



EST. 1901

Holy Name of Jesus Catholic School 2022-2023 Tuition & Fee Information

By signing below I acknowledge that I know the tuition and fees for the 2022-23 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	\$4250	\$ 8500	\$ 12,750
Preschool	\$4878	\$9,756	\$14,634

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

Fees:

Enrollment Fee

Enrollment Fee	PER STUDENT
March 1 st – April 30 th	\$30
May 1 st – August 31 st	\$60

Resource Fee

Resource Fee	
1 student	\$180
2 or more students	\$255

FACTS Fees

FACTS Grant & Aid	\$30
FACTS Tuition Management	\$43

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

Signature:

Date:

**Holy Name Catholic School
Family Registration Form**

School Year: _____ Family Last Name: _____ Check New or Returning family
Family Religious Affiliation: _____ Parish: _____

Home Info

Parental Status: Married Separated Divorced Remarried Single Widow/Widower Other

Students Live With: Both Parents/Guardian Mother Father Mother/Stepfather
 Father/Stepmother Grandparents Other

Language spoken at home: English Spanish Other: _____

Fill in the address of the person/s with whom the students live.

Address: _____ City: _____ State: _____ Zip: _____

Home Phone: _____ Silent Number. Other Phone: _____

Email Address _____ Exclude email from School Directory

If the family email address would be the same as the father or mother's email address, leave this blank.

Exclude family from the School Directory Exclude Address from School Directory

Father

Name: _____

Occupation: _____

Employer: _____

Cell Phone: _____

Exclude Father Cell from School Directory

Bus. Phone: _____

Father Email: _____

Exclude Father Email from School Directory

Religion: _____

Mother

Name: _____

Occupation: _____

Employer: _____

Cell Phone: _____

Exclude Mother Cell from School Directory

Bus. Phone: _____

Mother Email: _____

Exclude Mother Email from School Directory

Religion: _____ Maiden Name: _____

Other Children Living at this Home

Name: _____ Age: _____ Name: _____ Age: _____

Name: _____ Age: _____ Name: _____ Age: _____

Other Adults Living at this Home

Transportation

List anyone else who may pick up your students.

Emergency Contact

List persons who can be contacted in case of an emergency if Parent/Guardian is not available.

Name: _____ Phone: _____

Name 2: _____ Phone 2: _____

Medical

Doctor: _____ Phone: _____

Dentist: _____ Phone: _____

Hospital: _____

If a second family should receive information from the school, enter that information below.

Name: _____ Relationship to Student/s: _____

Address: _____

City: _____ State: _____ Zip: _____ Phone: _____

Comments: Enter any additional comments about your family you feel the school should have. _____

Parent Signature _____ Date _____

For Office Use Only:

Date Received: _____ Fee Paid: _____

Received By: _____ Check # _____ Cash _____

**Holy Name Catholic School
Student Enrollment Form**

School Year: _____ New or Current Student Grade in which to enroll: _____

First Name: _____ Middle Name: _____ Last Name: _____

Preferred First Name: _____ Family Last Name: _____

Male Female

Birth date: _____

Catholic Yes No

City & State of Birth: _____

Lives With: Both Parents Mother Father Mother/Stepfather Father/Stepmother Grandparents
Other _____

Federal guidelines require us to record the Race/Ethnicity of every child. You must answer the following question and then indicate your race. Hispanic is considered an ethnicity and not a racial group. If you are of Hispanic ethnicity, you must also select a racial group.

Are you Hispanic/Latino or of Spanish origin? Yes No

Select one or more from the following racial groups:

American Indian/Alaska Native Asian Black/African American Native Hawaiian/Pacific Islander White

Previous School Attended: _____

Public Grade School & District Area: _____

Does this student have an IEP? Yes If Yes, we will need a copy for our records.

<p>Medical Info</p> <p>Medications this student takes: _____</p> <p>List any Health Problems for this student here: _____</p> <p>_____</p> <p>List any Allergies for this student: _____</p> <p>May we give Tylenol to this student? <input type="checkbox"/> Yes or <input type="checkbox"/> No Advil? <input type="checkbox"/> Yes or <input type="checkbox"/> No Midol? <input type="checkbox"/> Yes or <input type="checkbox"/> No Benadryl? <input type="checkbox"/> Yes or <input type="checkbox"/> No TUMS? <input type="checkbox"/> Yes or <input type="checkbox"/> No</p> <p>May we give this student prescribed medications? <input type="checkbox"/> Yes or <input type="checkbox"/> No</p> <p>School Personnel must have parental consent and a physician's order to dispense medications. Child's name and dosage must be on the prescription bottle.</p>

<p>Comments: Enter any additional comments about this student here. _____</p> <p>_____</p> <p>_____</p>

If the student is Catholic, enter the following information if you have not previously submitted it.

