

TRENTON CATHOLIC ACADEMY at McCORRISTIN CAMPUS
K-8 Student Financial Registration 2017-2018
NEW STUDENT

(Please print)

STUDENT NAME _____ GRADE _____

PARENT/GUARDIAN NAME _____

STREET ADDRESS _____ CITY _____ ZIP _____

TELEPHONE NUMBERS _____
Home Work Cell

\$250.00 PER FAMILY NON-REFUNDABLE REGISTRATION DEPOSIT DUE AT REGISTRATION PLUS FIRST MONTH TUITION PAYMENT IF REGISTERING AFTER JULY 31.

*Referred to TCA by the _____ Family.
This referral qualifies the referring family for a tuition credit.*

Tuition (select one)

_____ I will pay tuition in full by July 31, 2017. This payment can be made by check, cash, or money order.
Tuition for the 2017-2018 school year is:

Active Catholic/Qualified: _____ \$4,400.00 (one child) _____ \$11,125.00 (three children)
_____ \$7,975.00 (two children) _____ \$14,420.00 (four children)

A LETTER FROM YOUR PASTOR MUST ACCOMPANY THIS FORM TO RECEIVE THE ACTIVE/QUALIFIED RATE AT TIME OF REGISTRATION.

Other/Non-Qualified: _____ \$5,800.00 (one child) _____ \$13,950.00 (three children)
_____ \$10,650.00 (two children) _____ \$18,095.00 (four children)

_____ Facts payments will begin June 1 or 15(12 months), August 1 or 15(10 months), with a one-time \$45.00 start-up fee per year included in your first payment. Examples are listed below.

_____ 10 months @ \$ 440.00 per month (qualified one child)
_____ 12 months @ \$ 366.67 per month (qualified one child)
_____ 10 months @ \$ 797.50 per month (qualified two children)
_____ 12 months @ \$ 664.58 per month (qualified two children)

_____ 10 months @ \$ 580.00 per month (non-qualified one child)
_____ 12 months @ \$ 483.33 per month (non-qualified one child)
_____ 10 months @ \$ 1065.00 per month (non-qualified two children)
_____ 12 months @ \$ 887.50 per month (non-qualified two children)

Parent/Guardian Signature _____ Date _____

Please return this form, with enclosures to: Trenton Catholic Academy
177 Leonard Ave
Hamilton, NJ 08610
Attn: Main Office

Extended Care is available. For additional information please contact the Main Office at 586-5888.

HR



The Lower School at McCorristin Campus
177 Leonard Avenue ♦ Hamilton, NJ 08610
Tel: (609) 586-5888 ♦ Fax: (609) 631-9295 ♦ www.trentoncatholic.org

January, 2017

Dear Parents/Guardians:

Registration time is here, a time to reflect on your child's education. It is our sincere hope that you will choose the educational experience here at Trenton Catholic Academy for your child/children.

The enclosed materials and a \$250 per family non-refundable tuition deposit are due in the school office before March 15, 2017 to get the reduced fee. We will process all **completed** registrations on a first come-first served basis.

Through the support of our fundraising efforts and financial assistance from the diocese, we have been able to keep tuition increases to a minimum. The tuition rates for the new school year are listed on the enclosed form.

Trenton Catholic Academy recommends that families needing financial assistance apply to the Diocese of Trenton. All forms are available on the www.trentoncatholic.org website in English and Spanish. Be mindful that all applications for Diocesan financial assistance are strictly confidential.

If you have registration concerns, call Mrs. Reap at 586-5888, extension 141.

May God graciously bless all of our Trenton Catholic Academy families.

Sincerely,

A handwritten signature in cursive script that reads 'S. Dorothy Payne, SSJ'.

S. Dorothy Payne, SSJ
President

The mission of Trenton Catholic Academy is to educate a culturally and academically diverse student body to be responsible citizens of a global community through a challenging and relevant curriculum centered in Catholic tradition and values.



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Federal Funds Letter and Survey

January, 2017

Dear Parents,

Children in our school are entitled to a variety of programs, materials, and services comparable to those provided to public school students through the use of Federal Funds. **In order for our children to benefit from these additional funds, it is very important for us to know how many children attending our school come from these families.** This information is essential to insure our continued participation in the federal programs, such as Title 1, currently serving your children.

I kindly ask that you review the attached Family Survey and simply indicate a “yes” or “no” to questions 1, 2, and 3. **Please sign the Family Survey, indicate your address, and return the form to my office no later than March 14.** All information will be kept confidential.

