



SPRINGS CHRISTIAN DAY SCHOOL

A MINISTRY OF BOILING SPRINGS FIRST BAPTIST CHURCH

SUMMER 2022 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.

| | |
|-------------------------------------|--------------------------------------------------------|
| <input type="checkbox"/> 2 Year Old | <input type="checkbox"/> 2 Day Tuesday/Thursday |
| <input type="checkbox"/> 3 Year Old | <input type="checkbox"/> 3 Day Monday/Wednesday/Friday |
| <input type="checkbox"/> 4 Year Old | <input type="checkbox"/> 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# _____ |

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

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 _____

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.

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 _____

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

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

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 _____