Baptism Date: _____	Parish: _____
First Reconciliation Date: _____	Parish: _____
First Communion Date: _____	Parish: _____
Confirmation Date: _____	Parish: _____



**MEDICAL RECORD FOR ALL CHILDREN IN CHILD CARE FACILITIES,
INCLUDING PROVIDER'S OWN CHILDREN**

Parents are to complete the Medical Record and the History of Immunizations for each child in licensed child care facilities. The Medical Record, History of Immunizations, and Child Health Assessment are 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 _____
First Last

Date of Birth _____ Gender _____
MM/DD/YYYY M/F

Parent/Guardian Information

Parent/Guardian Information

Name _____

Name _____

Home Address _____
Street City Zip Code

Home Address _____
Street City Zip Code

Home Phone Number _____

Home Phone Number _____

Employer _____

Employer _____

Work Phone Number _____

Work Phone Number _____

Cell Phone Number _____

Cell 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 _____

Child's Dentist _____

Phone Number _____

Hospital Preference (for emergencies) _____

Has your physician approved the use of any non-prescription medications for your child such as acetaminophen, cough syrup, or ointments that can be given by the child care provider? No Yes, as follows: _____

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:** _____

History of 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 of age; not required						
Influenza(Flu) ** Recommended annually >6 mo of age; 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 _____HepA _____HepB _____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:** _____

Child Health Assessment

The Child Health Assessment form is to be completed and signed by a nurse approved by KDHE to perform Child Health Assessments or a Licensed Physician. If a Physician Assistant (PA) completes the Child Health Assessment, the signature of the Licensed Physician authorizing the PA is to be included at the bottom of this form.

A Child Health Assessment, recorded on a KDHE Form or other acceptable Forms mentioned below, is required for all children including children of the provider or staff in Licensed Day Care Homes, Group Day Care Homes, Child Care Centers and Preschools. A Kan-Be-Healthy Assessment Form is a KDHE Form and is acceptable, a Physician Health Assessment Form is acceptable, and a School Health Assessment Form is acceptable for school-age children or youth. The Health Assessment Form used should be attached to the KDHE Medical Record Form (CCL. 029).

Child's Name _____ **Date of Birth** _____
First Last

Health history and medical information pertinent to routine child care and emergencies (describe, if any): <input type="checkbox"/> None	Do you see this child for regular health supervision: <input type="checkbox"/> Yes <input type="checkbox"/> No
Allergies to food or medicine (describe, if any): <input type="checkbox"/> None	
List current medications (if any): <input type="checkbox"/> None	

Length/Height: _____ IN/CM %ILE _____	Weight: _____ LB/KG %ILE _____	
Physical Examination	<input checked="" type="checkbox"/> If Normal	If Abnormal - Comments
Head/Ears/Eyes/Nose/Throat		
Teeth		
Cardio/Respiratory		
Abdomen/GI		
Genitalia/Breasts		
Extremities/Joints/Back/Chest		
Skin/Lymph Nodes		
Neurologic & Developmental		
Screening Tests	Screening Date	Note Here if Results are Pending or Abnormal
Lead		
Anemia (HGB/HCT)		
Urinalysis (UA)		
Hearing		
Vision		

Health Problems or Special Needs, Recommended Treatment/Medications/Special Care (Attach additional sheets if necessary)
 None

Signature of Licensed Physician or Nurse approved for Child Health Assessments	Date
Print the Name of the Individual Signing Above	Phone Number

Address	City	Zip Code
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PARENTAL PERMISSION FORM FOR OFF-PREMISES TRIPS

Name of the Facility (exactly as stated on the license)			License #	
Holy Name Preschool + Child Care Center			0237-007	
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	1007 Southwest Blvd	KC	-	Walk
Signature of Parent or Guardian			Date Signed	

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

Place	Street Address	City	By Vehicle	Walk/Bike
Holy Name Modulars	1007 Southwest 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	

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. <u>Holy Name Preschool + Child Care Center</u>	License # <u>0237-007</u>
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I authorize _____ (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 August 2022 and May 2023.
MM/DD/YYYY MM/DD/YYYY

Is child covered by health insurance? Yes No

If yes, complete the following:

Health Insurance Policy Name _____ Policy Number _____

Medical Assistance Program _____ Card Number _____

Military Medical Care I.D. Number _____

If known, date of last Tetanus inoculation: _____
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
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Witness to Parent's or Guardian's signature if required by the local hospital or clinic.	Date Signed
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Notarization of Parent's or Guardian's signature if required by local hospital or clinic.

State of <u>Kansas</u> County of _____
Signed or attested before me on _____ by _____ MM/DD/YYYY Name of Person
(Seal, if any.)
_____ Signature of notarial officer
_____ Title (and Rank)
My appointment expires: _____

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 transported by the facility.