

*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# \_\_\_\_\_  
\_\_\_\_\_  
(mm/dd/yyyy) Gender: Male or Female (circle one)

Mailing Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Parents'/Guardians' Names \_\_\_\_\_

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?

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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?

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

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List any medications the child takes on a daily basis:

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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

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(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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***Application for Academic Year 2024-2025***  
***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 10<sup>th</sup> 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 10<sup>th</sup> for the upcoming school year, with 9 monthly payments of \$\_\_\_\_\_, due in full by June 30<sup>th</sup>, 2025.
- (C) 12 Month Payment plan, with a ***non-refundable*** down payment of \$500.00 per student due by July 10<sup>th</sup> for the upcoming school year, with 11 monthly payments of \$\_\_\_\_\_, due in full by June 30<sup>th</sup>, 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 \_\_\_\_\_

**NOTE: 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:**

\_\_\_\_\_