SAINT PAUL CHRISTIAN SCHOOL

1700 Mendioka St. Dededo, Guam 96929 • Tel: (671)637-9855 Fax: (671)637-2697

RETURNING STUDENT APPLICATION
SCHOOL YEAR AUGUST 20___ – MAY 20___

Registration Fee:	**$300.00**
Capital Improvement Fund:	**$415.00**

Curriculum Resources (depending on your child's grade level) **is as follows:**

K3 - K5 grade	**$550.00**
1st - 5th grade	**$580.00**
6th - 8th grade	**$590.00**
9th - 12th grade	**$600.00**

NOTE: ALL FEES ARE NON-REFUNDABLE AND DUE UPON REGISTRATION.

Monthly Tuition Fees (based on a ten-month contract) is as follows:

K3- 8th grade	**$360.00**
9th- 12th grade	**$425.00**

Additional Fees: ***
ESL English Classes for Non-English speaking students $100.00 (Elementary/High School)
Senior Graduation Fee: $150.00
K5, 5th, and 8th Grade Promotional Fee: $50.00

OTHER FEES:

Returned Check Fee: **$50.00**- A Returned Check Fee will be charged for all checks returned for any reason.

Late Payment Fee: **$50.00**- A Late Payment Fee per child will be assessed on any outstanding balance unpaid after 10 days. **Tuition must be paid on the 1st of every month.** Parents are afforded a ten-day grace period to pay off existing balances on their account before the late payment fee is charged.

Early Withdrawal Fee: **$150.00**- An Early Withdrawal Fee will be assessed if you choose to voluntarily withdraw your child after enrollment or before the school officially closes.

Please complete all forms attached and submit to the school main office.
At the time the application is submitted, please be sure to attach the copies of immunization record, birth certificate, passport, report card, etc. **If the student is not a US citizen, then the proper visa and/or permanent resident card must be submitted. NO STUDENT WILL BE ACCEPTED WITHOUT THE REQUIRED DOCUMENTS.**

REGISTRATION FORM **SY 20__-20__**

DATE:	SCHOOL YEAR: SY 20___-20___
STUDENT NAME:	ENTERING GRADE:
STUDENT NAME:	ENTERING GRADE:
STUDENT NAME:	ENTERING GRADE:
STUDENT NAME:	ENTERING GRADE:

FORMS TO BE SUBMITTED:	Date Submitted:	Received By:	Comments:
Registration Form			
Student Medical Information Sheet			
Immunization Record *(with annual PPD)*			
General Physical / Student Medical Exam Form			
Sports Physical *(MS/HS)*			
If applicable: Notarized Legal Guardianship Document or Notarized Power of Attorney			

Accounting Use Only:	*Date Received:*	*OR#:*	*Received by:*

PERSON RESPONSIBLE FOR ACCOUNT AND OTHER EXPENSES:

I have read and understand the rules and regulations as well as the financial obligations as set forth in the Student Handbook, and I agree to abide by them. I understand that Textbook, Enrollment, and Re-enrollment Fees are non-refundable. I also understand that should my child be withdrawn or dismissed from school for any reason, tuition for any portion of that month is due and non-refundable. As a parent/guardian, I agree to support the Administration of Saint Paul Christian School; however, should I feel I can no longer support the Administration; I will promptly withdraw my child.

DATE

PARENT/GUARDIAN'S SIGNATURE

PRINT NAME

REGISTRATION FORM

SY 20__-20__

STUDENT INFORMATION
Name (Last, First, Middle Initial): ______
Date of Birth: ______ Age: ______ Gender: ______ Social Security #: ______
☐ US Citizen? ☐ Permanent Resident? If not, what type of visa do you hold?______ Expiration Date: ______
Ethnicity: ______ First Language: ______
Grade Entering: ______ Previous School Attended: ______
Home #: ______ Cell #: ______ Email Address: ______
Mailing Address: ______

FATHER'S INFORMATION
Name *(Last, First, Middle Initial)*:______
Date of Birth: ______ Age: ______ Social Security #: ______
Marital Status:______ Home #: ______ Cell Phone #: ______
Mailing Address: ______
Email Address: ______ Occupation:______
Employer:______ Work Phone #: ______
Employer Address: ______

MOTHER'S INFORMATION
Name *(Last, First, Middle Initial)*:______
Date of Birth: ______ Age: ______ Social Security #: ______
Marital Status:______ Home #: ______ Cell Phone #: ______
Mailing Address: ______
Email Address: ______ Occupation:______
Employer:______ Work Phone #: ______
Employer Address: ______

LEGAL GUARDIAN'S INFORMATION
Name *(Last, First, Middle Initial)*:______
Date of Birth: ______ Age: ______ Social Security #: ______
Marital Status:______ Home #: ______ Cell Phone #: ______
Mailing Address: ______
Email Address: ______ Occupation:______
Employer:______ Work Phone #: ______
Employer Address: ______

Student resides with: ☐ **Both Parents** ☐ **One Parent:** ______

☐ **Legal Guardian:** ______

Note: Please provide a Notarized Legal Guardianship Document or a Notarized Power of Attorney if student is not residing with natural parents.

