Temple Christian High School

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

Application for Academic Year 2024-2025
New Full-time Student Information

Date Completed_____

Student Full Name

_____
(Last, First, Middle)

Date of Birth Grade _____ Student's SSN# _____

_____ Gender: Male or Female (circle one)
(mm/dd/yyyy)

Mailing Address _____

City_____ State_____ Zip_____

Parents'/Guardians' Names _____

Parents' email(s)_____

Phone numbers:

home_____ work_____ cell_____

Emergency Contact:

_____ phone_____

Please list any friends and family that are authorized to pick up your student:

_____

_____

_____

Do both parents live in the home?_____

Parent(s)'s Church Affiliation_____

Name & Address of last school attended_____

Does student wear glasses or contacts? _____

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

_____

_____

It is the policy of this school to notify the parent 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 carried immediately to a doctor & this information must be in the school records.

Are there any medications or treatments to which the child is allergic?

_____

List any medications the child is on or may be given for allergic reaction:

_____

List any medications the child takes on a daily basis:

_____

Please answer "yes" or "no" to the following questions and sign below.

Is student allowed to take Tylenol? _____

Is student allowed to take Ibuprofen? _____

Is student allowed to take Pepto Bismol? _____

Is student allowed to take Tums? _____

Specific Dosages: (Example: 2 adult, 1 child, etc.) _____

Parent/Guardian Signature

_____

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

- All prescription drugs, which a student must take during school hours, must be kept in the school office. Please contact the office staff for procedures for prescription drugs.
- 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 students' possession at any time at school (exception: inhalers and Epi-pens with prior administration approval).

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Financial Agreement

I. Family Information

Responsible Party:

First Name _____ Last Name _____

Billing Address _____

_____

Primary Phone _____ 2nd Phone_____

Tuition is $4200 per academic year for full-time students. This tuition includes books. If your student is taking AP-Computer Science Principles, there will be an additional $100 fee to pay for the exam.

II. Please Select Payment Option for full-time students:

- ❑ (A) Tuition of $4,200 per student ($4300 if AP-CSP student) paid in full by July 10th for the upcoming school year, less 5% for paying in full.
- ❑ **If multi-student discount applies, check here. (10% discount per student, after the first student)
- ❑ (B) 10 Month Payment plan, with a ***non-refundable*** down payment of $500.00 per student due by July 10th for the upcoming school year, with 9 monthly payments of $_____, due in full by June 30th, 2025.
- ❑ (C) 11 Month Payment plan, with a ***non-refundable*** down payment of $500.00 per student due by July 10th for the upcoming school year, with 10 monthly payments of$_____, due in full by June 30th, 2025.

III. Student Information:

Grade	Name	Student Tuition
_____	_____	$_____
_____	_____	$_____
_____	_____	$_____
_____	_____	$_____

AP-CSP Exam fee	$_____
Total Tuition	$_____
Down Payment Recd. (Options. B & C)	$-_____
Balance Due School	$_____

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 Prescription Medication Form

for Academic Year 2024-2025

Please complete one form for each medication.

Student's Name:_____

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

Address:

_____

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 restrictions:

_____

_____

Physician 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 new prescription slip is required (or copy of prescription) and labeled medication if the dosage, time, or type of medication is changed.

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Student Medical/Emergency Information

for Academic Year 2024-2025

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#_____

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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Academic and Discipline Inquiry Authorization Form

I, _____, the parent/guardian of the below named student do authorize Temple Christian High School and its representatives to obtain a copy of all records for the ***Academic*** and ***Disciplinary*** History of _____.

Signature of Parent
or Legal Guardian: _____

Date: _____