



Holy Name of Jesus Catholic School 2026-2027 Tuition & Fee Information

By signing below I acknowledge that I know the tuition and fees for the 2026-27 school year BEFORE financial aid. I also know that any financial aid awarded will only apply to tuition.

Parents/Guardians:

Address:

City:

State:

Zip:

Home Phone:

Tuition Rates:

Grade	1 Child	2 Children	3 Children
K-8	\$5120	\$ 10,240	\$ 15,360
Preschool	\$5850	\$11,700	\$17,550

**Tuition Assistance is not available for Preschool students.*

**Tuition Rates subject to change*

Fees:

Enrollment Fee

Enrollment Fee	PER STUDENT
March 1 st – April 30 th	\$75
May 1 st – August 31 st	\$100

Resource Fee

Resource Fee	
1 student	\$200
2 or more students	\$275

FACTS Fees

FACTS Grant & Aid	\$30
FACTS Tuition Management	\$50

**** If you choose to withdraw from Holy Name these fees are non-refundable.**

Signature:

Date:

Holy Name Catholic School
Formulario de Inscripción del Estudiante

Año escolar: _____ Nuevo o Estudiante actual Grado en el que se inscribe: _____
Nombre: _____ Segundo nombre: _____ Apellido: _____
Nombre preferido: _____ Apellido de la familia: _____
 Masculino Femenino Fecha de nacimiento : _____
Católico: Sí No Ciudad y estado de nacimiento: _____
Vive con: Ambos padres Madre Padre Madre / padrastro Padre / madrastra
 Abuelos Otro _____

Las pautas federales requieren que registremos la raza / origen étnico de cada niño. Debe responder a la siguiente pregunta y luego indicar su raza. El hispano se considera una etnia y no un grupo racial. Si es de origen hispano, también debe seleccionar un grupo racial.

¿Es usted hispano / latino o de origen español? Sí No

Seleccione uno o más de los siguientes grupos raciales:

Indio americano / nativo de Alaska Asiático Negro / afroamericano Nativo de Hawái / de las Islas del Pacífico Blanco

Escuela anterior a la que asistió: _____

Escuela de primaria pública y área del distrito: _____

¿Tiene este estudiante un IEP? Sí No En caso afirmativo, necesitaremos una copia para nuestros registros.

Información médica:

Medicamentos que toma este estudiante: _____

Enumere los problemas de salud de este estudiante aquí: _____

Enumere las alergias de este estudiante: _____

¿Podemos darle Tylenol a este estudiante? Sí o No Advil? Sí o No Midol? Sí o No

Benadryl? Sí o No TUMS? Sí o No ¿

Podemos darle medicamentos recetados a este estudiante? Sí o No (El personal de la escuela debe tener el consentimiento de los padres y la orden de un médico para dispensar medicamentos. El nombre del niño y la dosis deben estar en el frasco de prescripción.)

Comentarios: Ingrese aquí cualquier comentario adicional sobre este estudiante.

Si el estudiante es católico, ingrese la siguiente información si no la ha enviado previamente.

Fecha de bautismo: _____ Parroquia: _____

Fecha de primera reconciliación: _____ Parroquia: _____

Fecha de primera comunión: _____ Parroquia: _____

Fecha de confirmación: _____ Parroquia: _____

Holy Name Catholic School
Formulario de inscripción Familiar

Año escolar: _____ Apellido de la familia: _____

Marque: Nuevo o Familia que regresa

Familia Afiliación religiosa: _____ Parroquia: _____

Información de La Casa

Estado paterno: Casado Separado Divorciado Volvido a casarse Soltero Viudo/Viuda Otros

Estudiantes viven con: Madre Padre Madre/Padrastra Padre/Madrastra Abuelos Otro

Idioma que se habla en casa: Inglés Español Otro: _____

Escriba la dirección de las personas con quienes viven los estudiantes.

Dirección: _____ Ciudad: _____

Estado: _____ Código postal: _____

Teléfono de casa: _____ Otro teléfono: _____

Correo electrónico _____ Excluir el correo electrónico del directorio escolar

Si la dirección de correo electrónico de la familia sería la misma que la dirección de correo electrónico del padre o la madre, deje este espacio en blanco.