REGISTRATION FORM

SY 20__-20__

Student Name: ____

EMERGENCY CONTACT INFORMATION (other than parents):				
NAME	**RELATION**	**DAYTIME PHONE #**		
1.		H:	C:	W:
2.		H:	C:	W:
3.		H:	C:	W:

THOSE AUTHORIZED TO PICK UP YOUR CHILD FROM SCHOOL (other than parents):				
NAME	**RELATION**	**DAYTIME PHONE #**		
1.		H:	C:	W:
2.		H:	C:	W:
3.		H:	C:	W:

Please give us information on the following:
Church Affiliation (if any):
Name of Church:
How often do you attend?

Please indicate if your child has received any special education services. Yes ______ No______

If yes, please explain: ____

____

LIABILITY AGREEMENT

I agree that I am responsible for my child's transportation from school by 4:00pm. I acknowledge that Saint Paul Christian School and/or Saint Paul Assembly of God Church, its employees, Board Members, or agents, are not held responsible for my child's safety and wellbeing, should they be on campus, after 4:00pm.

Parent/Guardian Signature: ______________________________ **Print Name:** ____________________________

PHOTO RELEASE/VIDEO RELEASE

Throughout the year, Saint Paul Christian School catalogs events through pictures and videos. These pictures and videos are used in various printed and electronic mediums such as newspaper ads, brochures, websites, and DVDs. Please indicate whether or not SPCS has permission to use any pictures or videos of your child. Agreement would not be restricted to the above mentioned mediums.

______Yes, I give SPCS permission to use any pictures of my child in the above stated media.

______ No, I do not want my child's picture to be used in the above stated media.

Children who attend Saint Paul Christian School, not knowing Jesus, will be shown the love of Christ in the daily school program. They will be encouraged to accept Jesus Christ as their Personal Savior.

"Whatever you do, do it all for the glory of God." *1 Corinthians 10:31*

STUDENT MEDICAL INFORMATION

NAME: ____________________
GRADE:______ SY 20___-20___

MEDICAL HISTORY:

Does your child have any **health problems?** _____ Yes _____ No
If yes, please specify: ____
Please indicate which of the following communicable diseases your child has had.
___ Chicken Pox ___ Diphtheria ___ Measles ___ German Measles ___ Mumps
___ Influenza ___ Pneumonia ___ Scarlet Fever ___ Whooping Cough
Please indicate whether your child has any persistent problems with any of the following:
___ Asthma ___ Colds ___ Coughs ___ Headaches ___ Stomach aches
___ Hay fever ___ Tonsillitis ___ Nose Bleeds ___ Epilepsy or Seizures
Others:____
Does your child take any special medication for it? ___ Yes ___ No
If yes, please specify what medication: ________________________________
Is your child up to date on his/her immunizations? ___ Yes ___ No
Has your child had any serious accidents that required him/her to be hospitalized? ___ Yes ___ No
If yes, please specify: ____
Has your child had any operations? ___ Yes ___ No If yes, please specify:____________________
Does your child wear glasses? ___ Yes ___ No Date of last Eye Exam? ______________
Does your child have regular dental check ups? ___ Yes ___ No
Date of last dental check up?____
Does your child have any hearing problems? ___ Yes ___ No
Date of last Hearing Exam? ____
Does your child have any **allergies?** ___ Yes ___ No If yes, please specify: ____________________
Does your child have any **allergies to medicine?** ___Yes ___No If yes, please specify: ____________
__ Long term medications prescribed by medical doctor: ______________________________
__ Short term medications-OTC: (e.g. Antibiotics) ____________________________________

*****Need current parental consent for the Nurse or designated personnel to dispense such medication.***

EMERGENCY INFORMATION:

Please indicate a contact person (other than parent or guardian) who has agreed to care for and provide transportation for your child in case he/she becomes ill or injured and you can not be reached. If you have a family physician, please write the name in case medical assistance is necessary.

