Springs 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. Early Arrival is only available for 5:30pm Extended Care Students.

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.

******Please see Tuition/Fees insert for rates.******

- ☐ 12 Weeks Old 5 Day (Mon-Fri) 8:30-11:30
- ☐ 1 Year Preschool-5 Day (Mon-Fri) 8:30-11:30
- ☐ 2 Year Preschool-5 Day (Mon-Fri) 8:30-11:30
- ☐ 3 Year Preschool-5 Day (Mon-Fri) 8:30-11:30
- ☐ 4 Year Preschool-5 Day (Mon-Fri) 8:15-11:45
- ☐ Preschool Extended Care until 2:00*
- ☐ Preschool Extended Care until 5:30
- ☐ Early Arrival (Mon-Fri) Opens at 7 AM

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 5-day preschool student will be issued a year-long reservation for the 5 days a week they attend preschool.)

GENERAL STUDENT INFORMATION

DOB____/____/____ Gender: M or F Present Age_____ Age Child will be September 1, 2024_____

Street Address_____ City_____

State_____ Zip_____ Dad Phone _____Mom Phone_____

Parents Names _____

List Teacher Preference if any:_____

STUDENT ACADEMIC HISTORY

List other schools/daycares your child has attended:

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

Rev. 02/25

Book/Activity Fee $ _____ □ Cash □ Check CK#_____ Date Paid _____

5K Graduation Included _____

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_____

Phone # 1 _____ Phone # 2 _____Email Address_____

Employer_____ Occupation_____

Business Address_____
Street City State Zip

Work Hours_____ Work 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_____

Phone # 1 _____Phone # 2 _____Email Address _____

Employer_____ Occupation_____

Business Address_____
Street City State Zip

Work Hours_____ Work 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 ALL who live in the home. Please include any siblings attending SCDS.

Name_____ Relation to child_____Attend SCDS_____

Name_____ Relation to child_____Attend SCDS_____

Name_____ Relation to child_____Attend SCDS_____

Name_____ Relation to child_____Attend SCDS_____

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:

1) Name_____ Phone_____ 3) Name_____ Phone_____

2) Name_____ Phone_____ 4) Name_____ Phone_____

***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

Dental Care Provider:_____

Name Address Phone Number

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

PARENT/GUARDIAN SIGNATURES

I give/do not give (circle one) Springs Christian Day School permission for my child to appear in photographs, CD's, DVDs, 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 the end of the school year constitutes a $300 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.

(This also includes withdrawal from Extended Care.)

Parent/Guardian Signature_____ ***Date***_____

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