Thank you for your assistance with this survey.

Sincerely yours,

A handwritten signature in cursive script that reads 'Mrs. Reap'.

Mrs. Anne Reap
Lower School Director

New Jersey Department of Education
Improving America's Schools Act
LEA Consolidated Formula Subgrant Application
 July 1, 2016-June 30, 2017
Private School Survey
 (Title I Only)

Family Survey

1. Find your family size and the annual, monthly or weekly income level listed beside it on the chart below:

Source: Income Eligibility Guidelines

<u>Family Size</u>	<u>Annual</u>	<u>Monthly</u>	<u>Weekly</u>
1	\$21,978	\$1,832	\$423
2	\$29,637	\$2,470	\$570
3	\$37,296	\$3,108	\$718
4	\$44,955	\$3,747	\$865
5	\$52,614	\$4,385	\$1,012
6	\$60,273	\$5,023	\$1,160
7	\$67,951	\$5,663	\$1,307
8	\$75,647	\$6,304	\$1,455
For each additional family member add:	+\$7,696	+\$642	+\$148

Is your family income less than this amount? Yes _____ No _____

2. Are you receiving assistance under the Aid to Families with Dependent Children program? Yes _____ No _____

3. Are any of your children eligible to receive medical assistance under the Medicaid program? Yes _____ No _____

Signature _____

Name (please print) _____

Address _____

Dear Parents:

TRENTON RESIDENTS ONLY!!

Please be advised that we have been informed by the **TRENTON** Department of Transportation that all applications for Private School Transportation **MUST BE ACCOMPANIED WITH PROOF OF RESIDENCY. WITHOUT THIS INFORMATION, THE APPLICATION WILL NOT BE ACCEPTED.** This can be a copy of a phone bill, PSE&G bill. **NO credit card bills.**

Thank you in advance for your cooperation in this matter.

Mrs. Anne Reap

SCHOOL YEAR 2017-2018

RESIDENT DISTRICT BOARD OF EDUCATION _____

STUDENT'S NAME _____ DATE OF BIRTH _____
LAST FIRST MIDDLE MONTH DAY YEAR

GENDER _____ PARENT/GUARDIAN NAME _____ DAYTIME PHONE _____
M or F AREA CODE + NUMBER

HOME ADDRESS _____ CITY or TWP _____ ZIP _____

NEAREST INTERSECTION TO STUDENT'S RESIDENCE _____

MAILING ADDRESS _____ ZIP _____

FULL NAME OF SCHOOL TO BE ATTENDED TRENTON CATHOLIC ACADEMY PHONE 609-586-5888

ADDRESS OF SCHOOL 177 LEONARD AVE., HAMILTON, NJ 08610

STUDENT'S GRADE FOR THE COMING YEAR _____ SHORTEST ONE-WAY MILEAGE BETWEEN HOME AND SCHOOL _____
(MEASURED VIA THE SHORTEST ROUTE ALONG PUBLIC ROADWAYS OR WALKWAYS IN MILES AND TENTHS)

DATE SCHOOL OPENS 9/1/2017 CLOSES 6/8/18 SCHOOL HOURS FROM 7:50 AM TO 2:20 PM
MILES TENTHS

NAME AND ADDRESS OF LAST SCHOOL OF ATTENDANCE _____

DATE _____ SIGNATURE _____

DO NOT WRITE BELOW THIS LINE * FOR PUBLIC SCHOOL USE ONLY

YOUR APPLICATION HAS BEEN REVIEWED BY THE RESIDENT DISTRICT BOARD OF EDUCATION. THE FOLLOWING DETERMINATION HAS BEEN MADE:

_____ TRANSPORTATION WILL BE PROVIDED _____ YOU ARE ELIGIBLE FOR PAYMENT IN LIEU OF TRANSPORTATION

_____ INELIGIBLE _____ (REASON)

DATE _____ SIGNATURE _____ TITLE _____

INSTRUCTIONS FOR COMPLETING THE APPLICATION FOR PRIVATE SCHOOL TRANSPORTATION (B6T) N.J.A.C. 6A:27-2.5

1. IT IS THE OBLIGATION OF THE PARENT OR GUARDIAN OF PRIVATE SCHOOL STUDENTS TO:

- ANNUALLY OBTAIN THE APPLICATION FOR PRIVATE SCHOOL TRANSPORTATION FROM THE ADMINISTRATIVE OFFICE OF THE PRIVATE SCHOOL FOR EACH STUDENT FOR WHICH TRANSPORTATION SERVICES ARE BEING REQUESTED. SUBMIT A SEPARATE APPLICATION FOR EACH STUDENT.

