PLEASE ATTACH RECENT PHOTO

Office Use Only

Reg. Fee Pd.: Yes ___ No ___

Form of Pymt.: _____

Date of Pymt.:_____

Amount Pd.:_____

Check#:_____

Application for School Year 2025-2026

Anticipated Grade Level:_____

Student's Legal Name _____
first middle last

Address _____
street city state zip code

Phone (____)_____ Sex ____ Date of Birth _____ Social Security _____

Current School:_____School District:_____

Address _____
street city state zip code

How did you hear about SCA? Friend ☐ *Social Media* ☐ *Sign* ☐ *Church* ☐ *Website* ☐ *Other* ☐

FATHER / STEP-FATHER / GUARDIAN ***(please circle)***

Name _____ Living with child? _____

Occupation _____Employer_____

Home Phone (__)_____ Cell Phone (___)_____

E-mail Address _____

MOTHER / STEP-MOTHER / GUARDIAN ***(please circle)***

Name _____ Living with child? _____

Occupation _____Employer_____

Home Phone (___) _____ Cell Phone (___)_____

E-mail Address _____

* If parents are separated, with whom does the child reside? _____

SCHOOL

Does your child require any special accommodations for a learning disability, developmental delay, physical disability, etc.? _____ Yes _____ No
If yes, please comment: _____
_____
_____

Does your child have an IEP or 504 plan? _____Yes* _____ No
*If yes, a copy of the ETR/IEP or 504 plan must be provided to SCA.

Has or is your child receiving counseling or in the process of psychological testing? _____Yes _____ No

Has or is your child experienced any physical, emotional, mental, or social struggles at home or at school?
_____Yes* _____ No *If yes, please explain: _____
_____
_____

Has your child ever been retained a grade level, suspended, expelled, or asked to withdraw from a school?
_____ Yes _____ No If yes, please comment: _____
_____
_____

Do you agree as parent(s) to support all of the policies and standards of SCA as long as your child is enrolled here? _____ Yes* _____ No

CHRISTIAN BACKGROUND

Name of your current local church affiliation (If applicable): _____

Do you understand that SCA is a Christian school that follows Scriptural teachings and will always conduct the education of students according to the dictates of God's Word? _____Yes _____No

PAYMENT PLAN - TUITION

Children Enrolled (Please include grade level): _____

_____

Parent/Guardian Name(s): _____

Party Accepting Financial Responsibility: _____

Address:_____

Email: _____

Phone #:_____

Choose Payment Method For the Balance of Your Tuition After EdChoice or Full Tuition (if no EdChoice was applied for)

____ **Annual**: Due the 1st week of August, 2025

____ **Semi-Annual**: Due the 1st week of August, 2025 and the 1st week of January, 2026

____ **Monthly**: 11 monthly ACH transfers **on the 15th of each month** from 8/15/25 - 6/15/26

____ **Add Facility/Tech Fee** to payment option checked above

Only complete the bottom portion of this form if you are paying your tuition balance monthly or if you would like your annual or semi-annual tuition balance withdrawn via ACH. **Your payment will be automatically transferred via ACH every month on the 15th beginning 8/15/25 and ending 6/15/26.**

AUTHORIZED AGREEMENT FOR DIRECT PAYMENT

I hereby authorize Salem Christian Academy Schools to initiate ACH transfers from my:

____ Checking Account _____Savings Account

*** ATTACH A VOIDED CHECK, COPY OF A CHECK OR LETTER FROM BANK HERE ***

Name on Account:_____

Financial Institution: _____

Routing #:_____

Account #: _____

This authority is to remain in full force and effect until Salem Christian Academy Schools has received written notification from me at least 2 weeks prior to termination.

