



# BELLEVUE CHRISTIAN SCHOOL

## Student Enrollment

**PARENT/GUARDIAN LAST NAME** \_\_\_\_\_

<u>Student(s) Full Name to be Enrolled</u>	<u>Birthdate</u>	<u>Grade to Enter</u>	<u>Ethnicity</u>
1. _____	_____	_____	M/F
2. _____	_____	_____	M/F
3. _____	_____	_____	M/F

**FATHER /GUARDIAN'S NAME** \_\_\_\_\_ Phone \_\_\_\_\_

Address \_\_\_\_\_

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

Email \_\_\_\_\_

Employer \_\_\_\_\_ Phone \_\_\_\_\_ Employer Address \_\_\_\_\_

Marital Status ( ) married ( ) widowed ( ) divorced ( ) separated ( ) remarried ( ) single

**MOTHER /GUARDIAN'S NAME** \_\_\_\_\_ Phone \_\_\_\_\_

Address \_\_\_\_\_

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

Email \_\_\_\_\_

Employer \_\_\_\_\_ Phone \_\_\_\_\_ Employer Address \_\_\_\_\_

Marital Status ( ) married ( ) widowed ( ) divorced ( ) separated ( ) remarried ( ) single

**CHURCH INFORMATION** Does your family attend church? \_\_\_\_\_ YES \_\_\_\_\_ NO \_\_\_\_\_ Sometimes

Church Name \_\_\_\_\_ Pastor \_\_\_\_\_

**Medical Information:**

**Which hospital you would like your child to be sent to, or check closest\*:**

**Hospital Name:** \_\_\_\_\_ **Ph #** \_\_\_\_\_

**Hospital Address:** \_\_\_\_\_ **City:** \_\_\_\_\_

\_\_\_\_\_\* Closest Hospital: North Suburban Medical Center 9191 Grant Street, Thornton, CO 80229 (303) 451-7800

**Doctor/Clinic:** \_\_\_\_\_ **Ph #** \_\_\_\_\_

**Address:** \_\_\_\_\_ **City:** \_\_\_\_\_

**Name of Insurance Company:** \_\_\_\_\_ **Policy #:** \_\_\_\_\_

**Date of Last Medical Visit:** \_\_\_\_\_ **Medical Issues or Allergies:** \_\_\_\_\_

**Dentist/Clinic:** \_\_\_\_\_ **Ph #** \_\_\_\_\_

**Address:** \_\_\_\_\_ **City:** \_\_\_\_\_

**Name of Insurance Company:** \_\_\_\_\_ **Policy #:** \_\_\_\_\_

**Date of Last Dental Visit:** \_\_\_\_\_ **Dental Issues:** \_\_\_\_\_

**Eye Doctor/Clinic:** \_\_\_\_\_ Ph # \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_

Name of Insurance Company: \_\_\_\_\_ Policy #: \_\_\_\_\_

Date of Last Eye Exam: \_\_\_\_\_ Vision Issues: \_\_\_\_\_

Therapies or Support Services your child is participating in such as Speech, Behavioral, Physical, Auditory, Visual, Occupational, Etc:

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**In the event that your child is ill/injured at school, who should we call? Please number 1<sup>st</sup>, 2<sup>nd</sup>, 3<sup>rd</sup> the following people who are allowed to pick up my child. We do require ID for verification.**

\_\_\_ **Mother's Name:** \_\_\_\_\_ Cell Ph# \_\_\_\_\_

\_\_\_ **Father's Name:** \_\_\_\_\_ Cell Ph# \_\_\_\_\_

\_\_\_ **Additional Person:** \_\_\_\_\_ Cell Ph# \_\_\_\_\_

Address: \_\_\_\_\_

Work Place: \_\_\_\_\_ Work # \_\_\_\_\_

Work Address: \_\_\_\_\_ City: \_\_\_\_\_

Relationship: \_\_\_\_\_

\_\_\_ **Additional Person:** \_\_\_\_\_ Cell Ph# \_\_\_\_\_

Address: \_\_\_\_\_

Work Place: \_\_\_\_\_ Work # \_\_\_\_\_

Work Address: \_\_\_\_\_ City: \_\_\_\_\_

Relationship: \_\_\_\_\_

\_\_\_ **Additional Person:** \_\_\_\_\_ Cell Ph# \_\_\_\_\_

Address: \_\_\_\_\_

Work Place: \_\_\_\_\_ Work # \_\_\_\_\_

Work Address: \_\_\_\_\_ City: \_\_\_\_\_

Relationship: \_\_\_\_\_

\_\_\_\_\_ **Please check if NO ONE else may pick up my child.**

Parent/Guardian Signature \_\_\_\_\_ Date: \_\_\_\_\_

# FINANCIAL COMMITMENT

**PARTY RESPONSIBLE FOR PAYMENT** \_\_\_\_\_ SS# \_\_\_\_\_

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

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

Relationship (if other than parent) \_\_\_\_\_

**REQUIRED** Name as it appears on card \_\_\_\_\_

Credit Card # \_\_\_\_\_

Expiration Date \_\_\_\_\_ V-Code \_\_\_\_\_ (final 3-digits on back of card)  VISA  MasterCard  Discover

**PARTY RESPONSIBLE FOR PAYMENT** \_\_\_\_\_ SS# \_\_\_\_\_

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

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

Relationship (if other than parent) \_\_\_\_\_

**REQUIRED** Name as it appears on card \_\_\_\_\_

Credit Card # \_\_\_\_\_

Expiration Date \_\_\_\_\_ V-Code \_\_\_\_\_ (final 3-digits on back of card)  VISA  MasterCard  Discover

**Enrollment Fee\*** \$ \_\_\_\_\_  Childcare = \$150  K = \$300  1 - 5<sup>th</sup> = \$350  6<sup>th</sup> - 12<sup>th</sup> = \$500

Tour coupon \$50 credit Family Cap \$1,000 (1st-12th)

**Material/ Field Trip** \$ \_\_\_\_\_ \*  K \$50 Includes CCAP Students

**Tuition Due** \$ \_\_\_\_\_ Childcare Days/Hours \_\_\_\_\_

**ETC** \$ \_\_\_\_\_  School Hours + (6:30-6:00 pm Monthly Rate) or  Hourly rate

**Total Paid Today** \$ \_\_\_\_\_  Cash  Check #: \_\_\_\_\_  Credit Card

\*CCAP Students are required to pay the Material/Field Trip fee.

\*The Enrollment Fee is NON-REFUNDABLE/NON-TRANSFERABLE. Final enrollment is based upon submission of all paperwork, fees and acceptance to Belleview.

I understand all payments must be paid on or in advance of due dates and that my account must be current before records can be released. I understand I will receive a statement by email, and that it is my responsibility to make timely payments. **Failure to meet my payment schedule will result in charges made to my credit card, including late fees.** Past due accounts may result in the dismissal of my child.

I have read and understand this application and all of the answers are accurate to the best of my knowledge.

\_\_\_\_\_  
Parent's Signature

\_\_\_\_\_  
Date

**Please Note: This information will remain confidential.**