Alternate Emergency Contact Name: ______________________________Relationship to Student:____________
Address: ____Daytime Phone Number: ____________
Family's Doctor Name: __________________________________Hospital Clinic: ____________________
Do you have medical insurance? ________ If yes, please specify: ________________Clinic Phone #:__________

I hereby give my consent to the Administration at Saint Paul Christian School to obtain emergency medical treatment for my child. School authorities must attempt to contact me before relying on this authorization.

Print Parent's Name & Signature: ______________________________________ Date: ________________

TEL: Work: _______________________ Home: _______________________ Cell: ________________

I HEREBY CERTIFY THAT THE FOREGOING INFORMATION IS TRUE AND CORRECT TO THE BEST OF MY KNOWLEDGE.

Print Parent's Name & Signature: ______________________________________ Date: _____________

"Whatever you do, do it all for the glory of God." *1 Corinthians 10:31*

ST. PAUL CHRISTIAN SCHOOL STUDENT MEDICAL EXAMINATION

Student's Full Name: ____________________ **Date of EXAM:** ____________

Phone: ____________ Race: ________ Sex: ____

Address: ____________________ Birth date: ____________ Age: ________

____________________ Birth place: ____________________

Father's name: ____________________ Mother's name: ____________________

SCHOOL YEAR:

STUDENTS LAST NAME:

STUDENTS FIRST NAME:

A. -HISTORY OF IMMUNIZATIONS, DISEASES, OPERATIONS, INJURIES-

IMMUNIZATION OR DISEASE	DATE OF ILLNESS	DATE OF IMMUNIZATION	LAST BOOSTER		DATE	COMMENTS
				CHICKENPOX		
DIPHTHERIA				SCARLET FEVER		
PERTUSSIS (whooping cough)				RHEUMATIC FEVER		
TETANIUS				DIABETES		
POLIO - ORAL				ANEMIA (sickle cell)		
POLIO - SALK				PARASITES (worms-type?)		
MEASLES (Rubeola)				ALLERGY (type?)		
SMALLPOX				SEIZURES		
MUMPS				INJURY, FRACTURE		
GERMAN MEASLES (Rubella)				OPERATION		
OTHER( )				OTHER /ALLERGIES (specify)		

TUBERCULIN TEST (type)   DATE: NEGATIVE: ☐   POSITIVE: ☐   X-RAY?

B. PHYSICAL EXAMINATION   HEIGHT: WEIGHT: BLOOD PRESSURE:

CHECK (✎) ONLY	IF ABNORMAL OR		NEEDS FOLLOW UP	PHYSICIAN'S COMMENTS, FINDINGS, TESTS (use back side if needed)	
NUTRITION					
NEUROLOGIC					
ORTHOPEDIC (incl. arches)					
SKIN, SCALP					
EYES	R	L			
VISUAL ACUITY	R	L		HAS GLASSES?	CONTACT LENSES?
COLOR VISION					
EARS	R	L			
AUDITORY ACUITY	R	L		HAS HEARING AID?	
SPEECH					
NOSE, THROAT					
MOUTH, TEETH					
GLANDS, THYROID					
HEART, LUNGS					
ABDOMEN					
GENITALIA					

C. LABORATORY (if needed)   HEMOGLOBIN: GM.,   HEMATOCRIT: %, URINE: FECES:

D. PHYSICIAN   CHECK (✎) BOX:

	NO	YES	PHYSICIAN'S COMMENTS (use back side if needed)
EMOTIONAL/MENTAL/BEHAVIOR PROBLEM			
HEALTH HABITS PROBLEM			
PHYSICAL DISABILITY -- LIMITS ACTIVITY			
RESTRICTION NEEDED			
ENCOURAGE PARTICIPATION			
OTHER DISABILITY			
SEIZURES			
ON MEDICATION ( )			
FOLLOW-UP RECOMMENDED			
FOLLOW-UP COMPLETED			

This student has completed the immunizations required by the Government: YES____NO_____and in my opinion is free of any communicable disease and may be admitted to school YES_____NO _____

Student's usual Physician: ____________________ Examining Physician: ____________________

Telephone#: ____________________ Telephone#: ____________ License #: ____________

In my opinion, this student is______/ is not_______physically qualified to participate in athletics_____, driver education_____, other____________________as of (date) ____________

Examining Physician: ____________________ **Telephone#:**____________ **License #:** ____________

