Skyline Christian Academy
A ministry of Church at Skyline
7655 Stonewall Jackson Hwy
Post Office Box 1582
Front Royal, VA 22630
540-635-9003
skylinechristianacademy.va@gmail.com
skylinechristianacademy.com

Dear Parent and Student,

We are excited about your inquiry into Skyline Christian Academy and are looking forward to meeting with you. Attached is the Financial Agreement with tuition and fees, along with other paperwork. SCA will start school on Tuesday, September 2nd, 8:00-3:30, Monday-Thursday.

Please call to arrange a time to visit the school, meet the teachers, and answer any questions you may have.

Once your paperwork is complete, please bring it to the school office Monday – Thursday, to schedule a meeting.

We are looking forward to hearing from you soon.

Felicia Giovinazzo
SCA Administrator

Finally, my brethren, be strong in the Lord and in the power of His might. Eph. 6:10

Skyline Christian Academy
Financial Agreement

Skyline Christian Academy is a private Christian school that relies solely on the support of tuition. The school does not receive government funding or government sponsored grants. Non-compliance with the tuition policy-payment schedule listed below will limit the student's ability to complete course and credit requirements.

	Fees	
Non-refundable Registration Fee	$75.00	$100.00 Family
Book & Technical Fees – per student		
Preschool and K5	$300.00	
1st - 8th	$650.00	
9th - 11th	$725.00	

Tuition Payment Plan

Preschool

Full Day	$139 Weekly
4 Half days (8am – 12pm)	$75 Weekly

All weekly payments are due the Thursday prior
Payments received 2 weeks late will accrue a late fee of $45.00
Return check fee is $40.00

___ Full day ___Half day

K5 – 11th Grade

		10 Month August – May	9 Month September – May
Tuition per child	$ 5,000.00	$ 500.00	$ 555.56
2nd child 10% off tuition	9,500.00	950.00	1,055.56
3rd child 15% off tuition	13,750.00	1,375.00	1,527.78
Homeschool Program	40.00 per day		

All monthly payments are due on the 5th of each month.
Payments received after the 15th will accrue a late fee of $45.00.
Return check fee is $40.00.

___ 10 months ___ 9 months Monthly payment of _____ due by the 5th of each month

I agree to the tuition and fees as stated. I agree to make my payments on or before the 5th of each month according to the payment plan, I chose. Payments should be made by check, money order, or cash. I understand there is a 10-day grace period. If tuition is not received by the 15th, a $45.00 late fee will be applied to my account. I understand that if my delinquent account is not paid by the end of the month, my child/ren will be denied services and dismissed from Skyline Christian Academy until balance is paid in full.

I certify, by signing below, that I have read and agree to the terms and conditions stated above.

_____ _____
Mother/Guardian Signature Date Social Security No.

_____
Print Name

_____ _____
Father/Guardian Signature Date Social Security No.

_____
Print Name

_____
SCA Administrator Signature Date

Office Use Only

Date:_____ Ck #:_____ Cash:_____
Fees Paid:_____

Skyline Christian Academy

Application Form

Student's First Name _____ M. I. _____ Last Name_____

Address _____

City _____ State _____ Zip _____

Home Phone _____ Student's Email_____

Birth Date ____/____/____ Social Security # _____ Grade Entering: _____

A Birth Certificate and Immunization Record are required upon enrollment.

Medical conditions and/or allergies. List Current Medications and allergic reaction _____

_____

_____

Church _____ Pastor _____

Church Address _____ Phone _____

Is Father a Christian? _____ Mother? _____ Student? _____

Father's First Name: _____ Last Name _____

Cell Phone _____ Email _____

Employer _____Work Phone _____

Mother's First Name _____ Last Name _____

Cell Phone _____ Email _____

Employer _____Work Phone_____

How did you hear about our school? _____

Emergency Contact Name	**Relationship**	**Daytime Phone**
1.		
2.		
3.		
4.		

Parent/Guardian Signature _____ Date _____

Skyline Christian Academy

Media and Promotional Release

I hereby consent to be photographed, recorded, interviewed, videotaped or filmed by representative of Skyline Christian Academy for purposes of publication, display or broadcast (print, web, digital display and all other forms of media, including social media).

I hereby release Skyline Christian Academy, its affiliates, employees, representatives and agents from any and all claims, demands, costs and liability that may arise from the use of these interviews, recordings, photographs, videotapes or films, and/or any reproductions of same in any form, as described above, arising out of being photographed, recorded, interviewed, videotaped or filmed.

I acknowledge that I have read this consent form in its entirety, or it has been read (or translated) to me, and I have had the opportunity to ask questions about it and understand it.

