______________________ Relation to child______________________

You must have two individuals who have the authority to obtain emergency medical treatment for the child:

Person to contact in case of emergency, if the person legally responsible cannot be reached:

1. Emergency Name________________Relation____________ Phone____________

Street Address________________City____________State________Zip_____

2. Emergency Name________________ Relation____________ Phone____________

Street Address________________City____________State________Zip_____

In addition to the people listed above, list others who have permission to pick up your child from school:

Name______________ Relation________ Phone____________ Address__________

Name______________ Relation________ Phone____________ Address__________

***Custody, in case of divorce: (In order to enforce custody restrictions, a copy of court documents must be on file in the SCDS office.)**

Please list any person(s) who are legally barred from picking up your child from school.

Name______________________ Relation to child______________________

Name______________________ Relation to child______________________

Date____________________ Student Name____

HEALTH INFORMATION
TO BE COMPLETED BY PARENT OR GUARDIAN
Please check all that apply to your child:

- ☐ Hearing Loss/Hearing Aids
- ☐ Heart Condition/Murmur
- ☐ Migraines
- ☐ Severe Headaches
- ☐ Kidney Disorder
- ☐ Diabetes
- ☐ Glasses/Contacts
- ☐ Speech Difficulties — Attending Speech Classes ☐ Yes ☐ No
- ☐ ADD/ADHD — Medication Taken ☐ Yes ☐ No
- ☐ Asthma/Respiratory Problems — Medication Taken ☐ Yes ☐ No
- ☐ Seizures/Epilepsy — Describe:____
- ☐ Learning Disability — Describe:____
- ☐ Physical Handicaps — Describe:____
- ☐ Allergies-medication, latex, food, etc.____

Symptoms of reaction:____

Treatment prescribed:____

Please list any other problems, special needs or information about your child's health________________________________

____

If the student needs prescription medication during school hours, a completed **Medication Form** must be on file. This form may be obtained from the SCDS office. This form must be completed and signed by the parent/legal guardian. All medications must be in the original container and have a current prescription label attached.

Please indicate any medications your child takes on a regular basis____

Family Physician or Health Resource:____

Name Address Phone Number

Dental Care Provider:____

Name Address Phone Number

Health Insurance Provider:____

I certify that to the best of my knowledge my child, listed above, is in good mental and physical health and is able to participate in the program at SCDS. ***Parent/Guardian Initial***____________________________

Authorization For Emergency Care

In the event of an emergency, when I am not readily available, I, the undersigned parent or legal guardian of the student listed above, hereby authorize the staff of Springs Christian Day School to act as my Agents, to consent to medical, surgical or dental examination and/or treatment. In case of emergency, I hereby authorize treatment, and/or care at any hospital. I hereby give permission to our family physician and/or attending physician to hospitalize and/or provide proper treatment for my child. I also give permission for school personnel to provide emergency care as needed. In the event emergency treatment is required, my child will be taken to Spartanburg Regional Medical Center.

Parent/Guardian Signature____***Date***________________