Physician and/or Clinic STAMP HERE

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SPORT PHYSICAL AND PARENT CONSENT FORM

Date: ______________

THIS PORTION TO BE COMPLETED BY PARENTS:

Name: ____ Grade: ____________

Date of Birth: ______ / ______ / ______ ______Male ______Female

PARENTS: Father: ________________________ Mother: ______________________________

Legal Guardian: ____

ADDRESS: Home:______________________________________ Telephone:________________

Father's Employer:_____________________________ Telephone:________________

Mother's Employer:____________________________ Telephone:________________

MEDICAL HISTORY:

1. Any Head Injuries? _____Yes _____No When:____________________
2. Any Fractures? _____Yes _____No What:____________________
3. Any Allergies? _____Yes _____No What:____________________
4. Any Lung Disease? _____Yes _____No Type: ____________________
   (i.e. Asthma, etc.)
5. Any Heart Disease? _____Yes _____No Type:____________________
6. Previous Hospitalization _____Yes _____No Why:____________________
   When:____________________
7. Currently taking any medication? _____Yes _____No
   Name of Medication(s)____
   For What Reason:____
8. Any medical reasons why this child should not participate in Athletics? ____________________

PARENTAL CONSENT:

I, hereby give permission for the physician to examine my child so that he/she may obtain health clearance to participate in athletic activities. Therefore, neither the examining physician nor Saint Paul Christian School is to be held liable for any abnormalities not detected in this examination.
Permission is also granted for my child *(Name)* ______________________________ to participate in the athletic activities approved by the doctor as initialed below for **School Year: 20___-20___.**

Parent's Signature:____ Date:____________________

(SEE BACK OF FORM)

"Whatever you do, do it all for the glory of God." *1 Corinthians 10:31*

THIS PORTION TO BE COMPLETED BY PHYSICIAN:

PHYSICAL EXAMINATION: ____

____

Blood Pressure: ______________ Temperature: ________ Pulse: __________ Respiration: ____________

Height: ____________ Weight: ____________#

VISION: Left__________ Right__________

ATHLETIC CLEARANCE:

I have examined the above named student and find him/her physically able to participate in the following activities initialed below:

ALL ACTIVITIES BELOW: [ ]

Basketball	______	Cross Country	______	Football	______
Gymnastics	______	Raquetball	______	Rugby	______
Soccer	______	Softball	______	Tennis	______
Track & Field	______	Volleyball	______		
Cheerleading & POM POM Squad			______		

Wrestling (Including minimum weight allowed to participate): ________

Excluding the following sports: ____

Non-Contact: ______________________________

No Activities: ______________________________

Further medical examination is indicated: ______________________________________

PHYSICIAN'S SIGNATURE & "STAMP":

____ DATE: ________________

FINANCIAL AGREEMENT

Ten (10) Month Installment Basis

Date: ________________________

Enrollment Fees: OR # ___________________________
Application: ________ Capital Improvement: ________
Registration: _______ Book Rental: ________

For services received, (parent/guardian) Name: __________________________________ promises to pay to the order of Saint Paul Christian School, Harmon, Guam, the amount of $ ________________ representing tuition fees for School Year commencing August 20___ and ending May 20___ for:

Name of Student ____ Grade ________________________
Name of Student ____ Grade ________________________
Name of Student ____ Grade ________________________
Name of Student ____ Grade ________________________

PAYMENT SCHEDULE: This note is payable in installment basis as scheduled below.

TUITION MUST BE PAID BY THE 1ST OF EACH MONTH.

Due Date:	Amount Due:	Due Date:	Amount Due:
Aug. 1	$ ___________	Jan. 1	$___________
Sep. 1	$___________	Feb. 1	$___________
Oct. 1	$___________	Mar.1	$___________
Nov. 1	$___________	Apr. 1	$___________
Dec. 1	$___________	May 1	$___________

LATE PAYMENT / INVOLUNTARY WITHDRAWAL FROM SCHOOL:

If payment has not been made by the tenth (10th) of the month, it is considered delinquent and a service charge (late fee) of $50.00 (per child) will be added to the past due account. ______________________

(Parent/Guardian Signature)

Should the Administration decide to remove your child from school within the year for any reason, tuition for that month, the following month, and all fees are due and **non-refundable**. Any account outstanding on the date of the removal must be settled before the student's cumulative record and grades can be released. Last tuition payment must be paid in cash only. Checks will not be accepted due to clearing of account for immediate release of records. ______________________

(Parent/Guardian Signature)

The School Administration reserves **the right to put a student with 30 days overdue account under administrative suspension** until the account is settled or a special payment scheme is agreed upon by both parties. The student is subject to dismissal if financial obligations remain unpaid after payment negotiation. In such cases, unpaid accounts will be referred to a collection agency. The "Payer" will pay all other fees incurred in collecting past due accounts.

