

FAMILY NAME _____

2024-25 REGISTRATION CHECKLIST



All new and returning Pre-K families must complete and return all applicable forms. Please use the Registration Checklist below:

FORM/FEE	DETAILS /DEADLINE	
FAMILY REGISTRATION FORM	You only need to complete one form per family. Return this form with your \$75.00 registration fee ASAP to secure your spot for 2024-25.	<input type="checkbox"/>
STUDENT ENROLLMENT FORM	Complete one form for each student you wish to register. Return this form ASAP to secure your spot for 2024-25.	<input type="checkbox"/>
\$75 PER FAMILY REGISTRATION FEE	The registration fee for both new and returning families for 2024-25. is \$75 per family. The registration fee is non-refundable.	<input type="checkbox"/>
FAITH IN EDUCATION PARTNERSHIP AGREEMENT	A signed copy of this form must accompany your registration papers and registration fee.	<input type="checkbox"/>
PRELIMINARY SCHEDULING FORM	Please complete and return this form ASAP. Complete one form for each student you wish to register. This form must be returned by March 1, 2024.	<input type="checkbox"/>
BIRTH CERTIFICATE	If you are a new family, please include a copy of your child's birth certificate.	<input type="checkbox"/>
IMMUNIZATION RECORDS	Please include a copy of your child's immunization records.	<input type="checkbox"/>
LEAD TEST/WAIVER	Please include a copy of your child's lead test results or sign the waiver.	<input type="checkbox"/>

SCHOOL YEAR _____

FAMILY LAST NAME _____

RELIGIOUS AFFILIATION _____

PARISH _____

☐ NEW FAMILY ☐ RETURNING FAMILY

FAMILY REGISTRATION FORM



HOME INFORMATION

PARENTAL STATUS

☐ Married ☐ Separated ☐ Divorced
☐ Remarried ☐ Single ☐ Widow/Widower
☐ Other

STUDENTS LIVE WITH

☐ Both Parents/Guardian ☐ Mother ☐ Father
☐ Mother/Stepfather ☐ Father/Stepmother
☐ Grandparent ☐ Other

LANGUAGE SPOKEN AT HOME

☐ English ☐ Spanish ☐ Other

ADDRESS WHERE STUDENTS LIVES

Address _____

City _____

State _____ Zip _____

Email Address _____

Primary Phone _____

Other Phone _____

MOTHER

Name _____

Occupation _____

Employer _____

Bus. Phone _____

Cell Phone _____

Email _____

Religion _____

Maiden Name _____

FATHER

Name _____

Occupation _____

Employer _____

Bus. Phone _____

Cell Phone _____

Email _____

Religion _____

OTHER ADULTS LIVING AT THIS HOME

LIST ANYONE ELSE WHO MAY PICK UP YOUR STUDENTS(S).

EMERGENCY/MEDICAL INFORMATION

List a person who can be contacted in case of an emergency if Parent/Guardian is not available.

Name _____

Phone _____

Doctor _____ Phone _____

Dentist _____ Phone _____

Hospital _____

If a second family member 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.



2024-25 FAITH IN EDUCATION PARTNERSHIP AGREEMENT

I. TUITION FOR THE 2024-25 SCHOOL YEAR: MOTHER'S DAY OUT PROGRAM

Tuition includes tuition for one or two children enrolled.

(tuition and fees paid MAY be considered for income tax deductions. Please consult with your tax preparer to ensure accuracy and eligibility).

"Tuition" does not, however, include the Registration Fee. The Registration Fee for both new and returning families for 2024-25 is \$75 per family. The registration fee is non-refundable.

TUITION FOR NEW FAMILIES:

WEEKLY SCHEDULE	ONE CHILD/YEAR	TWO CHILDREN/YEAR*
3 Days (8:00am- 12:15pm)	\$3,947	\$7,000
2 Days (8:00am- 12:15pm)	\$2,582	\$4,647

*This price reflects a Sibling Discount when two children are enrolled in the program at the same time.

- Tuition is based on a yearly tuition rate. To calculate your monthly tuition rate, divide the applicable yearly fee by 10.
- If you are making monthly payments, you will need to enroll in the FACTS Tuition Management Program.
- For families enrolled in the FACTS program, payments are expected each month for the 10 month period starting in August 2024 and ending in May 2025. (10 monthly payments total).

2024-25 FAITH IN EDUCATION PARTNERSHIP AGREEMENT – (CONTINUED)

II. PAYMENT OF TUITION

Please note, any credit card charge, no matter the size, will result in a 2.2% fee.

☐ ANNUAL PAYMENT (ONE PAYMENT):

There is a discount of **\$100.00 per child** for using the annual payment option. See the appropriate tuition & fee schedule for your total cost. Subtract the correct amount from this total cost. The annual payment is due by **July 1st, 2024**.

