HOLY FAMILY SCHOOL

ONE FAMILY . . . UNITED IN CHRIST

Application for Admission 2024-2025
PreSchool & PreKindergarten Checklist

To complete the application process, please note the following:

Content and check off list:

* Instructions, p 2

Please return the following paperwork as soon as possible

☐ Preschool Pick Your Program Form & $100 Registration Fee

☐ Holy Family School Application Form

☐ Akron Children's Hospital – School Health Record
(Completed and signed by Parent)

☐ Parent Observation Form

☐ Birth Certificate (copy only)

☐ Baptismal Certificate (copy only)

☐ Recent Photo

☐ Church envelope (or provide church membership id#)

In addition to completed forms:

The following items **MUST** be returned on the child's first day of school.

☐ Information Regarding Legal Custody Form
☐ Custodial papers (if applicable)

☐ Child Medical Statement for Childcare (Signed and dated by Physician & Parent) **RETURN ON THE FIRST DAY OF SCHOOL**

☐ Dentist's Report (Signed and dated by Dentist) **RETURN ON THE FIRST DAY OF SCHOOL**

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Application for Admission 2024-2025 – Instructions

If you have any questions in the completion of the admissions application, you are welcome to call Katrine Franklin at 330.688.6412 or email kfranklin@holyfamilyschoolstow.org

Please return the **COMPLETED APPLICATION** to Holy Family as soon as possible. We will verify receipt of your completed application BY EMAIL.

Holy Family School Application Form: Please complete as thoroughly as possible.

Preschool Pick Your Program Form: Please select your program and your preferred payment method.

Information Regarding Legal Custody Form: Please complete as thoroughly as possible. If applicable, please include current custodial papers.

Akron Children's Hospital – School Health Record: Please complete as thoroughly as possible. Must be signed by a parent.

Parent Observation Form: Please complete as thoroughly as possible.

Application does not guarantee enrollment. We may not be able to accommodate all students who apply.

Tuition: A **non-refundable** registration payment of $100 per student is due.

Please return the following on the first day of school:

Child Medical Statement for Child Care: This form must be completed and signed by your child's Physician and by one parent and returned to Holy Family School on the first day of school. Can be faxed to school at 330.688.3474

Dentist Report: This form must be completed and signed by your child's Dentist and returned to Holy Family School on the first day of school. Can be faxed to school at 330.688.3474

Informational Pieces:

Volunteer *Virtus* Guidelines

HOLY FAMILY SCHOOL

APPLICATION FORM

STUDENT INFORMATION

Date of Application: _____ Entering PreK: ❒ Prek3-2 ❒ Prek3-3 ❒ Prek4-4 ❒ PreK-Full Day
Entering Grade: ❒ K, ❒ 1, ❒ 2, ❒ 3, ❒ 4, ❒ 5, ❒ 6, ❒ 7, ❒ 8

Student First Name: _____ Middle Name: _____

Student Last Name: _____

Student Address: _____

City: _____ State: _____ Zip: _____

Student Sex: _____ Student Date of Birth: _____/_____/_____
MM DD YYYY

Student Birthplace: _____
(City, State, County)

Ethnicity: ❒White ❒Asian ❒Black/African American ❒Hispanic ❒Multiracial
❒Native Hawaiian/Pacific Islands ❒Native American ❒Unknown/Other ❒Do Not Wish to Disclose

Religious Affiliation: _____ Parish: _____

Baptism Date: _____ Parish: _____

Reconciliation Date: _____ Parish: _____

Communion Date: _____ Parish: _____

Previous School: _____ Phone: _____

Previous School Address: _____
(Street, City, State)

Public School District and name of public school student would attend: (ex: Stow-Munroe Falls, Fishcreek Elementary)

_____ _____
District Name School Name

PARENT/LEGAL GUARDIAN INFORMATION

❒ Parents married; student resides with parents ❒ Parents are divorced ❒ Parents are separated
Student resides primarily with: ❒ Natural Mother ❒ Natural Father ❒ Custodial Mother ❒ Custodial Father
❒ Legal guardian/Other _____ (Name, relationship to student)