NOTE:

- IF THERE IS A CHANGE OF HOME ADDRESS, A NEW APPLICATION SHALL BE SUBMITTED TO THE PUBLIC SCHOOL DISTRICT OF RESIDENCE.
- IF THERE IS A CHANGE IN THE NONPUBLIC SCHOOL OF ATTENDANCE, A NEW APPLICATION SHALL BE SUBMITTED TO THE PUBLIC SCHOOL DISTRICT OF RESIDENCE.

- COMPLETE THIS APPLICATION AND RETURN IT TO THE PRIVATE SCHOOL ON OR BEFORE MARCH 10TH PRECEDING THE SCHOOL YEAR IN WHICH TRANSPORTATION IS BEING REQUESTED.

LATE APPLICATIONS – ANY APPLICATION RECEIVED AFTER MARCH 10TH WILL BE A LATE APPLICATION AND MUST BE ACCOMPANIED BY A STATEMENT OF THE REASON FOR LATENESS. ELIGIBLE STUDENTS WILL RECEIVE TRANSPORTATION OR AID IN LIEU OF TRANSPORTATION BASED ON THE DATE THE APPLICATION IS RECEIVED BY THE PUBLIC SCHOOL.

2. IT IS THE OBLIGATION OF THE NONPUBLIC SCHOOL ADMINISTRATOR TO ANNUALLY COLLECT THE APPLICATION AND SUBMIT IT TO THE PUBLIC SCHOOL FROM WHICH TRANSPORTATION IS BEING REQUESTED PRIOR TO MARCH 15TH.

3. IT IS THE OBLIGATION OF THE PUBLIC SCHOOL ADMINISTRATOR TO NOTIFY THE PARENT OR GUARDIAN AS TO THE DETERMINATION OF EACH APPLICATION BY AUGUST 1ST.

A DISTRICT BOARD OF EDUCATION SHALL PAY AID IN LIEU OF TRANSPORTATION TO THE PARENT OR GUARDIAN OF AN ELIGIBLE STUDENT ONLY AFTER RECEIVING A SIGNED "REQUEST FOR PAYMENT OF TRANSPORTATION AID" VOUCHER AS PRESCRIBED BY THE COMMISSIONER OF EDUCATION.

Dear Parents:

TRENTON RESIDENTS ONLY!!

Please be advised that we have been informed by the **TRENTON** Department of Transportation that all applications for Private School Transportation **MUST BE ACCOMPANIED WITH PROOF OF RESIDENCY. WITHOUT THIS INFORMATION, THE APPLICATION WILL NOT BE ACCEPTED.** This can be a copy of a phone bill, PSE&G bill. **NO credit card bills.**

Thank you in advance for your cooperation in this matter.

Mrs. Anne Reap

**Diocese of Trenton
Permanent Elementary School Record**

School Trenton Catholic Academy
City/Town Hamilton

Last Name _____ First _____ Middle _____ Sex: M F Date of Registration _____

Address _____ ZIP code _____ Telephone _____ Public School District of Residence _____

Parent Email _____ Name-Work Telephone _____

Place of Birth (city, state) _____ Date of Birth month day year _____ Country of Citizenship _____

Religion _____ Registered Parish _____ City/Town _____ Admitted from _____ Date _____ Grade _____

	Parish	City & State	Date
Baptism			
First Penance			
First Eucharist			
Confirmation			

School _____ City, State _____

Withdrawal Record

Date	To	Cause*

*Withdrawal Causes: 1. Illness; 2. Death; 3. Change of Residence; 4. Financial Difficulties; 5. Parent Request; 6. Academics; 7. School Request; 8. Other Reasons

Re-entry Record

Date	From	Grade

Graduation Date _____ High School Entered _____ City/Town _____

FAMILY BACKGROUND

Name	Address	Occupation	Religion	Date of Death	Education
Father					<input type="checkbox"/> Elem. <input type="checkbox"/> Coll. <input type="checkbox"/> Sec. <input type="checkbox"/> Adv.
Mother <i>(include maiden name)</i>					<input type="checkbox"/> Elem. <input type="checkbox"/> Coll. <input type="checkbox"/> Sec. <input type="checkbox"/> Adv.
Guardian					<input type="checkbox"/> Elem. <input type="checkbox"/> Coll. <input type="checkbox"/> Sec. <input type="checkbox"/> Adv.