☐ SEMI-ANNUAL PAYMENT (TWO PAYMENTS):

See the appropriate tuition & fee schedule for your total cost. Divide this cost in two. Two equal payments are due by **July 1st, 2024** and **December 1st, 2024**.

☐ MONTHLY PAYMENTS:

If you do not choose either the annual or semi-annual payment option, you **MUST** enroll in the monthly payment program, known as FACTS. Enrolling in the FACTS Tuition Management Program allows you to make your tuition payments by automatic withdrawal from a bank account, or with a monthly credit card payment. If you are enrolled in the FACTS Tuition Management Program, tuition will be collected during 10 months, from August through May each year. There is no cost for you to enroll in this program. If you choose this option, sign up online at <https://online.factsmgt.com/signin/42ZLL>. You will need to complete this form and supply the appropriate banking or credit card information. The responsible party must contact tuition@stjamesthegreater.org if there are any changes to the banking or credit card information throughout the year. For returning families already enrolled in FACTS, you will automatically be re-enrolled for 2023-24.

If you would like to make your monthly payment lower, you can pre-pay any amount you choose. Pre-payments must be made before August 1st, 2024. To make pre-payments, please call the office at (314) 647-5244.

Periodically throughout the school year, the office will review whether any tuition payments are past due and send a delinquency notice to those families. However, **it is the responsibility of each family to know whether they are behind on tuition and to contact the office to work out a solution.** If a family is delinquent and has not made arrangements with the office, the following penalties may be imposed:

- Registration for the next school year will not be accepted.
- Entry into the program the following semester will not be permitted.

If the office's repeated attempts to rectify any tuition-related situation are met with inaction on the part of the school family, then entry into the Early Childhood Education Center may be denied at any point during the school year.

New families who enter the program during the school year must pay full registration fees regardless of when they register. Tuition for partial year students will be charged on a pro-rata basis.

III. I HAVE READ AND UNDERSTAND THE FAITH IN EDUCATION PARTNERSHIP AGREEMENT FOR 2024-25.

Parent/Guardian Signature _____

Date _____

Parent/Guardian Signature _____

Date _____

Please list all students who will attend St. James the Greater Early Childhood Education Center in 2023-24 (First & Last Name):

Name _____ Grade _____ Name _____ Grade _____

Name _____ Grade _____ Name _____ Grade _____



PRELIMINARY SCHEDULING FORM FOR THE 2024-25 SCHOOL YEAR

MOTHER'S DAY OUT TWO'S PROGRAM

(Children must be two years of age by Aug. 1, 2023)

Student First Name: _____

Student Last Name: _____

Student Birth Date (mm/dd/yyyy): _____

ANTICIPATED WEEKLY ATTENDANCE:

PLEASE CHECK ONE OF THE FOLLOWING:

_____ 2 Half Days/week

_____ 3 Half Days/week

Mother's Day Out hours are from 8:00am- 12:15pm (no before care)

IF YOU INDICATED TWO DAYS:

Please indicate which days of the week your child will attend (check 2):