Date:_____

Student Name (print):

_____

Student signature:

_____

*Parent or Legal Guardian name (print):

_____

*Parent or Legal Guardian signature:

_____

*Parent or Legal Guardian name signature required for individuals under age 18

Skyline Christian Academy

Pick - up Form

Student's Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone_____

Only the people listed below may pick up the student listed above, unless written permission is given to the school by the student's legal guardian. Approved by ☐ Mother ☐ Father

Name	Phone Number	Relationship to the child

Parent/Guardian Signature: _____ Date: _____

Skyline Christian Academy
Parent Agreement

By enrolling, you agree to the following terms:

- ✞ Parent(s)/Guardian(s) understand that students enrolled in Skyline Christian Academy will become full-time students of Skyline Christian Academy and are under the Virginia State Board of Education guidelines for graduation requirements.
- ✞ Parent(s) agree that students must attend school daily as scheduled and be on time. Excessive absences and/or tardiness will be reported to the local truancy officer.
- ✞ Parent(s)/Guardian(s) agree to provide a copy of child's birth certificate, immunization records, school physical form, previous school records, transcripts, and any other pertinent documents. All documents **must be received within 30 days of registration and before the student starts school.**
- ✞ Parent(s)/Guardian(s) acknowledge that a course must be successfully completed to be given credit.
- ✞ Parent(s)/Guardian(s) agree have students take annual diagnostic tests or standardized tests.
- ✞ Parent(s)/Guardian(s) agree to spend ½ an hour with their student each evening, reviewing class material, reading aloud, practicing flash cards, and/or completing teacher suggested additional.
- ✞ Parent(s) agree to support students' responsibility for exhibiting ethical, moral, and Christian behaviors at all times.
- ✞ I realize that attending Skyline Christian Academy is a privilege and not a right. It is my intention to abide by the decisions and support the discipline of the administration.
- ✞ I have read the school handbook, and I agree to abide by the standards listed within.

Parent/Guardian Signature: _____ Date: _____

Parent/Guardian Signature: _____ Date: _____

Skyline Christian Academy
Student Agreement

As a student, you agree to the following terms:

- ✞ I will attend school daily as scheduled and be on time. Excessive absences and/or tardiness will be reported to the local truancy officer.
- ✞ I will do my best academically, which includes, but is not limited to, participating with my class in drills and activities.
- ✞ I will complete my work in a timely manner. Assignments which are not completed on time will result in deducted points.
- ✞ I will complete my homework each evening. If I do not understand an activity, I will contact my teacher for help.
- ✞ I will exhibit ethical, moral, and Christian behaviors at all times.
- ✞ I will obey the school dress code.
- ✞ I have read the school handbook, and I agree to abide by the standards listed within.

Student's Signature: _____ Date: _____

RETURN TO SCHOOL

Emergency Medical Release
2025-2026

Student Information:

Student's Full Name:_____

Date of Birth:_____ /_____ /_____ Age:_____ Gender: Male ☐ Female ☐

Address:_____

City:_____ State: _____ Zip:___

Home Phone:_____ Cell Phone:_____

Parent/Guardian Information:

Father ☐ Stepfather ☐ Guardian ☐ Mother ☐ Stepmother ☐ Guardian ☐

Name:_____ Name:_____

Cell Phone:_____ Cell Phone:_____

Work Phone:_____ Work Phone:_____

Medical conditions and/or allergies (including reactions to medications):_____

_____

_____

Current Medications:_____

Any other medical or physical conditions SCA Staff should know:_____

_____

Physician:_____ Phone:_____

Dentist:_____ Phone:_____

Health Insurance Carrier:_____ Policy #: _____

Name of Policy Holder:_____ Relationship:_____

Date of last Tetanus Shot:_____

_____ _____

Father's/Guardian's Signature **Mother's/Guardians Signature**

Skyline Christian Academy
Emergency Medical Release Form
2025 – 2026 School Year

This form will be on file in the school office for the current school year.

I/we agree that in the case of an accident, illness, or other life-threatening emergency to the student listed below, I/we give permission for Skyline Christian Academy's Staff to contact Emergency Medical Services (911) immediately.

I/we authorize and consent to any examination, x-rays, anesthetic, medical, dental, or surgical diagnosis or treatment and hospital care deemed necessary in the best judgment of a licensed physician or dentist.

I/we agree to assume all financial responsibility for expenses incurred as a result of any of these services being provided, including emergency medical transportation.

Student's Full Name:_____
(Please Print)

Date of Birth:_____
(MM/DD/YYYY)

Father's/Guardian's Full Name:_____
(Please Print)

Father's/Guardian's Signature:_____

Date:_____

Mother's/Guardian's Full Name:_____
(Please Print)

Mother's/Guardian's Signature:_____

Date:_____

*Both parents/guardians are to sign this form unless parent/guardian has sole custody of student.

Please notify the school office of any changes during the school year.

ALLERGY ACTION

PART I TO BE COMPLETED BY PARENT/GUARDIAN:

Student: _____ **D.O.B.** _____

ALLERGY: _____ **Teacher/Grade:** _____

1. Emergency Contact: _____ **Phone:** _____

2. Emergency Contact: _____ **Phone:** _____

Asthmatic ☐ **Yes*** ☐ **No** ***Higher Risk for severe reaction**

PART II TO BE COMPLETED BY LICENSED HEALTHCARE PROVIDER:

TREATMENT PLAN FOR ABOVE ALLERGY

For medications administered during school sanctioned activities, complete required EpiPen/Medication Authorization forms.

