



## SAINT PAUL CHRISTIAN SCHOOL

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

### RETURNING STUDENT APPLICATION SCHOOL YEAR AUGUST 2024 – MAY 2025

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
1 <sup>st</sup> - 5 <sup>th</sup> grade	\$580.00
6 <sup>th</sup> - 8 <sup>th</sup> grade	\$590.00
9 <sup>th</sup> - 12 <sup>th</sup> 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- 8 <sup>th</sup> grade	\$360.00
9 <sup>th</sup> - 12 <sup>th</sup> grade	\$425.00

Additional Fee: \*\*\*

ESL English Classes for Non-English speaking students \$100.00 (Elementary/High School)

Senior Graduation Fee: \$200.00

K5, 5<sup>th</sup>, and 8<sup>th</sup> Grade Promotional Fee: \$75.00

#### **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 1<sup>st</sup> 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.

#### **Elementary**

**After School Care:** \$215.00/month or \$12.00/day –After School Care is available per child, per day from 3:30- 5:30 pm. Thereafter, an additional charge of \$12.00 will be assessed for every 15 minutes your child is not picked up after 5:30pm.

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**

**RETURNING STUDENTS ONLY**

DATE:	SCHOOL YEAR: 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 <i>(with annual PPD)</i>			
General Physical / Student Medical Exam Form			
Sports Physical <i>(MS/HS)</i>			
If applicable: Notarized Legal Guardianship Document or Notarized Power of Attorney			

<i>Accounting Use Only:</i>	<i>Date Received:</i>	<i>OR#:</i>	<i>Received by:</i>

**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: \_\_\_\_\_

# 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: \_\_\_\_\_

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

IMMUNIZATION OR DISEASE	DATE OF ILLNESS	DATE OF IMMUNIZATION	LAST BOOSTER	CHICKENPOX	DATE	COMMENTS
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)

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

SCHOOL YEAR: \_\_\_\_\_

STUDENTS LAST NAME: \_\_\_\_\_

STUDENTS FIRST NAME: \_\_\_\_\_



# SAINT PAUL CHRISTIAN SCHOOL

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

## 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*

SPORT PHYSICAL AND PARENT CONSENT FORM (continued)

**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 SY 20\_\_-20\_\_

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 1<sup>ST</sup> 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 (10<sup>th</sup>) 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)

**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**

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**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.



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## Please complete the information below:

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

indicated below for \$ \_\_\_\_\_ on the 1<sup>st</sup> of each month for payment of my  
(day or date)  
tuition and fees.

Billing Address \_\_\_\_\_

Phone# \_\_\_\_\_

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

Email \_\_\_\_\_

### Credit Card

Student Name(s): \_\_\_\_\_

Grade Level: \_\_\_\_\_

Notes:  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

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