Excluir a la familia del directorio de la escuela

Padre

Nombre: _____

Ocupación: _____

Empleador: _____

Teléfono celular: _____

Excluir el celular del padre del directorio escolar

Teléfono de Trabajo: _____

Correo electrónico: _____

Excluir el correo electrónico del directorio escolar

Religión: _____

Excluir la dirección del directorio de la escuela

Madre

Nombre: _____

Ocupación: _____

Empleador: _____

Teléfono celular: _____

Excluir el celular de la madre del directorio escolar

Teléfono de Trabajo: _____

Correo electrónico: _____

Excluir el correo electrónico del directorio escolar

Religión: _____

Otros niños que viven en este hogar

Nombre: _____ Edad: ____ Nombre: _____ Edad: ____

Nombre: _____ Edad: ____ Nombre: _____ Edad: ____

Otros adultos que viven en este hogar

Transporte

Indique a cualquier otra persona que pueda recoger a sus estudiantes.

Contactos de Emergencia

Enumere a las personas que pueden ser contactadas en caso de una emergencia si el padre/tutor no está disponible.

Nombre: _____ Teléfono: _____

Nombre 2: _____ Teléfono 2: _____

Información Médica

Médico: _____ Teléfono: _____

Dentista: _____ Teléfono: _____

Hospital: _____

Si una segunda familia debe recibir información de la escuela, ingrese esa información a continuación.

Nombre: _____ Relación con el/los estudiante/s: _____

Dirección: _____ Ciudad: _____ Estado: _____

Código postal: _____ Teléfono: _____

Comentarios: Ingrese cualquier comentario adicional sobre su familia que crea que la escuela debería tener. _____

Firma del Padre _____ **Fecha** _____

Solo para uso de oficina:

Fecha de recepción: _____ Cuota pagada: _____

Recibida por: _____ Cheque # _____ Efectivo _____



Permission Form for Children to go Off-Premises

Name of the Facility (exactly as stated on the license)			License #	
Holy Name Preschool and Child Care Center			0237-016	
Street Address of the Facility	City	Zip Code	County	
1007 Southwest Boulevard	Kansas City	66103	Wyandotte	

_____ may go to the following locations off the premises with adult supervision:

First and Last Name of Child or Youth

Place	Street Address	City	By Vehicle	Walk/Bike
Holy Name Church	1001 SW Blvd.	KC	-	Walk
Signature of Parent or Guardian			Date Signed	

Place	Street Address	City	By Vehicle	Walk/Bike
Holy Name Cafeteria	1007 SW Blvd	KC	-	Walk
Signature of Parent or Guardian			Date Signed	

Place	Street Address	City	By Vehicle	Walk/Bike
Holy Name Modulars	1007 SW Blvd	KC	-	Walk
Signature of Parent or Guardian			Date Signed	

Place	Street Address	City	By Vehicle	Walk/Bike
Signature of Parent or Guardian			Date Signed	

Place	Street Address	City	By Vehicle	Walk/Bike
Signature of Parent or Guardian			Date Signed	

Place	Street Address	City	By Vehicle	Walk/Bike
Signature of Parent or Guardian			Date Signed	



Authorization for Emergency Medical Care

Written permission for emergency medical treatment must be on file at the facility. Consult with the local emergency medical facility to be sure this form is acceptable. Reference K.A.R. 28-4-127(b)(1)(A). School Age Programs reference K.A.R. 28-4-582(e)(2).

Name of facility exactly as stated on the license	License #
Holy Name Preschool and Child Care Center	0237-016

I authorize Holy Name School (caregiver/staff) who is/are representative(s) of the above-named facility to give consent for any and all necessary emergency medical care for my child or youth _____ (child's first and last name) while child or youth is in the facility's custody between 08 / 01 / 2026 and 05 / 31 / 2027.
MM/DD/YYYY MM/DD/YYYY

List any known allergies or other information about the medical conditions of this child or youth pertinent in case of emergency:

Signature of Parent or Guardian	Date Signed

The Medical Record/Assessment Form (Or Health Status History form for School Age Programs) and the authorization for Emergency Medical Care must be taken to the emergency room. Both forms must also be in a vehicle when the child or youth is off premised from the facility.