Relationship of guardian to student _____

Home situation: Two parents One parent Parents separated or divorced

(Check all that apply) Restructured-mother/stepfather Father remarried Mother remarried

Restructured-stepmother/father Other

Child resides with _____

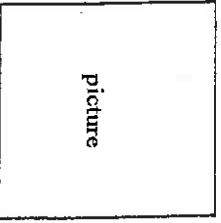
Parental rights (in case of separation; attach court order) _____

Language spoken at home _____ Ethnic background _____

SIBLINGS

Complete Name	Date of Birth

OTHER PERTINENT INFORMATION:



**Diocese of Trenton
Permanent Elementary School Record**

School Trenton Catholic Academy
City/Town Hamilton

Last Name _____ First _____ Middle _____ Sex: M F Date of Registration _____

Address _____ ZIP code _____ Telephone _____ Public School District of Residence _____

Parent Email _____ Name-Work Telephone _____

Place of Birth (city, state) _____ Date of Birth _____ Country of Citizenship _____

Religion _____ Registered Parish _____ City/Town _____

Admitted from _____ Date _____ Grade _____

	Parish	City & State	Date
Baptism			
First Penance			
First Eucharist			
Confirmation			

School _____ City, State _____

Withdrawal Record

Date	To	Cause*

*Withdrawal Causes: 1. Illness; 2. Death; 3. Change of Residence; 4. Financial Difficulties; 5. Parent Request; 6. Academics; 7. School Request; 8. Other Reasons

Re-entry Record

Date	From	Grade

Graduation Date _____ High School Entered _____

City/Town _____

FAMILY BACKGROUND

	Name	Address	Occupation	Religion	Date of Death	Education
Father						<input type="checkbox"/> Elem. <input type="checkbox"/> Coll. <input type="checkbox"/> Sec. <input type="checkbox"/> Adv.
Mother <small>(include maiden name)</small>						<input type="checkbox"/> Elem. <input type="checkbox"/> Coll. <input type="checkbox"/> Sec. <input type="checkbox"/> Adv.
Guardian						<input type="checkbox"/> Elem. <input type="checkbox"/> Coll. <input type="checkbox"/> Sec. <input type="checkbox"/> Adv.

Relationship of guardian to student _____

Home situation:

Two parents

One parent

Parents separated or divorced

(Check all that apply)

Restructured-mother/stepfather

Father remarried

Mother remarried

Restructured-stepmother/father

Other

Child resides with _____

Parental rights (in case of separation; attach court order) _____

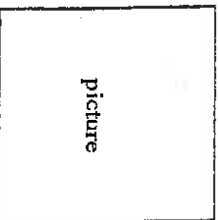
Language spoken at home _____

Ethnic background _____

SIBLINGS

Complete Name	Date of Birth

OTHER PERTINENT INFORMATION:



UNIVERSAL CHILD HEALTH RECORD

Endorsed by: American Academy of Pediatrics, New Jersey Chapter
New Jersey Academy of Family Physicians
New Jersey Department of Health