Tuesday____ Wednesday____ Thursday____

REGISTRATION: I have included \$75 registration fee _____



MISSOURI DEPARTMENT OF
CHILD CARE

CHILD CARE ENROLLMENT FORM FOR LICENSE-EXEMPT FACILITIES

FACILITY/PROVIDER NAME		ADMISSION DATE	DISCHARGE DATE
CHILD'S NAME		GENDER	BIRTHDATE
ADDRESS (STREET, CITY, STATE, ZIP CODE)			
IDENTIFYING INFORMATION			
MOTHER'S/GUARDIAN'S NAME		HOME TELEPHONE NUMBER	
ADDRESS (STREET, CITY, STATE, ZIP CODE) OR CHECK IF SAME AS ABOVE <input type="checkbox"/>		CELL PHONE NUMBER	
E-MAIL ADDRESS			
EMPLOYER OR SCHOOL ATTEND		WORK/SCHOOL SCHEDULE	
EMPLOYER/SCHOOL ADDRESS (STREET, CITY, STATE, ZIP CODE)		WORK TELEPHONE NUMBER	
FATHER'S/GUARDIAN'S NAME		HOME TELEPHONE NUMBER	
ADDRESS (STREET, CITY, STATE, ZIP CODE) OR CHECK IF SAME AS ABOVE <input type="checkbox"/>		CELL PHONE NUMBER	
E-MAIL ADDRESS			
EMPLOYER OR SCHOOL ATTEND		WORK/SCHOOL SCHEDULE	
EMPLOYER/SCHOOL ADDRESS (STREET, CITY, STATE, ZIP CODE)		WORK TELEPHONE NUMBER	
EMERGENCY CONTACT AND PERSONS AUTHORIZED TO TAKE CHILD FROM FACILITY (OTHER THAN PARENT) AT LEAST ONE EMERGENCY CONTACT IS REQUIRED.			
NAME	RELATIONSHIP TO CHILD	TELEPHONE NUMBERS (CELL, WORK, HOME)	
ADDRESS (STREET, CITY, STATE, ZIP CODE)			
NAME	RELATIONSHIP TO CHILD	TELEPHONE NUMBERS (CELL, WORK, HOME)	
ADDRESS (STREET, CITY, STATE, ZIP CODE)			
AUTHORIZATION FOR EMERGENCY MEDICAL CARE			
I UNDERSTAND THAT I WILL BE NOTIFIED AT ONCE IN CASE OF AN EMERGENCY WITH MY CHILD, AND I WILL MAKE ARRANGEMENTS FOR MEDICAL CARE OF MY CHILD WITH THE PHYSICIAN OR HOSPITAL OF MY CHOICE.			
IF I CANNOT BE REACHED TO MAKE NECESSARY ARRANGEMENTS, OR IN A CRITICAL EMERGENCY REQUIRING MEDICAL CARE, I AUTHORIZE			
DAY CARE PROVIDER			
TO CONTACT THE FOLLOWING:			
PHYSICIAN OR CLINIC		TELEPHONE NUMBER	
NAME			
PREFERRED HOSPITAL			
NAME		TELEPHONE NUMBER	

The Department of Elementary and Secondary Education does not discriminate on the basis of race, color, religion, gender, gender identity, sexual orientation, national origin, age, veteran status, mental or physical disability, or any other basis prohibited by statute in its programs and activities. Inquiries related to department programs and to the location of services, activities, and facilities that are accessible by persons with disabilities may be directed to the Jefferson State Office Building, Director of Civil Rights Compliance and MOA Coordinator (Title VI/Title VII/Title IX/504/ADA/ADAAA/Age Act/GINA/USDA Title VI), 5th Floor, 205 Jefferson Street, P.O. Box 480, Jefferson City, MO 65102-0480; telephone number 573-526-4757 or TTY 800-735-2966; email civilrights@dese.mo.gov.

ACKNOWLEDGEMENTS		
A	I HAVE BEEN INFORMED OF THE REQUIRED HEALTH AND SAFETY INSPECTIONS AND THE INSPECTION FORMS ARE AVAILABLE FOR REVIEW.	PARENT/GUARDIAN INITIALS
B	WHEN MY CHILD IS ILL, I UNDERSTAND AND AGREE THAT S/HE MAY NOT BE ACCEPTED FOR CARE OR REMAIN IN CARE.	PARENT/GUARDIAN INITIALS
C	I <input type="checkbox"/> DO <input type="checkbox"/> DO NOT GIVE PERMISSION FOR FIELD TRIPS/EXCURSIONS. I UNDERSTAND I WILL BE NOTIFIED IN ADVANCE WHEN THEY ARE PLANNED.	PARENT/GUARDIAN INITIALS
D	I <input type="checkbox"/> DO <input type="checkbox"/> DO NOT GIVE PERMISSION FOR THE FACILITY TO TRANSPORT MY CHILD.	PARENT/GUARDIAN INITIALS
E	I HAVE BEEN NOTIFIED THAT I MAY REQUEST NOTICE AT INITIAL ENROLLMENT OR ANY TIME THERE AFTER WHETHER THERE ARE CHILDREN CURRENTLY ENROLLED IN OR ATTENDING THE FACILITY FOR WHOM AN IMMUNIZATION EXEMPTION HAS BEEN FILED.	PARENT/GUARDIAN INITIALS
HEALTH REPORT FOR SCHOOL-AGE CHILD		
CHILD'S HEALTH HISTORY AND CURRENT HEALTH PROBLEMS		
<input type="checkbox"/> MY CHILD IS IN GOOD HEALTH, IS ABLE TO PARTICIPATE IN GROUP CARE, HAS NO SPECIAL HEALTH OR MEDICAL REQUIREMENTS.		
<input type="checkbox"/> MY CHILD IS ABLE TO PARTICIPATE IN GROUP CARE BUT HAS SPECIAL HEALTH OR MEDICAL REQUIREMENTS AS LISTED BELOW.		
ANY ALLERGIES, SPECIAL MEDICAL CONDITIONS, INCLUDING CHRONIC HEALTH PROBLEMS		
ANY SPECIAL MEDICATIONS AND/ OR RESTRICTIONS		
PARENT/GUARDIAN SIGNATURE		DATE
FORM TO BE RETAINED FOR ONE YEAR AFTER DISCHARGE.		
FILING: FILE FORM IN CHILD'S INDIVIDUAL RECORD.		