____

(Parent/Guardian Signature)

VOLUNTARY WITHDRAWAL FROM SCHOOL:

Should you decide to withdraw your child from school for any reason within the year; a withdrawal fee of **$ 150.00** will be charged. Tuition for that month, and all fees are due and non-refundable. Any account outstanding on the date of withdrawal must be settled before the student's cumulative record and grades can be released. Should you decided to bring your child back after the official withdrawal date, re-application must be made with all the corresponding fees. Last tuition payment must be paid in cash only. Checks will not be accepted due to clearing of account for immediate release of records.

____

(Parent/Guardian Signature)

"Whatever you do, do it all for the glory of God." *1 Corinthians 10:31*

STUDENT RECORDS

There is a **$25.00** fee that must be paid before your child's records can be released to their new school. We are only allowed to release an official transcript to another school. If you know which school your child will be attending, the new school can request the transcript from us. No records can be released unless the balance on account has been paid in full. ___

____

(Parent/Guardian Signature)

BOOKS

There is a **$75.00** fee for lost or damaged books. ____________________

(Parent/Guardian Signature)

RETURNED CHECKS

If a check is returned due to insufficient funds, a fee of fifty dollars **($ 50.00)** will be charged for administrative costs. Any family that has one returned check during the school year would be required to make all future payments in cash, cashier's check. All checks must be dated with the correct date. Postdated checks will not be accepted. ____________________

(Parent/Guardian Signature)

NOTICE

All notices or communications regarding any changes to this note must be made in writing, either by mail or hand-delivered to the address indicated on enrollment form. Verbal communication such as calls will be used as reminders for follow-up on outstanding bills.

LEGAL / ATTORNEY'S FEES

If any legal action should arise to enforce or interpret the terms of this note, the Holder/Payee of this note shall be entitled to reasonable attorney's fees, cost and any other necessary expenses incurred, all of which are to be collected from the Payer. In case of default by Payer, the Payee has the right to seek professional help (collection agency, legal attorney(s) or both) as deemed to collect any and all unpaid balances will be at the expense of the Payer.

IMPORTANT TAX INFORMATION

Parents need to keep all receipts for tax purposes. Upon request, the school can provide parents with a full statement for the calendar year for a cost of **$ 50.00**

By my signature, I signify that I have read and agree to the terms listed in the "Saint Paul Christian School Financial Agreement."

Parent/Legal Guardian Name: ______________________________ Date: ____________________

Signature: ______________________________

Home no: ____________________ Work No: ____________________ Cell : ______________

Recurring Credit Card Payment Authorization Form

Schedule your payment to be automatically deducted from your Visa OR MasterCard.

Please complete the information below:

I ______________________________ authorize Saint Paul Christian School to charge my credit card
(full name)

indicated below for $_______________ on the 1st of each month for payment of my
(day or date)

tuition and fees.

Billing Address ______________________________ Phone# __________________________

City, State, Zip ______________________________ Email __________________________

Student Name(s):

____

Grade Level: _________________________

Notes:

____

____

____

Credit Card

☐ Visa ☐ MasterCard

Cardholder Name ___________________________

Account Number ___________________________

Exp. Date _____________

CVC code _____________

SIGNATURE ____ DATE ____________________

I understand that this authorization will remain in effect until I cancel it in writing, and I agree to notify Saint Paul Christian School in writing of any changes in my account information or termination of this authorization at least 15 days prior to the next billing date. If the above noted payment dates fall on a weekend or holiday, I understand that the payments may be executed on the business day prior to holiday. In the case of a transaction being rejected for Non Sufficient Funds (NSF) I understand that Saint Paul Christian School may at its discretion attempt to process the charge again within 30 days and may be subject to additional fee if its keeps occurring. I acknowledge that the origination of ACH transactions to my account must comply with the provisions of U.S. law. I certify that I am an authorized user of this credit card/bank account and will not dispute these scheduled transactions with my bank or credit card company; so long as the transactions correspond to the terms indicated in this authorization form.

--------TURN IN FORM TO BUSINESS OFFICE ONCE COMPLETED. --------

"Whatever you do, do it all for the glory of God." *1 Corinthians 10:31*