Symptoms: **Medication:**	**Give Checked**	
If food allergen has been ingested, but no symptoms:	☐ Epinephrine	☐ Antihistamine
Mouth – itching, tingling, or swelling of lips, tongue, mouth	☐ Epinephrine	☐ Antihistamine
Skin – Hives, itchy rash, swelling of face or extremities	☐ Epinephrine	☐ Antihistamine
Gut – Nausea, abdominal cramps, vomiting, diarrhea	☐ Epinephrine	☐ Antihistamine
*Throat – Tightening of throat, hoarseness, hacking cough	☐ Epinephrine	☐ Antihistamine
*Lung – shortness of breath, repetitive coughing, wheezing	☐ Epinephrine	☐ Antihistamine
*Heart – Thready pulse, low blood pressure, fainting, pale, blueness	☐ Epinephrine	☐ Antihistamine
*Other -	☐ Epinephrine	☐ Antihistamine
If reaction is progressing (several of the above areas affected), give	☐ Epinephrine	☐ Antihistamine

***Potentially life-threatening. The severity of symptoms can quickly change.**

DOSAGE		
Epinephrine: inject intramuscularly (mark one)	☐ EpiPen ®	☐ EpiPen ® Jr.
Antihistamine: give		
Medication/dose/route		
Other: give		
Medication/dose/route		

PLACE EMERGENCY CALLS

1. **Call 911. State that an allergic reaction has been treated, and additional epinephrine may be needed.**
2. **Dr.** _____ **at** _____

_____	_____	_____	_____
Licensed Health Care Provider (Print)	**Licensed Health Care Provider (Signature)**	**Telephone**	**Date**

I approve of this Allergy Action Plan; I give permission for school personnel to perform and carry out the tasks as outlined. I consent to the release of the information contained in this management plan to all staff members and others who have custodial care of my child and who may need to know this information to maintain my child's health and safety.

_____	_____	_____
Parent/Guardian Signature	**Telephone**	**Date**

PART I TO BE COMPLETED BY PARENT/GUARDIAN

I hereby request Skyline Christian Academy to administer an epinephrine injection by this authorization. I agree to release, indemnify and hold harmless SCA school personnel, or agents from lawsuits, claim expense, demand or action, etc., against them administering this injection, provided SCA school personnel comply with the Licensed Healthcare Provider (LHCP) or parent/guardian orders set forth in accordance with provision of part II below. I am aware that the injection may be administered by a specifically trained non-health professional. I assume responsibility as required.

I understand that Emergency Medical Services (EMS) will always be called when epinephrine is given, whether or not the student manifests and symptoms of anaphylaxis.

Student's Full Name: _____ **D.O.B.** _____

Allergies: _____ **School:** Skyline Christian Academy **School Year:** _____

_____ _____ _____

Parent's/Guardian's Signature **Daytime Telephone** **Date**

PART I TO BE COMPLETED BY LICENSED HEALTH CARE PROVIDER WITH NO ABBREVIATIONS

Emergency injections may be administered by non-health professionals. For this reason, only pre-measured does of epinephrine (Epi-Pen auto injector) may be given. It should be noted that these staff members are not trained observers. They cannot observe for the development of symptoms before administering the injection.

The following injection will be given immediately after report exposure to: (indicate specific allergens)

Route of exposure: (Check appropriate boxes)

☐ Ingestion ☐ Skin contact ☐ Inhalation ☐ Insect bite or sting

EpiPen ☐
- ☐ Give the pre-measured dose of 0.3 mg of epinephrine 1:1000 aqueous solution (0.3cc) by auto injection in the thigh.
- ☐ Repeat the dose in 15 minutes if EMS has not arrived. (Two pre-measured doses will be needed in school.)

EpiPen Jr. ☐
- ☐ Give the pre-measured does of 0.15 mg of epinephrine 1:2000 aqueous solution (0.3cc) by auto injection in the thigh.
- ☐ Repeat the dose in 15 minutes if EMS has not arrived. (Two pre-measured doses will be needed in school.)

COMMON SIDE EFFECTS: _____

Effective Date: Start: _____ **End:** _____

Check appropriate box:

☐ I believe that this student has received adequate information on how and when to use an EpiPen, and has demonstrated its proper use.
   a. The student is to carry and EpiPen during school hours with the School Administrator's approval to use in an emergency.
   b. One additional dose, to be used as back-up, should be kept in the school office.

☐ The EpiPen will be kept in the school office or other school approved location.

***Allergy Action Plan is attached.**

_____ _____ _____ _____

Licensed Health Care Provider (Print) **Licensed Health Care Provider (Signature).** **Telephone** **Date**

_____ _____ _____ _____

Parent/Guardian (Print) **Parent/Guardian Signature** **Telephone** **Date**

_____ _____

Student Signature (Required if student carries EpiPen) **Date**