FIRST PARENT OR GUARDIAN: ❒ Father ❒ Mother ❒ Legal guardian

Full name: _____
FIRST MIDDLE LAST

Maiden name: _____ Is parent a Holy Family School alumnus/a ____ If yes, class year ____

Address: _____
(If different from student's)

Home# (_____) _____ Cell# (_____) _____

Email_____

Education: ❒High School Graduate ❒ College Non-Graduate ❒ College Graduate ❒Beyond College

Place of Work_____Work#_____

Occupation/Title: _____

Religious Affiliation: _____ Parish: _____

SECOND PARENT OR GUARDIAN: ❒ Father ❒ Mother ❒ Legal guardian

Full name: _____
FIRST MIDDLE LAST

Maiden name: _____ Is parent a Holy Family School alumnus/a _____ If yes, class year ____

Address: _____
(If different from student's)

Home# (_____) _____ Cell# (_____) _____

Email_____

Education: ❒High School Graduate ❒ College Non-Graduate ❒ College Graduate ❒Beyond College

Place of Work_____ Work# _____

Occupation/Title: _____

Religious Affiliation: _____ Parish: _____

Other children in the family/list name & birth dates:

Name	Birth date
Name	Birth date
Name	Birth date
Name	Birth date
Name	Birth date

Language Spoken at Home: ❒ English ❒ Other (list)_____

RELATIVES (other than parents) WHO ARE HOLY FAMILY SCHOOL ALUMNI:

Name	Relationship	Class Year
Name	Relationship	Class Year
Name	Relationship	Class Year

Preschool & Prekindergarten Program Offerings

- 3 year old Preschool Program-2 days a week
  Monday and Tuesday
  8:30am-11:00am
  *must be 3 years old by September 30th.

- 3 year old Preschool Program-3 days a week
  Wednesday, Thursday, Friday
  8:30am-11:00am
  *must be 3 years old by September 30th.

- 4 year old Prekindergarten Program-4 days
  Monday-Thursday
  12:00pm-3:00pm

- 4-5 year old Prekindergarten Program-5 days
  Monday-Friday
  8:00am-3:05pm*

*Students are eligible to enroll in and attend the Holy Family School Extended Hours program.

Full time certified teacher
Full time certified aid
No bussing available

Located at 3163 Kent Road, Stow, Ohio 44224
Rooms 105, 106, 107 in Holy Family School

Director: Mrs. Michelle Kightlinger
mkightlinger@holyfamilyschoolstow.org or 330-688-6412

Preschool & Prekindergarten Program Offerings

2024-2025 Registration

Please indicate your program choice as well as your payment option. A $100.00 non-refundable registration fee is due at time of registration. The fee will be credited towards your 2024-2025 tuition.

☐ **3 year old Preschool Program** – 2 days a week ~ 8:30am – 11:00am ~ Monday & Tuesday
- Tuition is $1,500/year

Payment Options

☐ $1,400 one-time payment due by September 6th
☐ $155.56 monthly due by the 10th of each month (September – May)

☐ **3 year old Preschool Program** – 3 days a week ~ 8:30am – 11:00am ~ Wednesday, Thursday, Friday
- Tuition is $2,000/year

Payment Options

☐ $1,900 one-time payment due by September 6th
☐ $211.11 monthly due by the 10th of each month (September – May)

☐ **4 year old Prekindergarten Program** – 4 days a week ~ 12:00pm – 3:00pm ~ Monday – Thursday
- Tuition is $2,700/year

Payment Options

☐ $2,600 one-time payment due by September 6th
☐ $288.89 monthly due by the 10th of each month (September – May)

☐ **4/5 year old Full Day Prekindergarten Program** – 5 days a week ~ 8:10am – 3:10pm
- Tuition is $5,000/year

Payment Options

☐ $4,900 one-time payment due by September 6th
☐ $544.44 monthly due by the 10th of each month (September – May)

Please make all checks payable to **Holy Family School.** A 10% late fee will be assessed to any account not paid by the end of each month. Any Account in arrears for more than 30 days will result in dismissal of student from the program.

