



# 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:

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Address:

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City:

State:

Zip:

Home Phone:

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**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**

**Resource Fee**

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

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:

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**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 \_\_\_\_\_

## 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 \_\_\_\_\_



## 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:

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Signature of Parent or Guardian	Date Signed

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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 premises 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

Name \_\_\_\_\_

Home Address \_\_\_\_\_  
Street City Zip Code

Home/Cell Phone Number \_\_\_\_\_

Work Phone Number \_\_\_\_\_

E-mail Address \_\_\_\_\_

Best way to contact \_\_\_\_\_

### Parent/Guardian Information

Name \_\_\_\_\_

Home Address \_\_\_\_\_  
Street City Zip Code

Home/Cell Phone Number \_\_\_\_\_

Work 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 \_\_\_\_\_

Address \_\_\_\_\_

Phone Number \_\_\_\_\_

Name \_\_\_\_\_

Address \_\_\_\_\_

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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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: \_\_\_\_\_

Date of annual review: \_\_\_\_\_ Parent/Guardian Initials: \_\_\_\_\_ Provider Initials: \_\_\_\_\_

Date of annual review: \_\_\_\_\_ Parent/Guardian Initials: \_\_\_\_\_ Provider Initials: \_\_\_\_\_

Date of annual review: \_\_\_\_\_ Parent/Guardian Initials: \_\_\_\_\_ Provider Initials: \_\_\_\_\_

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 <sup>st</sup>	2 <sup>nd</sup>	3 <sup>rd</sup>	4 <sup>th</sup>	5 <sup>th</sup>	6 <sup>th</sup>
<b>Diphtheria, Tetanus, Pertussis (DTaP)</b>						
<b>Poliomyelitis (IPV/OPV)</b>						
<b>Measles, Mumps, Rubella (MMR)</b>						
<b>Hepatitis B (HepB)</b>						
<b>Varicella (VAR)</b>			Hx of Disease: Physician Signature		Date of Illness:	
<b>Hemophilus Influenzae Type B (Hib)</b>						
<b>Pneumococcal Conjugate (PCV)</b>						
<b>Hepatitis A (HepA)</b>						
<b>Rotavirus</b>						
<b>**Recommended &lt;8 mo.; not required</b>						
<b>Influenza (Flu)</b>						
<b>**Recommended annually &gt;6 mo.; not required</b>						

### Section II.

Complete this section only if your child is exempt 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: \_\_\_\_\_