Temple Christian High School

120 Pinewood Rd
Sumter, SC 29150
(803) 775-8139

New Concurrent Student Application Packet for Academic Year 2025-2026 Demographic Information

Date Completed_____

Student Name (Last, First, Middle):	
Date of Birth (mm/dd/yyyy):	Student's SSN#:
Grade entering this year:	Gender: Male or Female (circle one)
Complete Mailing Address:	

Parents/Guardians' Names and best contact numbers (please mark if cell, work, or landline)		
Name	Relationship	Phone

Emergency Contact Information (please mark if cell, work, or landline)		
Name	Relationship	Phone

Please list any friends and family that are authorized to pick up your student AND please list any **students** with whom your student is allowed to ride home (**not field trips** – this is not permitted per school insurance):

_____

_____

_____

_____

Do both parents live in the home? _____

Parent(s)'s Church Affiliation _____

Name and address of the last school attended:

_____

_____

Does the student wear glasses?_____

Does the student have any history of medical/physical problems which may affect his/her work at school?

_____

_____

Parent/Guardian Signature_____ Date _____

Application for Academic Year 2025-2026
Financial Agreement

I. Responsible Party Information

First and Last Name			
Billing Address			
Primary Phone		Secondary Phone	

Tuition is $800 per class for concurrent students. This tuition includes books. **If your student is taking AP-Computer Science Principles, there will be an additional $100 fee for the exam, billable in November of that academic year.** TCHS offers multi-student discounts for students **living in the same household.**

II. Student Information:

Student Name	Class Being Taken	Student Tuition Cost

Total Tuition	
Less $500 per student down payment received (Options A & B)	
Balance due TCHS	

III. Please select the Payment Plan Option for your full-time student(s):

❑ Option A (down payment, then ten (10) payments)

❑ Option B (down payment, then eleven (11) payments)

❑ Option C (paid in full to receive the five percent (5%) discount)

IV. Amount of Monthly Payment, if applicable $_____

Tuition Fee and Late Fee

I agree to pay the amount established by my school for the above students and realize that if I fail to make payments by the specified due dates, the inaction will result in late charges established by my school. I understand that I may be contacted when payments are not on time and charged a late fee of $25.00.

Signature_____ Date_____

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Permission for Medication Form (OTC and Rx)

for Academic Year 2025-2026

Student's Name				
Grade		Gender (circle)	Male	Female
Address				
Parent/Guardian Cell Phone				

Over-the-Counter Medications

It is the policy of this school to notify the parent/guardian when a student becomes ill or is hurt. However, in cases of emergency or when a parent cannot be contacted, it may be necessary that a student be taken immediately to a doctor and this information must be in the school records.

Are there any medications or treatments to which the student is allergic?	
List any medications your student may be given for an allergic reaction.	
List any medication (OTC or Rx) the student takes on a daily basis.	

Please circle the permission, if allowed, and the dosage of the over-the-counter medications below

	Permission to administer		Dosage	
Is your student allowed to take Tylenol (Acetaminophen)?	Yes	No	Child	Adult
Advil (Ibuprofen)?	Yes	No	Child	Adult
Pepto Bismol (chewable tablets)?	Yes	No	Child	Adult
Tums (chewable tablets)?	Yes	No	Child	Adult

If no dosage is specified, medication will be administered as the recommended dosage for age/weight on the medicine label)

- If your child has a medical condition or chronic problem requiring frequent or routine use of non-prescription drugs, those drugs may be sent to the office labeled with your student's name to be dispensed during the school day. This includes Tylenol, Ibuprofen, cough drops, cold medications, sinus, or allergy medications, Pepto Bismol, etc.
- Absolutely no medication may be kept in the student's possession at any time at school (exception: inhalers and Epi-pens with prior administration approval)

Prescription (Rx) Medications

All prescription drugs, that a student must take during school hours, must be kept in the school office. Please contact the office staff for procedures for prescription drugs.

Medication	
Dosage	
Time of day medication should be given at school	
Purpose of medication	
Number of days needed to be given at school	
Possible side effects/activity of medication	

Prescribing Physician's Information	
Physician	
Name of Practice	
Address	
Phone	

I HEREBY GIVE PERMISSION FOR_____

to take the above prescription at school as ordered. I understand that it is my responsibility to furnish the medication.

Parent/Guardian Signature _____

Date_____

N**OTE: The prescription medication is to be brought to school in a container appropriately labeled by the pharmacy, stating the name of the medication, dosage, and usage. Request two labeled containers and medications (one for school and one for home) if needed.**

A copy of any new prescription slips is required and labeled medication if the dosage, time, or type of medication is changed.

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Student Medical/Emergency Information

for Academic Year 2025-2026

Student's Name:_____

Grade:_____ Age:_____ Male or Female (circle one)

SSN#:_____

Address:

_____

_____

Mother's Name_____

Home Phone_____Work Phone_____

Cell_____

Father's Name_____

Home Phone_____Work Phone_____

Cell_____

Emergency Contact names and phone numbers:

_____ _____

(name) (phone #)

Physician Information

Physician_____

Name of Practice_____

Address_____

Phone_____

_____

Insurance Verification

Insurance Provider:_____

Policy#_____

If the student has no insurance, please check this box ❑

EMERGENCY INFORMATION AND MEDICAL TREATMENT CONSENT

I, _____, as the parent or guardian of _____, recognize that as a result of participation in student activities, medical treatment on an emergency basis may be necessary and further recognize that school personnel may be unable to contact me for my consent for emergency medical care. I do hereby consent in advance to such emergency care, including hospital care, as many be deemed necessary under the then existing circumstance.

Please make the following notations on my son or daughter's records:

Medical Allergies:

_____

Medications for long-term illness (list illness & medication):

_____

Relevant medical information (i.e. contact lens wearer, history of family diabetes, epilepsy, heart murmur, etc.):

_____

It is the parent's responsibility to keep all insurance and medical/emergency information current throughout the entire school year.

Signature of Parent or Legal Guardian:

_____

_____

Date

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Records Release Authorization Form

I, _____, the parent/guardian of:

_____

do authorize Temple Christian High School and its representatives to obtain a copy of all his/her records including the following:

Academic History

Disciplinary History

Individual Educational Plans (IEPs)

504 Accommodation Plans

Signature of Parent or Legal Guardian:

_____

Date: _____