



ROCK COUNTY CHRISTIAN SCHOOL

Date:

“Shaping Hearts And Minds In The Truth”

2026-2027 APPLICATION FOR ADMISSION

Elementary Campus 5122 Driftwood Dr Janesville • MS/HS Campus 916 Bushnell St Beloit
Phone 608-757-1000 • Website: www.rccs.us

STUDENT INFORMATION			
Name- First:		Middle	Last
Date of Birth	Grade applying for	Student lives with: <input type="checkbox"/> Both Parents <input type="checkbox"/> Mother <input type="checkbox"/> Father <input type="checkbox"/> Guardian	

FATHER'S / GUARDIAN'S INFORMATION			MOTHER'S / GUARDIAN'S INFORMATION		
Name		Primary Phone	Name		Primary Phone
Address- Street		City State	Address- Street		City State
Occupation	Employer	Work Phone	Occupation	Employer	Work Phone
Email Address		Churchnow attending	Email Address		Churchnow attending
Pastor		Phone	Pastor		Phone
Have you personally received Jesus Christ as your Lord and Savior? On what do you base your answer? <input type="checkbox"/> Yes <input type="checkbox"/> No			Have you personally received Jesus Christ as your Lord and Savior? On what do you base your answer? <input type="checkbox"/> Yes <input type="checkbox"/> No		
Church Attendance: <input type="checkbox"/> Regularly <input type="checkbox"/> Often <input type="checkbox"/> Seldom			Church Attendance: <input type="checkbox"/> Regularly <input type="checkbox"/> Often <input type="checkbox"/> Seldom		
Does this parent have full custodial rights including rights to school correspondence? <input type="checkbox"/> YES <input type="checkbox"/> NO Explain: _____ *Attach court order if applicable			Does this parent have full custodial rights including rights to school correspondence? <input type="checkbox"/> YES <input type="checkbox"/> NO Explain: _____ *Attach court order if applicable		
If child's last name is different from parents, please explain present home situation:					

OTHER CHILDREN LIVING AT HOME					
Name	Birth date	Current School	Name	Birth date	Current School
1			3		
2			4		

MEDICAL INFORMATION		
Doctor's Name		Phone
Health Insurance Carrier		Address
Health Insurance Company		Policy Number/Group Number
Authorized to call doctor? <input type="checkbox"/> Yes <input type="checkbox"/> No		Preferred Hospital:
Date of last physical exam		Date of last eye exam
		Date of last dental exam
Any serious illness? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, explain		
Any surgeries? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, explain		
Any allergies? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, explain		
Is student on any medication? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, please list		
Do you have any special health instructions for this student? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, explain		
Does your child have: <input type="checkbox"/> Speech difficulty <input type="checkbox"/> Hearing difficulty <input type="checkbox"/> Vision difficulty <input type="checkbox"/> Neurological disorder <input type="checkbox"/> Physical limitations <input type="checkbox"/> Learning difficulty <input type="checkbox"/> ADHD <input type="checkbox"/> LD		
Comments:		



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Date of Birth	Grade applying for:		

FATHER'S / GUARDIAN'S INFORMATION

MOTHER'S / GUARDIAN'S INFORMATION

Name		Primary Phone	Name		Primary Phone
Address- Street		City	State	Address- Street	
				City	
				State	
Occupation	Employer	Work Phone	Occupation	Employer	Work Phone
Email Address	Churchnow attending		Email Address	Churchnow attending	
Pastor	Phone		Pastor	Phone	
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MEDICAL INFORMATION

Doctor's Name	Phone	Address
Health Insurance Carrier	Health Insurance Company	Policy Number/Group Number
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Date of last physical exam	Date of last eye exam	Date of last dental exam
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Comments:		

Has this student had a history of, or been evaluated for, any physical or emotional condition which has required professional attention or might require special attention at RCCS? Yes No If yes, explain

Does this student receive professional psychological counseling? Yes No

Is this student on any medication on a regular basis that we should be aware of? Yes No
 If yes, does the medication need to be administered during school hours? Yes No

Does the student need to wear glasses? Yes No If yes, all of the time? Yes No

SCHOOL BACKGROUND INFORMATION – List all previous schools attended (most recent first)

School	Address	Dates Attended	Grades Completed

Has this student ever repeated a grade? Yes No
 If yes, what grade? _____

Has this student ever been suspended or expelled? Yes No
 If yes, explain _____

Name of School District in which you reside _____ Scholastic grades have been: Above average Average Below average

If your student has received or currently receives special education services, please list:

IEP: Disability: _____ **Services:** _____

Title I: Reading Yes No **Math** Yes No **Private Tutoring:** Yes No

504 Plan Yes No **Diagnosis:** _____

Did your child/children have any disciplinary problems while attending his/her past school? Yes No
 If yes, please explain: _____

Has your student been retained (or held back) in a grade? Yes No
 If so, what grade: _____ What was the reason for the retention? _____

Has your student been identified as Gifted and/or Talented in their previous school? Yes No
 If yes, explain: _____

Please explain any specific concerns related to this student's academic, social or physical progress.

It is understood that each student will be placed in the grade which best meets his/her individual needs.
 This is determined by the placement testing, along with the teacher and principal evaluation.

MISCELLANEOUS

Hobbies or special interests: _____

Comment on the student's personality traits (well-behaved, poised, responsible, congenial, temperamental, aggressive, fearful, etc.): _____

Why do you wish to send your child to Rock County Christian School? _____

Signatures and date:

 Father / Guardian Date Mother / Guardian Date