SECTION I - TO BE COMPLETED BY PARENT(S)					
Child's Name (Last) _____ (First) _____		Gender <input type="checkbox"/> Male <input type="checkbox"/> Female		Date of Birth _____	
Does Child Have Health Insurance? <input type="checkbox"/> Yes <input type="checkbox"/> No		If Yes, Name of Child's Health Insurance Carrier _____			
Parent/Guardian Name _____		Home Telephone Number _____		Work Telephone/Cell Phone Number _____	
Parent/Guardian Name _____		Home Telephone Number _____		Work Telephone/Cell Phone Number _____	
<i>I give my consent for my child's Health Care Provider and Child Care Provider/School Nurse to discuss the information on this form.</i>					
Signature/Date _____				This form may be released to WIC. <input type="checkbox"/> Yes <input type="checkbox"/> No	
SECTION II - TO BE COMPLETED BY HEALTH CARE PROVIDER					
Date of Physical Examination: _____		Results of physical examination normal? <input type="checkbox"/> Yes <input type="checkbox"/> No			
Abnormalities Noted: _____		Weight (must be taken within 30 days for WIC)		_____	
		Height (must be taken within 30 days for WIC)		_____	
		Head Circumference (if <2 Years)		_____	
		Blood Pressure (if ≥3 Years)		_____	
IMMUNIZATIONS		<input type="checkbox"/> Immunization Record Attached <input type="checkbox"/> Date Next Immunization Due: _____			
MEDICAL CONDITIONS					
Chronic Medical Conditions/Related Surgeries • List medical conditions/ongoing surgical concerns:		<input type="checkbox"/> None <input type="checkbox"/> Special Care Plan Attached		Comments _____	
Medications/Treatments • List medications/treatments:		<input type="checkbox"/> None <input type="checkbox"/> Special Care Plan Attached		Comments _____	
Limitations to Physical Activity • List limitations/special considerations:		<input type="checkbox"/> None <input type="checkbox"/> Special Care Plan Attached		Comments _____	
Special Equipment Needs • List items necessary for daily activities		<input type="checkbox"/> None <input type="checkbox"/> Special Care Plan Attached		Comments _____	
Allergies/Sensitivities • List allergies:		<input type="checkbox"/> None <input type="checkbox"/> Special Care Plan Attached		Comments _____	
Special Diet/Vitamin & Mineral Supplements • List dietary specifications:		<input type="checkbox"/> None <input type="checkbox"/> Special Care Plan Attached		Comments _____	
Behavioral Issues/Mental Health Diagnosis • List behavioral/mental health issues/concerns:		<input type="checkbox"/> None <input type="checkbox"/> Special Care Plan Attached		Comments _____	
Emergency Plans • List emergency plan that might be needed and the sign/symptoms to watch for:		<input type="checkbox"/> None <input type="checkbox"/> Special Care Plan Attached		Comments _____	
PREVENTIVE HEALTH SCREENINGS					
Type Screening	Date Performed	Record Value	Type Screening	Date Performed	Note if Abnormal
Hgb/Hct			Hearing		
Lead: <input type="checkbox"/> Capillary <input type="checkbox"/> Venous			Vision		
TB (mm of Induration)			Dental		
Other:			Developmental		
Other:			Scoliosis		
<input type="checkbox"/> I have examined the above student and reviewed his/her health history. It is my opinion that he/she is medically cleared to participate fully in all child care/school activities, including physical education and competitive contact sports, unless noted above.					
Name of Health Care Provider (Print) _____			Health Care Provider Stamp: _____		
Signature/Date _____					

UNIVERSAL CHILD HEALTH RECORD

Endorsed by: American Academy of Pediatrics, New Jersey Chapter
New Jersey Academy of Family Physicians
New Jersey Department of Health

SECTION I - TO BE COMPLETED BY PARENT(S)

Child's Name (Last) _____ (First) _____		Gender <input type="checkbox"/> Male <input type="checkbox"/> Female	Date of Birth ____/____/____
Does Child Have Health Insurance? <input type="checkbox"/> Yes <input type="checkbox"/> No	If Yes, Name of Child's Health Insurance Carrier _____		
Parent/Guardian Name _____	Home Telephone Number _____	Work Telephone/Cell Phone Number _____	
Parent/Guardian Name _____	Home Telephone Number _____	Work Telephone/Cell Phone Number _____	
<i>I give my consent for my child's Health Care Provider and Child Care Provider/School Nurse to discuss the information on this form.</i>			
Signature/Date _____		This form may be released to WIC. <input type="checkbox"/> Yes <input type="checkbox"/> No	

SECTION II - TO BE COMPLETED BY HEALTH CARE PROVIDER

Date of Physical Examination: _____	Results of physical examination normal? <input type="checkbox"/> Yes <input type="checkbox"/> No
Abnormalities Noted: _____	Weight (must be taken within 30 days for WIC) _____
	Height (must be taken within 30 days for WIC) _____
	Head Circumference (if <2 Years) _____
	Blood Pressure (if ≥3 Years) _____

