Holy Name of Jesus Catholic School
2025-2026 Tuition & Fee Information

EST. 1961

By signing below I acknowledge that I know the tuition and fees for the 2025-26 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	$4920	$ 9840	$ 14,760
Preschool	$5650	$11,300	$16,950

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

Fees:

Enrollment Fee

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

Love of God, Love of Neighbor, Love of Learning

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 ____

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Curtis State Office Building
Kansas Department of Health and Environment
1000 SW Jackson, Suite 200
Topeka, KS 66612-1274
Phone: 785-296-1270 | Fax 785-559-4244
Email: kdhe.cclr@ks.gov | kdhe.ks.gov/Childcare Licensing

Kansas
Department of Health and Environment

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					
	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.; 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:_____

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Curtis State Office Building
Kansas Department of Health and Environment
1000 SW Jackson, Suite 200
Topeka, KS 66612-1274
Phone: 785-296-1270 | Fax 785-559-4244
Email: kdhe.cclr@ks.gov | kdhe.ks.gov/Childcare Licensing

Kansas Department of Health and Environment

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): ☐ 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 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

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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 _____(*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 08/01/2025 and 05/31/2026.
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.

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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			0237-0116
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	