EST. 1901

Holy Name of Jesus Catholic School
2023-2024 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	$4450	$ 8900	$ 13,350
Preschool	$5121	$10,242	$15,363

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

Fees:

Enrollment Fee

Enrollment Fee	PER STUDENT
March 1st – April 30th	$50
May 1st – August 31st	$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.

Medical Info

Medications this student takes:_____

List any Health Problems for this student here: _____

_____

List any Allergies for this student:_____

May we give Tylenol to this student? ☐ Yes or ☐ No Advil? ☐ Yes or ☐ No Midol? ☐ Yes or ☐ No
Benadryl? ☐ Yes or ☐ No TUMS? ☐ Yes or ☐ No

May we give this student prescribed medications? ☐ Yes or ☐ No
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.

Comments: Enter any additional comments about this student here.

_____

_____

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:_____

Parent Signature _____ Date _____

CCL. 029
Rev. 5/2020

Kansas Department of Health and Environment
Bureau of Family Health Facilities
Child Care Licensing Program
1000 SW Jackson, Suite 200
Topeka, KS 66612-1274
Phone (785) 296-1270 Fax (785) 559-4244
Website: www.kdheks.gov/kidsnet

Kansas
Department of Health and Environment

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_____ Date of Birth_____ Gender_____
First Last MM/DD/YYYY M/F

Parent/Guardian Information

Name_____

Home Address_____
Street City Zip Code

Home Phone Number_____

Employer_____

Work Phone Number_____

Cell Phone Number_____

E-mail Address _____

Best way to contact_____

Parent/Guardian Information

Name_____

Home Address_____
Street City Zip Code

Home Phone Number_____

Employer_____

Work Phone Number_____

Cell Phone Number_____

E-mail Address_____

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					
	1st	2nd	3rd	4th	5th	6th
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:**_____

CCL. 029a
Rev. 05/2020

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): ☐ None	Do you see this child for regular health supervision: ☐ Yes ☐ No
Allergies to food or medicine (describe, if any): ☐ None	
List current medications (if any): ☐ None	

Length/Height: _____**IN/CM** **%ILE**_____ **Weight:** _____**LB/KG** **%ILE**_____

Physical Examination	✓ 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

CCL 010
Rev. 5/2020

Kansas Department of Health and Environment
Bureau of Family Health
1000 SW Jackson, Suite 200
Topeka, KS 66612-1274
Child Care Program: (785) 296 -1270 Fax: (785) 559-4244
Website: www.kdheks.gov/kidsnet

Kansas Department of Health and Environment

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 + Child Care Center	0237-007

I authorize Angelina Thomas + Randy Smith (*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 2023 (MM/DD/YYYY) and May 2024 (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

Witness to Parent's or Guardian's signature if required by the local hospital or clinic.	Date Signed

Notarization of Parent's or Guardian's signature if required by local hospital or clinic.

State of Kansas
County of _____

Signed or attested before me on _____ (MM/DD/YYYY) by _____ (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.

CCL. 034
Rev. 3/2020

Kansas Department of Health and Environment
Bureau of Family Health
Child Care Licensing Program
1000 SW Jackson, Suite 200
Topeka, KS 66612-1274
Phone: 785-296-1270 Fax: 785-559-4244
Website: www.kdheks.gov/kidsnet

Kansas Department of Health and Environment

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 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**	

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