IMMUNIZATIONS

- Immunization Record Attached
 Date Next Immunization Due: _____

MEDICAL CONDITIONS

Chronic Medical Conditions/Related Surgeries • List medical conditions/ongoing surgical concerns: _____	<input type="checkbox"/> None <input type="checkbox"/> Special Care Plan Attached	Comments _____
Medications/Treatments • List medications/treatments: _____	<input type="checkbox"/> None <input type="checkbox"/> Special Care Plan Attached	Comments _____
Limitations to Physical Activity • List limitations/special considerations: _____	<input type="checkbox"/> None <input type="checkbox"/> Special Care Plan Attached	Comments _____
Special Equipment Needs • List items necessary for daily activities _____	<input type="checkbox"/> None <input type="checkbox"/> Special Care Plan Attached	Comments _____
Allergies/Sensitivities • List allergies: _____	<input type="checkbox"/> None <input type="checkbox"/> Special Care Plan Attached	Comments _____
Special Diet/Vitamin & Mineral Supplements • List dietary specifications: _____	<input type="checkbox"/> None <input type="checkbox"/> Special Care Plan Attached	Comments _____
Behavioral Issues/Mental Health Diagnosis • List behavioral/mental health issues/concerns: _____	<input type="checkbox"/> None <input type="checkbox"/> Special Care Plan Attached	Comments _____
Emergency Plans • List emergency plan that might be needed and the sign/symptoms to watch for: _____	<input type="checkbox"/> None <input type="checkbox"/> Special Care Plan Attached	Comments _____

PREVENTIVE HEALTH SCREENINGS

Type Screening	Date Performed	Record Value	Type Screening	Date Performed	Note if Abnormal
Hgb/Hct			Hearing		
Lead: <input type="checkbox"/> Capillary <input type="checkbox"/> Venous			Vision		
TB (mm of Induration)			Dental		
Other:			Developmental		
Other:			Scoliosis		

I have examined the above student and reviewed his/her health history. It is my opinion that he/she is medically cleared to participate fully in all child care/school activities, including physical education and competitive contact sports, unless noted above.

Name of Health Care Provider (Print) _____	Health Care Provider Stamp: _____
Signature/Date _____	



TRENTON CATHOLIC ACADEMY

The Lower School at McCorristin Campus

177 Leonard Avenue ♦ Hamilton, NJ 08610

Tel: (609) 586-5888 ♦ Fax: (609) 631-9295 ♦ www.trentoncatholic.org

Request for Records

Student Name _____ Grade _____

Address _____

Date of Birth _____

Current School _____

School Address _____

Phone _____

To Parent/Guardian:

You are advised that pursuant to the provisions P>L> 93-380 (Family Education Rights and Privacy Act of 1974), these records will not be disclosed to any other party without written consent of the parent or guardian. Your signature indicates that you request a copy of your child's records to be sent to Trenton Catholic Academy for evaluation.

Parent Guardian _____

Date _____

To School Officials:

The above student is requesting admission to Trenton Catholic Academy. Please forward a copy of the records listed below:

Academic Records (current year and 3 years prior)

Health/Immunization Records

Standardized Test Scores (last 3 years)

Diagnostic Evaluations (may include psychological evaluations, psychiatric evaluations, I.E.P., or other records relative to Special Education classification)

Disciplinary Records and/or records related to the student's withdrawal or dismissal

Send all above information to:

Trenton Catholic Academy at McCorristin Campus

We're TCA—Expect the Exceptional



TRENTON CATHOLIC ACADEMY

The Lower School at McCorristin Campus

177 Leonard Avenue ♦ Hamilton, NJ 08610

Tel: (609) 586-5888 ♦ Fax: (609) 631-9295 ♦ www.trentoncatholic.org

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Standardized Test Scores (last 3 years)

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Disciplinary Records and/or records related to the student's withdrawal or dismissal

Send all above information to:

Trenton Catholic Academy at McCorristin Campus

We're TCA—Expect the Exceptional

TRENTON CATHOLIC ACADEMY
Lower School
Registration Information Sheet

Thank you for your interest in Trenton Catholic Academy. We have instituted this form to help ease you through the registration process. Please feel free to call our Main Office, 586-5888 ext. 141, with any questions. The following items must be received/completed in order to finalize your registration:

PreKindergarten Students:

Registration Form
Non Refundable Registration Fee
(\$250.00 per family if paid prior to 3/15 - \$300.00 after 3/15)
Copy of Official Birth Certificate
Copy of Baptismal Certificate
Completed Health Form
Immunization Record (Immunizations must be up to date)

Final Acceptance is issued for incoming Pre-Kindergarten students following submission of above.

Students Entering Kindergarten through 8th Grade:

Registration Form
Non Refundable Registration Fee
(\$250.00 per family if paid prior to 3/15 - \$300.00 after 3/15)
Copy of Official Birth Certificate
Copy of Baptismal Certificate
Completed Health Form
Immunization Record (Immunizations must be up to date)
Plus:

Student Interview with the Lower School Director
Report Cards from past two years
Standardized Test results from the past two years
Discipline Report from sending school
Copy of latest Child Study report if applicable

Final Acceptance is issued for incoming K through 8th grade students following submission of above, review of report cards, standardized testing and Director interview.