



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.

The 2026–2027 school year will start on Tuesday, September 8, 2026, with classes held Monday through Thursday from 8:15 AM to 3:30 PM.

Once your paperwork is complete, please bring it to the school office Monday – Thursday with necessary fees. Registration fees are required at the time of enrollment, and book fees must be submitted on or before the first day of school. Monthly tuition payments are due on the 5<sup>th</sup> of each month.

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.

	<b>Fees</b>	
Non-refundable Registration Fee	\$75.00	\$100.00 Family
Book & Technical Fees – per student		
Preschool and K5	\$300.00	
1 <sup>st</sup> - 8 <sup>th</sup>	\$650.00	
9 <sup>th</sup> - 12 <sup>th</sup>	\$725.00	

### Tuition Payment Plan

#### Preschool

Full Day	\$140 Weekly
4 Half days (8:15am – 11:45am)	\$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 – 12<sup>th</sup> Grade

		10 Month August – May	9 Month September – May
Tuition per child	\$ 5,200.00	\$ 520.00	\$ 578.00
2nd child 10% off tuition	9,880.00	988.00	1,098.00
3rd child 15% off tuition	14,300.00	1,430.00	1,589.00
Homeschool Program	40.00 per day		

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

10 months  9 months    Monthly payment of \_\_\_\_\_ due by the 5<sup>th</sup> of each month

I agree to the tuition and fees as stated. I agree to make my payments on or before the 5<sup>th</sup> 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 15<sup>th</sup>, 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

	<b>Office Use Only</b>	
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 reactions \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

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

## 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

## Media and Promotional Release

I hereby consent to be photographed, recorded, interviewed, videotaped or filmed by representatives of The Church at Skyline and 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 The Church at Skyline, 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

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



## Emergency Medical Release 2026-2027

### 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  
2026 - 2027 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:**

**Give Checked**

**Medication:**

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

## EPI-PEN AUTHORIZATION FORM

### 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:** 2025-2026

\_\_\_\_\_  
**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 doses 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 doses 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**

# Skyline Christian Academy

## School Records Release

Request/Authorization to Obtain School Records

To: \_\_\_\_\_ School  
\_\_\_\_\_  
\_\_\_\_\_ Address  
\_\_\_\_\_  
\_\_\_\_\_ City, State, Zip  
\_\_\_\_\_  
\_\_\_\_\_ Fax and Phone Number  
\_\_\_\_\_  
\_\_\_\_\_ Email

From: Skyline Christian Academy  
P.O. Box 1582  
Front Royal, VA 22630  
Phone: (540) 692-4531  
Email: skylinechristianacademy.va@gmail.com

I authorize Skyline Christian Academy to RECEIVE the indicated school records for:

Student's Full Name: \_\_\_\_\_ Birth Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

I am authorizing the release of the following records:

**Initial**

- \_\_\_ Report Cards
- \_\_\_ Transcripts
- \_\_\_ Psychological Records
- \_\_\_ Health Records
- \_\_\_ Exception/Special Educational Records (I.E.P.)
- \_\_\_ Standardized Testing Results
- \_\_\_ Diagnostic Evaluation
- \_\_\_ Attendance Records

Parent/Guardian's Name: \_\_\_\_\_

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

\*You must fill out one form for each student registered



# Skyline Christian Academy

## Required Enrollment Documents

Please turn in the following:

Completed SCA documents:

- Financial Agreement
- Application
- Media and Promotional Release
- Pick-up Form
- Signed Parent Agreement
- Signed Student Agreement
- Emergency Medical Release Form
- School records release (if applicable)

Copies of:

- Birth certificate
- Immunization record
- School entry physical