Medical Record Medical History

In accordance with K.A.R. 28-4-117, a completed medical record shall be on file for all children in care under 10 years of age and all children living in the home under 16 years of age. The Medical Record shall include a Medical History including current Immunizations and a Child Health Assessment.
The Medical Record is transferable when the child moves to another licensed child care facility.

Child's First Day in Child Care _____ Name of Child Care Facility _____

Child's Name _____ Date of Birth _____ Gender _____
First Last MM/DD/YYYY M/F

Parent/Guardian Information

Parent/Guardian Information

Name _____ Name _____
Home Address _____ Home Address _____
Street City Zip Code Street City Zip Code
Home/Cell Phone Number _____ Home/Cell Phone Number _____
Work Phone Number _____ Work Phone Number _____
E-mail Address _____ E-mail Address _____
Best way to contact _____ Best way to contact. _____

Persons authorized to pick up the child or to notify in case of emergency (other than the parents):

Name _____ Name _____
Address _____ Address _____
Phone Number _____ Phone Number _____

Child's Physician _____ Phone Number _____

Hospital Preference (for emergencies) _____

Any known allergies or medical conditions of child: _____

Any major changes at home that might affect your child in care: _____

Please provide additional information or special instructions that will help the person caring for your child:

Parent/Guardian Signature: _____ **Date:** _____

Date of annual review: _____ Parent/Guardian Initials: _____ Provider Initials: _____
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Child's First Day in Child Care _____ Name of Child Care Facility _____

Child's Name _____ Date of Birth _____ Gender _____
First Last MM/DD/YYYY M/F

Parent/Guardian Information

Parent/Guardian Information

Name _____ Name _____
Home Address _____ Home Address _____
Street City Zip Code Street City Zip Code
Home/Cell Phone Number _____ Home/Cell Phone Number _____
Work Phone Number _____ Work Phone Number _____
E-mail Address _____ E-mail Address _____
Best way to contact _____ Best way to contact. _____

Persons authorized to pick up the child or to notify in case of emergency (other than the parents):

Name _____ Name _____
Address _____ Address _____
Phone Number _____ Phone Number _____

Child's Physician _____ Phone Number _____

Hospital Preference (for emergencies) _____

Any known allergies or medical conditions of child: _____

Any major changes at home that might affect your child in care: _____

Please provide additional information or special instructions that will help the person caring for your child:

Parent/Guardian Signature: _____ **Date:** _____

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Date of annual review: _____ Parent/Guardian Initials: _____ Provider Initials: _____

Medical Record:

Medical History Cont. - Immunizations

Required for all children in child care facilities, including the provider's own children. A Kansas Certificate of Immunizations (KCI) may be substituted for this form and attached to the completed Medical Record.

Child's Name: _____ Date of Birth: _____
First Last MM/DD/YYYY

Section I. For a recommended schedule of immunizations, refer to the current schedule published by the Advisory Committee on Immunization Practices (ACIP).

Vaccine	Record the Month, Day and Year that each Dose of Vaccine was Received					
	1 st	2 nd	3 rd	4 th	5 th	6 th
Diphtheria, Tetanus, Pertussis (DTaP)						
Poliomyelitis (IPV/OPV)						
Measles, Mumps, Rubella (MMR)						
Hepatitis B (HepB)						
Varicella (VAR)			Hx of Disease: Physician Signature		Date of Illness:	
Hemophilus Influenzae Type B (Hib)						
Pneumococcal Conjugate (PCV)						
Hepatitis A (HepA)						
Rotavirus **Recommended <8 mo.; not required						
Influenza (Flu) **Recommended annually >6 mo.; not required						

Section II.

Complete this section only if your child is exempted from the law requiring immunizations [K.S.A. 65-508(g)].

The following two options are the ONLY exemptions allowed by law. Please check either (A) or (B) below and complete as required:

(A) Certification from licensed physician stating that immunization would endanger child's life:
 Exempt from following immunizations:
 ___DTaP/DT ___Tdap/TD ___Pertussis Only ___Polio ___MMR ___Hep A ___Hep B ___Hib
 ___PCV ___Varicella ___Other

Physician's Signature (required): _____ Date: _____

(B) My child is exempt under the law from immunizations. As the Parent or Legal Guardian, I state that I am an adherent of a religious denomination whose teachings are opposed to immunizations.

Section III.

Parent/Guardian Signature: _____ Date: _____