I have read and agree to the above terms and conditions.

_____

Parent(s) Name

_____

Student Name (PLEASE PRINT LEGIBLY)

Registration Requirements

Preschool: 2 day children must be three (3) years old by September 30. All children must be fully toilet trained before entry.

Preschool: 3 day children must be three (3) years old by September 30. All children must be fully toilet trained before entry.

Preschool: 4 day children must be four (4) years old by September 30. All children must be fully toilet trained before entry.

Pre-K: All day children must be four (4) years old by September 30th. All children must be fully toilet trained before entry.

Your toilet trained child will demonstrate the following:

- Tell the teacher when he/she needs to use the restroom.
- Is able to use the bathroom (either urinating or for a bowel movement) on his/her own.
- Manage removing clothing as appropriate, sitting on the toilet, wiping himself/herself, reclothing as appropriate, flushing the toilet and washing his/her hands.
- Will not be in diapers or pull-ups at all. He/she must be in regular underwear.

A child that has frequent accidents is not considered toilet trained! Frequency will be determined by the preschool team with the assistance of the school administration.

A child who has diarrhea should be kept home until they have been episode free for at least 24 hours.

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INFORMATION REGARDING LEGAL CUSTODY
to be completed as part of the registration/re-registration agreement

Date: _____

Child's Name: _____ Grade in 2024-2025 _____

Address of child's residence: _____
_____

Child lives with: _____ both parents _____ mother as custodial parent
_____ father as custodial parent
_____ grandparent(s) (with legal custody)
_____ other. Please explain: _____

Residential parent/guardian:

Name: _____
Address: _____
City, Zip: _____
Phone: _____
Email Address: _____

Is there a court order (or pending order) affecting the custody and/or residency of the child?

Please attach a certified copy of the entire custodial agreement including the case number and those sections referring to visitation rights and contacts with the school. Also include the page bearing the judge's signature and court seal. This copy should include any and all modifications made as of the date of registration of the child in this school. It is also the responsibility of the parents to inform the principal of any subsequent modifications during the child's tenure at the school.

Non-residential parent:

Name: _____
Address: _____
City, Zip: _____
Phone: _____
Email Address: _____

Does the non-residential parent have visitation rights?

Is there a court decision that states that the non-residential parent should NOT receive school information or attend school activities?

Is the non-residential parent responsible for paying tuition?

(A complete copy of the school's procedures dealing with family custody situations is included in the school handbook.)

Akron Children's Hospital

School Health Services

School Health History Record/Update

(Parent/Guardian to complete)

School Year: _____

Student Name: _____ **Male** ____ **Female** ____

Date of Birth: _____ **Grade:** _____

How does this child's development compare to other children, such as brothers/sisters or playmates?
About the same_____ Delayed_____ Advanced_____

Health Conditions: Please check any that your child has or had

Current	Past		Current	Past		Current	Past	
____	____	Allergies	____	____	Cancer	____	____	Hepatitis
____	____	Anaphylactic reaction	____	____	Chickenpox	____	____	Juvenile Arthritis
____	____	Asthma or wheezing	____	____	Cystic Fibrosis	____	____	Meningitis/Encephalitis
____	____	Attention Deficit	____	____	Diabetes	____	____	Seizures/Epilepsy
____	____	Behavior/Emotional concerns	____	____	Ear problems/poor hearing	____	____	Sore throat (frequent)
____	____	Birth/Congenital malformations	____	____	Eczema/skin conditions	____	____	Speech difficulties
____	____	Blood problems	____	____	Eye problems/poor vision	____	____	Toothaches/dental problems
____	____	Bone/Joint problems	____	____	Headache (frequent)	____	____	Urinary tract infections
____	____	Bowel problems	____	____	Heart Disease	____	____	Wetting during day/night

Current Health: Tell us about any current health conditions or concerns.

