



# Spirings Christian Day School

## A Ministry of Boiling Springs First Baptist Church

### Student Enrollment 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 fee. PLEASE PRINT NEATLY. Application must be completed in full and submitted before your child will be considered for admission.**

**Check The Class/Classes You Are Registering For**

Child must enroll in the class equal to the age he or she will be on or before September 1.

**Children entering 3 Year Preschool and above must be completely potty trained and able to use the restroom unassisted.**

<input type="checkbox"/> 2 Year Preschool-2 Day (Tues./Thurs.) 8:30-11:30	<input type="checkbox"/> Preschool (K2-K4) Extended Care until 2:00*
<input type="checkbox"/> 2 Year Preschool-3 Day (Mon, Wed, Fri) 8:30-11:30	<input type="checkbox"/> Preschool (K2-K4) Extended Care until 5:45*
<input type="checkbox"/> 2 Year Preschool-5 Day (Mon-Fri) 8:30-11:30	<input type="checkbox"/> Preschool Early Arrival 7AM*
<input type="checkbox"/> 3 Year Preschool-3 Day (Mon, Wed, Fri) 8:30-11:30	
<input type="checkbox"/> 3 Year Preschool-5 Day (Mon-Fri) 8:30-11:30	
<input type="checkbox"/> 4 Year Preschool-5 Day (Mon-Fri) 8:15-11:45	* Please see Tuition/ Fees insert for extended care rates

Extended care charges are added to the base tuition and require a permanent spot for a child that is equivalent to the days he/she attends preschool. (Ex: A 3 day preschool student will be issued a year-long reservation for the 3 days a week they attend preschool.)

## GENERAL STUDENT INFORMATION

DOB \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_ Gender \_\_\_\_\_ Present Age \_\_\_\_\_

Street Address \_\_\_\_\_ City \_\_\_\_\_

State \_\_\_\_\_ Zip \_\_\_\_\_ Home Phone \_\_\_\_\_ Parents' Names \_\_\_\_\_

Siblings attending SCDS \_\_\_\_\_

## STUDENT ACADEMIC HISTORY

List other schools/daycares your child has attended:

School/Daycare \_\_\_\_\_

School/Daycare \_\_\_\_\_

Do you have any concerns with your child's behavior or learning ability? \_\_\_\_\_

If yes, what are your concerns? \_\_\_\_\_

Has your child been tested for learning disabilities? \_\_\_\_\_ If yes, give the date and general results of the test:  
 \_\_\_\_\_

Has your child ever been suspended or expelled from school/daycare for any reason? \_\_\_\_\_ If yes, please give the reason(s): \_\_\_\_\_

**Office Use Only:**

Date Application received: \_\_\_\_\_ BSFBC Church Member \_\_\_\_\_ FBNS church member \_\_\_\_\_

Registration Fee \$ \_\_\_\_\_  Cash  Check CK# \_\_\_\_\_ Date Paid \_\_\_\_\_

Book/Activity Fee \$ \_\_\_\_\_  Cash  Check CK# \_\_\_\_\_ Date Paid \_\_\_\_\_

# 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                       Migraines                       Kidney Disorder

Heart Condition/Murmur                       Severe Headaches                       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: \_\_\_\_\_

Please indicate any medications your child takes on a regular basis: \_\_\_\_\_

Family Physician or Health Resource: \_\_\_\_\_

Name	Address	Phone Number
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Dental Care Provider: \_\_\_\_\_

Name	Address	Phone Number
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Health Insurance Provider: \_\_\_\_\_

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 and 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.

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** \_\_\_\_\_

# PARENT QUESTIONNAIRE

How did you hear about Springs Christian Day School? \_\_\_\_\_

State your reason(s) for wanting your child to attend SCDS: \_\_\_\_\_

\_\_\_\_\_

In order of importance, list what you consider to be the three most vital aspects of your child's education: Be specific:

1. \_\_\_\_\_

2. \_\_\_\_\_

3. \_\_\_\_\_

What do you see as your role or responsibility in the education of your son/daughter? \_\_\_\_\_

\_\_\_\_\_

From your perspective, what are the advantages of a Christian education at SCDS? \_\_\_\_\_

\_\_\_\_\_

What would you identify as the values that matter most to your family? \_\_\_\_\_

\_\_\_\_\_

Has student previously attended SCDS? \_\_\_\_\_ If yes, when? \_\_\_\_\_

Name of church you now attend \_\_\_\_\_ Denomination \_\_\_\_\_

Pastor's Name \_\_\_\_\_ Are you a member of this church?  Yes  No

Do you attend regularly?  Yes  No

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## PARENT/GUARDIAN SIGNATURES

**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, and costs assessed for damage to books or school property. It is understood that withdrawal prior to end of school year constitutes a \$200 withdrawal fee in addition to payment for the months enrolled. 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* \_\_\_\_\_

3600 Boiling Springs Road, Boiling Springs, SC 29316

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Website: [www.scdssaints.com](http://www.scdssaints.com)

SC DSS Reg #924