Authorized Signature: _____

Print Name:_____**Date:**_____

PAYMENT PLAN - FACILITY / TECH FEE 2025-2026

Children Enrolled (Please include grade level): _____

_____

Parent/Guardian Name(s): _____

Party Accepting Financial Responsibility: _____

Address:_____

Email: _____

Phone #:_____

Choose Payment Method For Your Facility / Tech Fee:
$250 - 1st child; $225 - 2nd child; $200 - 3rd child; $175 - 4th child

____ **Annual**: Due the 1st week of August, 2025

____ **Semi-Annual**: Due the 1st week of August, 2025 and the 1st week of January, 2026

____ **Monthly**: **5** monthly ACH transfers **on the 15th of each month** from 8/15/25 - 12/15/25

____**Monthly: 10** monthly ACH transfers **on the 15th of each month** from 8/15/25 - 5/15/26

Only complete the bottom portion of this form if you are paying the Facility/Tech Fee monthly or if you would like your annual or semi-annual payment withdrawn via ACH. **Your payment will be automatically transferred via ACH every month on the 15th beginning 8/15/25 for the period designated above.**

AUTHORIZED AGREEMENT FOR DIRECT PAYMENT
I hereby authorize Salem Christian Academy Schools to initiate ACH transfers from my:

____ Checking Account _____Savings Account

Annual $_____; Semiannual $_____; 5 Monthly $_____; 10 Monthly - $_____

*** ATTACH A VOIDED CHECK, COPY OF A CHECK OR LETTER FROM BANK HERE ***

Name on Account:_____

Financial Institution: _____

Routing #:_____

Account #: _____

This authority is to remain in full force and effect until Salem Christian Academy Schools has received written notification from me at least 2 weeks prior to termination.

Authorized Signature: _____

Print Name:_____**Date:**_____

SIGNATURE PAGE

The following is the signature page for documents referenced below. The full documents can be found at salemchristianacademy.com. Please read through each document and use this page to sign for acknowledgement /agreement.

AGREEMENT OF COOPERATION

Parent Signature: _____ Date: _____

Parent Signature: _____ Date: _____

GRIEVANCE COVENANT

Parent Signature: _____ Date: _____

Parent Signature: _____ Date: _____

PARENT COMMITMENT FORM

Parent Signature: _____ Date: _____

Parent Signature: _____ Date: _____

ADMISSION POLICY AND PROCEDURE

Parent Signature: _____ Date: _____

Parent Signature: _____ Date: _____

SCA POSITIONAL FOUNDATION

Parent Signature: _____ Date: _____

Parent Signature: _____ Date: _____

2025-2026

EMERGENCY MEDICAL AUTHORIZATION FORM

Salem Christian Academy, LLC

Allergy Alert ☐

Student Name: _____ Grade: _____
(please print) Last First

Address: _____ Birth Date: _____ Male ☐
MM/DD/YYYY

City/Zip Code: _____ Student resides with: _____ Female ☐

PARENT/GUARDIAN & EMERGENCY CONTACT INFORMATION

Relationship:	Name:	Home Phone:	Cell Phone:	Work Phone:	Can Pick Up:
Parent/Guardian					☐
Parent/Guardian					☐
					☐
					☐
					☐

Please indicate if your child has any of the following:

1. Allergies:* _____

***CHOOSE ONE** - If your child has allergies, should he/she eat lunch: ☐ at the class table - or - ☐ at the table for students w/ allergies?

2. Medications:** _____

3. Inhalers:** _____

4. Other medical concerns or conditions: _____

**Use of any medication at school requires the appropriate documentation to be completed & on file with the school office. Any listed medication & completed Student Medication Form MUST be turned in to the office prior to the 1st day of school. *Student Medication Forms can be found at SalemChristianAcademy.com*

PART I OR II MUST BE COMPLETED

PART I: TO GRANT CONSENT

I Hereby Grant Consent for the following medical care providers and local hospital to be called:

Doctor: _____ Phone: _____

Dentist: _____ Phone: _____

Medical Specialist: _____ Phone: _____

Local Hospital/Emergency Room Phone: _____

_____ _____
Signature of Parent/Guardian Date

PART II: REFUSAL TO CONSENT

I Do Not Grant Consent for emergency medical treatment of my child. In the event of illness or injury requiring emergency treatment, I wish the school authorities to take the following action:

_____

_____

_____

_____ _____
Signature of Parent/Guardian Date