_____

_____

_____

Illness, Injuries & Hospitalizations (please explain):

_____

_____

_____

Medical Home: Please provide us with your child's current health care provider's name and contact information.

Healthcare Provider/Physician Name: _____ Phone: _____

Address: _____

Student Name:_____

Allergies: If your child has any food or environmental allergies, please obtain the Allergy Action Plan form from the school clinic for your child's health record.

Allergy	Reaction	Treatment

Medications: Describe medicine your child takes regularly. If your child must take medication at school, please obtain the Medication Administration Authorization form from the school clinic to be completed by you and your child's healthcare provider.

Medication	Reason	How often?	What time?

Explain any special assistance your child may need during the school day:

_____

_____

_____

Please add any comments or concerns you have about your child's health, development, behavior, family or home life that you would like the school to be aware of: _____

_____

_____

Please check with your health care provider to be sure your child's immunizations are all current and up to date. You will be requested to provide an updated copy of immunization records to the school if the records on file with the school are not current.

If you have questions or concerns about your child's health or would like information about a medical home for your child or community services that may be available, please contact your school clinic.

_____ _____ _____

Name of Person Completing Form | Signature | Date

HOLY FAMILY SCHOOL

Please answer the questions on this form in the best way you can. You will be able to answer some quite easily, and you will have difficulty in making a decision on others. Your answers on this form will help the school staff, and will involve you in deciding with the teacher what kind of educational program is best suited for your child. This questionnaire is ***confidential*** and your responses will be shared only with professional personnel, and only if the information learned will help in planning an educational program for your child.

Name of Child _____ Birthdate _____

Parents' Names _____

Child's Family includes:

Brothers (names and ages)		Sisters (names and ages)	
_____	_____	_____	_____
_____	_____	_____	_____

Other Family Members Living in home:

_____	_____	_____	_____

I. General Health History:

Please check any health concern that you or your doctor have noticed.

____ Asthma	____ Bed wetting	____ Lack of consciousness
____ Indigestion	____ Allergies	____ Chronic ear infections (more than 2 per year)
____ Constipation	____ Heart trouble	____ Serious blows to head
____ Diarrhea	____ Headaches	____ Overtired or lacking pep
____ Vomiting	____ Nightmares	____ Medical problems immediately after birth
____ Stomach aches	____ Thumb sucking	____ Hyperactivity
____ Frequent fevers	____ Nail biting	____ Sinus trouble
____ Epilepsy (seizures)	____ Nose bleeding	____ Diabetes

____ Other physical problems or limitations (explain): _____

Is your child presently on medication? _____ What? _____

Has your child had any significant injuries or hospitalizations? _____

II. Hearing Assessment:

Has your child ever had an ear/hearing examination or treatment? _____
When? _____ By Whom? _____ Results? _____

A. Do you suspect any hearing problems?	Yes	No
B. Does your child		
1. seem to have difficulty hearing?	Yes	No
2. turn up the TV louder than family members?	Yes	No
3. seem to favor one ear over the other?	Yes	No
4. jump or appear to be more startled than others if there is a sudden noise?	Yes	No
5. seem to hear you if you talk in a whisper?	Yes	No
6. make you talk loudly or repeat frequently?	Yes	No
7. become confused in following more than two verbal commands at a time?	Yes	No
8. have difficulty remembering things for a long time?	Yes	No
9. have difficulty remembering things for a short time?	Yes	No
10. speak loudly in normal conversation?	Yes	No

III. Language Development:

At what age did your child first begin to speak? Give approximate age if you do not remember exact age.

