



# 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**

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**

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  
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 \_\_\_\_\_



# Holy Name Catholic School

1007 Southwest Boulevard, Kansas City, KS  
66103

P: 913.722.1032 F:913-722.4175

## Release of Records

Student: First	M.I.	Last
School:	Current Grade:	DOB:

**Please send the requested records by mail or fax to:**

Holy Name Catholic School  
1007 Southwest Boulevard  
Kansas City, KS 66103

FAX: 913.722.4175

Holy Name Catholic School hereby request all of the following school records:

- Attendance
- Discipline
- Standardized Test Scores
- Report Cards
- Medical

Parent/Guardian Signature:	Date:

*Love of God, Love of Neighbor, Love of Learning*



## 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: \_\_\_\_\_

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>
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 <b>**Recommended &lt;8 mo.; not required</b>						
Influenza (Flu) <b>**Recommended annually &gt;6 mo.; not required</b>						

### 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: \_\_\_\_\_



## Medical Record: Child Health Assessment

The Child Health Assessment form is to be completed and signed by a nurse approved to perform health assessments, a licensed physician, or physician's assistant (PA). The health assessment shall be conducted not more than 12 months before and no later than 60 calendar days after enrollment at the child care facility.

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 Family Child 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.

**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	✓ 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 pages if necessary)  
 None

Signature of Licensed Physician or Nurse approved for Child Health Assessment	Date
Print the Name of the Individual Signing Above	Phone Number
Address	City
Zip Code	



## Grant & Aid Assessment

FACTS makes quality education affordable for families by assisting schools in awarding financial aid. We work with schools to create a custom application and collect financial data so schools can make accurate award decisions based on financial need.

To apply for financial aid, visit <https://online.factsmgt.com/aid> or <https://online.factsmgt.com/signin/43BFJ>

After completing the online application, you will need to upload all required supporting documentation.

### The following supporting documents are required to complete the application process:

- **IRS Federal Income Tax Return**, including all supporting schedules (the year of the tax return depends on the tax requirements of your school). If applicant and co-applicant file separately, we require both tax returns for the same tax year.
- Copies of **all the current year W-2 Wage and Tax Statements** for both the applicant and co-applicant.  
**NOTE:** If you are applying before you have received all the current year W-2 Wage and Tax Statements, please submit them as soon as they become available.
- Copies of all supporting tax documents if you have business income/loss from any of the following:
  - Business** - send Schedule C or C-EZ and Form 4562 Depreciation and Amortization
  - Farm** - send Schedule F and Form 4562 Depreciation and Amortization
  - Rental Property** - send Schedule E (page 1)
  - S-Corporation** - send Schedule E (page 2), Form 1120S (5 pages), Schedule K-1 and Form 8825
  - Partnership** - send Schedule E (page 2), Form 1065 (5 pages), Schedule K-1 and Form 8825
  - Estates and Trusts** - send Schedule E (page 2), Form 1041 and Schedule K-1

**IMPORTANT: If you file a tax return but do not have W-2 wages because you are self-employed, you will be required to submit a copy of your current year Federal Form 1040 Tax Return.**

- Copies of all supporting documentation for household Non-Taxable Income such as: Social Security Income, Welfare, Child Support, Food Stamps, Workers' Compensation, and Temporary Assistance for Needy Families (TANF). If you do not file a tax return, you are required to provide documentation of all income received.

**All documentation received is imaged upon receipt and then destroyed.**

You may log in to your FACTS user account to review the status of your application. Please allow 2 weeks processing time before inquiring further about receipt and/or status of the uploaded documents. Application deadlines are set by the institution awarding the aid. If you are applying after the deadline, contact your school to ensure that your application will be accepted.

**A non-refundable application fee may be required before your application will be submitted.**

**NOTE:** Award decisions are made by the institution providing the financial aid, not FACTS.