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

**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
Formulario de Inscripción del Estudiante

Año escolar: ________________ ○Nuevo o ○Estudiante actual Grado en el que se inscribe: ________
Nombre: ____________________ Segundo nombre: _________________ Apellido: ___________________
Nombre preferido: ________________ Apellido de la familia: _________________
○ Masculino ○ Femenino Fecha de nacimiento : __________
Católico: ○Sí ○No Ciudad y estado de nacimiento: _________________________
Vive con: ○Ambos padres ○Madre ○Padre ○Madre / padrastro ○Padre / madrastra
○Abuelos ○Otro ___________________

Las pautas federales requieren que registremos la raza / origen étnico de cada niño. Debe responder a la siguiente pregunta y luego indicar su raza. El hispano se considera una etnia y no un grupo racial. Si es de origen hispano, también debe seleccionar un grupo racial.
¿Es usted hispano / latino o de origen español? ○ Sí ○ No
Seleccione uno o más de los siguientes grupos raciales:
○ Indio americano / nativo de Alaska ○ Asiático ○ Negro / afroamericano ○ Nativo de Hawái / de las Islas del Pacífico ○ Blanco
Escuela anterior a la que asistió: ____________________________________
Escuela de primaria pública y área del distrito: ________________________________
¿Tiene este estudiante un IEP? ○Sí ○No En caso afirmativo, necesitaremos una copia para nuestros registros.
**Información médica:**
Medicamentos que toma este estudiante: ________________________________________
Enumere los problemas de salud de este estudiante aquí:________________________________________
_____________________________________________________________________________
Enumere las alergias de este estudiante: ________________________________________________________

¿Podemos darle Tylenol a este estudiante? ○Sí o ○ No Advil? ○Sí o○ No Midol? ○ Sí o○ No
Benadryl? ○Sí o ○No TUMS? ○Sí o ○No ¿

Podemos darle medicamentos recetados a este estudiante? ○Sí o ○No (El personal de la escuela debe tener el consentimiento de los padres y la orden de un médico para dispensar medicamentos. El nombre del niño y la dosis deben estar en el frasco de prescripción.)

**Comentarios**: Ingrese aquí cualquier comentario adicional sobre este estudiante.
_____________________________________________________________________________
_____________________________________________________________________________

Si el estudiante es católico, ingrese la siguiente información si no la ha enviado previamente.
Fecha de bautismo: _______________ Parroquia: ___________________________________
Fecha de primera reconciliación: _____________ Parroquia: ___________________________________
Fecha de primera comunión: _______________ Parroquia: ___________________________________
Fecha de confirmación: _______________ Parroquia: ___________________________________

Holy Name Catholic School
Formulario de inscripción Familiar

Año escolar: _______________ Apellido de la familia: __________________
Marque: ○Nuevo o ○Familia que regresa
Familia Afiliación religiosa: _____________ Parroquia: __________________________

**Información de La Casa**

Estado paterno: ○Casado ○Separado ○Divorciado ○Volvido a casarse ○Soltero ○ Viudo/Viudo ○Otros
Estudiantes viven con: ○Madre ○Padre ○Madre/Padrastro ○Padre/Madrastra ○Abuelos ○Otro
Idioma que se habla en casa: ○Inglés ○Español ○Otro: ___________________
Escriba la dirección de las personas con quienes viven los estudiantes.
Dirección: _______________________________ Ciudad: _____________________
Estado: __________ Código postal: ___________
Teléfono de casa: ______________________ Otro teléfono: ____________________
Correo electrónico ________________________○Excluir el correo electrónico del directorio escolar
Si la dirección de correo electrónico de la familia sería la misma que la dirección de correo electrónico del padre o la madre, deje este espacio en blanco.
○Excluir a la familia del directorio de la escuela ○Excluir la dirección del directorio de la escuela

Padre
Nombre: _____________________________
Ocupación: ___________________________
Empleador: __________________________
Teléfono celular: ______________________
○Excluir el celular del padre del directorio escolar
Teléfono de Trabajo: ____________________
Correo electrónico: ______________________
○Excluir el correo electrónico del directorio escolar
Religión: ___________________________

Madre
Nombre: ____________________________
Ocupación: __________________________
Empleador: __________________________
Teléfono celular: ______________________
○Excluir el celular de la madre del directorio escolar
Teléfono de Trabajo: ___________________
Correo electrónico: ____________________
○Excluir el correo electrónico del directorio escolar
Religión: ____________________________

Otros niños que viven en este hogar
Nombre: ________________________ Edad: ___Nombre: __________________________ Edad: ___
Nombre: ________________________ Edad: ___Nombre: __________________________ Edad: ___
Otros adultos que viven en este hogar
________________________________ ________________________________

**Transporte**

Indique a cualquier otra persona que pueda recoger a sus estudiantes.
____________________________________________________

**Contactos de Emergencia**

Enumere a las personas que pueden ser contactadas en caso de una emergencia si el padre/tutor no está disponible.
Nombre: _______________________ Teléfono: _______________
Nombre 2: _____________________ Teléfono 2: _____________
Información Médica
Médico:________________________ Teléfono: _______________
Dentista: ______________________ Teléfono: _______________

Hospital: ______________________________
Si una segunda familia debe recibir información de la escuela, ingrese esa información a continuación.
Nombre: ____________________________ Relación con el/los estudiante/s: ____________________
Dirección: ____________________________ Ciudad: ________________ Estado: _____________
Código postal: ____________ Teléfono: ______________
Comentarios: Ingrese cualquier comentario adicional sobre su familia que crea que la escuela debería tener.______________________________________________________________________________

__________________________________________________________________________________

**Firma del Padre** ______________________________ Fecha __________________

**Solo para uso de oficina:**
Fecha de recepción: ____________________ Cuota pagada: ________________
Recibida por: ____________________________ Cheque #____________ Efectivo ____

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1000 SW Jackson, Suite 200
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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 ________________________ 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 | | | | | |
|---|---|---|---|---|---|---|
| | 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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# 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):<br>☐ None | Do you see this child for regular health supervision:<br>☐ Yes ☐ No |
|---|---|
| Allergies to food or medicine (describe, if any):<br>☐ None | |
| List current medications (if any):<br>☐ 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)<br>☐ 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 | | | 0237-016 |
| 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 | – | a pie |
| Signature of Parent or Guardian | | | Date Signed | |

| Place | Street Address | City | By Vehicle | Walk/Bike |
|---|---|---|---|---|
| Holy Name Cafeteria | 1007 SW Blvd | KC | – | a pie |
| Signature of Parent or Guardian | | | Date Signed | |

| Place | Street Address | City | By Vehicle | Walk/Bike |
|---|---|---|---|---|
| Holy Name Modulars | 1007 SW Blvd | KC | – | a pie |
| 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 | |