First words _____ Two or three words together _____

Sentences _____

Does your child		
1. stutter?	Yes	No
2. have difficulty expressing ideas and concepts?	Yes	No

IV. Visual Assessment:

Has your child ever had a vision examination or treatment? Yes No

When? _____ By Whom? _____ Results? _____

A. Do you suspect any vision problems?	Yes	No
B. Does your child		
1. seem to have difficulty seeing small lines or pictures?	Yes	No
2. seem to have a problem seeing things far away?	Yes	No
3. squint?	Yes	No
4. wear glasses?	Yes	No
5. have eyes that turn in?	Yes	No
6. have eyes that turn out?	Yes	No
7. sit very close to the TV?	Yes	No
8. rub eyes a lot?	Yes	No
9. turn head as to use primarily one eye?	Yes	No
10. lower one side of the head when looking at others?	Yes	No

V. Motor Development:

Your child began walking at age (approximate if unsure) _____.

Do you feel your child has adequate large muscle coordination?	Yes	No
Does your child		
1. catch a ball thrown to him/her?	Yes	No
2. enjoy physical activities?	Yes	No
3. lose balance, trip and fall more often than normal?	Yes	No
4. have difficulty running?	Yes	No

VI. Social Development:

Does your child

1. have regular playmates the same age?	Yes	No
2. have difficulty getting along with other children?	Yes	No
3. prefer to play with other children instead of alone?	Yes	No
4. become easily frustrated?	Yes	No
5. cry often?	Yes	No
6. have a quick temper?	Yes	No
7. enjoy cooperating with others?	Yes	No
8. become frequently irritated or moody?	Yes	No
9. become upset by changes in routine?	Yes	No
10. have difficulty dealing with family stress, such as illness, death or separation?	Yes	No
11. demand much individual adult attention?	Yes	No
12. accept discipline and limits?	Yes	No

VII. Other Pertinent Information:

Is there any other information that will help us get to know your child? _____

_____

Has your child attended preschool? Yes No _____ # of years

Name of preschool _____

Does your child know how to read? Yes No
Does your child know how to write? Yes No

Would you like an individual conference with staff psychologist and kindergarten teacher to relate any information you don't feel you can include on this form? Yes No

Thank you for your patience in completing this form. Your insights will help us provide an appropriate educational program for your child.

Akron Children's Hospital
SCHOOL HEALTH SERVICES

Healthcare Provider Report

Early Childhood Education/Preschool Special Education Program

School Year:_____ **Grade:**_____ Date of Exam:

Name: _____ **Male** ____ **Female** ____ **Date of Birth:** _____

Height: _____(_____%ile) **Weight:** _____(_____%ile) **B.P.:**_____ **Pulse:** _____

Immunizations	Please Circle One		Exempt from Immunizations	Please Circle One	
Complete for Age	Yes	No	Health Concern	Yes	No
In Process	Yes	No	Religious/Philosophical	Yes	No

Assessments/Screenings	Completed Please Circle One	Date Completed (please enter if completed previously)	Reason Not Completed Please list reason
Vision	Yes No		
Hearing	Yes No		
Dental	Yes No		
Lead	Yes No		
Hemoglobin	Yes No		

Special Health Conditions (allergies, medications, chronic conditions, etc)

This child has been examined and is in suitable condition to participate in group care

_____ _____

Healthcare Provider Signature **Healthcare Provider Name (please print)**

_____ _____

Healthcare Provider address **Healthcare Provider phone**

Akron Children's Hospital

School Health Services

Dentist Report

Child's Name: _____ **Birth Date:** _____

The following services have been performed:

_____ Examination Date of Exam: _____

_____ Radiographs _____ Prescription for fluoride supplements

_____ Diagnosis _____ Oral prophylaxis _____ Topical application of fluoride

The following oral hygiene instruction was provided:

_____ Toothbrushing _____ Diet counseling

_____ Flossing _____ Home/school use of fluoride mouth rinse

The following statements are applicable:

_____ All necessary services have been performed
_____ Further treatment is indicated
_____ No restorative services are required at this time
_____ Further appointments have been arranged

Comments:

Please Print or Stamp:

Dentist's Name:	**Signature:**
Address:	**Date Signed:**
Phone:	

Please return this completed and signed dentist form to your child's school clinic.