

Child's/Children's Last Name \_\_\_\_\_

# ST. THOMAS ACADEMY

## Kindergarten - 8th Grade Student Registration Packet 2024-2025

### Mission Statement

St. Thomas Academy provides a safe community for students, focused on academic excellence infused with Catholic beliefs.

### Vision:

To graduate inspired learners motivated to lead the world with faith and moral character.

# REDMOND, OREGON

# Registration Checklist

To ensure your child's place in a class at St. Thomas Academy, the following must be submitted at the time of registration.

Placement will be given to those with \***Completed** registration packets, and full registration payment.

\*Many of our classes have waiting lists for 2024-2025.

## **Registration Forms**

- Fill out Authorization to Administer Medication at School (only if needed). Dr. signature required
- Fill out Food Allergy & Anaphylaxis Emergency Care Plan (only if needed). Dr. signature required

## **Birth Certificate** (New students only)

## **Immunization Records** (New students only. Current students, please check their immunization status)

# 2024-2025 Registration Form

## Student Information

First: \_\_\_\_\_ Middle: \_\_\_\_\_ Last: \_\_\_\_\_

Gender: \_\_\_ Grade: \_\_\_ DOB: \_\_\_\_\_ Shirt Size: 4T, YS, YM, YL, YXL, or Adult S,M, L

Office Use Only:  
Student ID#

First: \_\_\_\_\_ Middle: \_\_\_\_\_ Last: \_\_\_\_\_

Gender: \_\_\_ Grade: \_\_\_ DOB: \_\_\_\_\_ Shirt Size: 4T, YS, YM, YL, YXL, or Adult S,M, L

Office Use Only:  
Student ID#

First: \_\_\_\_\_ Middle: \_\_\_\_\_ Last: \_\_\_\_\_

Gender: \_\_\_ Grade: \_\_\_ DOB: \_\_\_\_\_ Shirt Size: 4T, YS, YM, YL, YXL, or Adult S,M, L

Office Use Only:  
Student ID#

First: \_\_\_\_\_ Middle: \_\_\_\_\_ Last: \_\_\_\_\_

Gender: \_\_\_ Grade: \_\_\_ DOB: \_\_\_\_\_ Shirt Size: 4T, YS, YM, YL, YXL, or Adult S,M, L

Office Use Only:  
Student ID#

## Family Information

Office Use Only:  
Family Code:

**Father's Name:** \_\_\_\_\_

Complete Address: \_\_\_\_\_

### Phone Numbers:

Home: \_\_\_\_\_ Wk: \_\_\_\_\_ Cell: \_\_\_\_\_  Text OK

Employer: \_\_\_\_\_ Occupation: \_\_\_\_\_ Email: \_\_\_\_\_

**Mother's Name:** \_\_\_\_\_

Complete Address: \_\_\_\_\_

### Phone Numbers:

Home: \_\_\_\_\_ Wk: \_\_\_\_\_ Cell: \_\_\_\_\_  Text OK

Employer: \_\_\_\_\_ Occupation: \_\_\_\_\_ Email: \_\_\_\_\_

### Please Check One:

- St. Thomas Parishioner** (Contributing and Participating)
- Catholic Non-Parishioner** (Parish: \_\_\_\_\_)
- Non-Catholic** (or non-participating Catholic)

**Student Race:**  Caucasian  Multi-Racial  African American  Asian  Hispanic  American Indian  Pacific Islander

**Directory:**  **DO NOT** list our address in the parent directory

**DO NOT** list our email in the parent directory

**DO NOT** list our phone number in the parent

**EMERGENCY TREATMENT RELEASE: Please initial each paragraph and sign & date where indicated.**

**INITIAL**

\_\_\_\_ I/We voluntarily consent to the rendering of such care, including diagnostic procedures, surgical and medical treatment, and blood transfusions, by authorized members of the hospital staff or their designees, as may in their professional judgment be necessary.

\_\_\_\_ I/We hereby acknowledge that no guarantees have been made to me as to the effect of such examinations or treatment of my child's condition. I/We have read this form and certify that I/we understand its contents. I/We hereby give our consent to the staff at St. Thomas Academy who will be caring for my/our child during the period of September 2024 - June 2025 (school year or portion thereof) to arrange for emergency medical/dental care and treatment necessary to preserve the health of my/our child. I/We acknowledge that I/we are responsible for all reasonable charges in connection with care and treatment rendered during the period stated above.

\_\_\_\_ In an emergency, St. Thomas Academy has my/our permission to call an ambulance or take my/our child to any available physician or hospital at my/our expense.

\_\_\_\_ In case of an emergency, a parent or guardian is expected to meet the St. Thomas Academy staff person at the hospital or physician's office as soon as possible.

**Parent/Guardian Signature** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Child' First Name:** \_\_\_\_\_ **Allergies:** \_\_\_\_\_

**Medications:** \_\_\_\_\_

**Other Information (injuries, etc.):** \_\_\_\_\_

**Child' First Name:** \_\_\_\_\_ **Allergies:** \_\_\_\_\_

**Medications:** \_\_\_\_\_

**Other Information (injuries, etc.):** \_\_\_\_\_

**Child' First Name:** \_\_\_\_\_ **Allergies:** \_\_\_\_\_

**Medications:** \_\_\_\_\_

**Other Information (injuries, etc.):** \_\_\_\_\_

**Child' First Name:** \_\_\_\_\_ **Allergies:** \_\_\_\_\_

**Medications:** \_\_\_\_\_

**Other Information (injuries, etc.):** \_\_\_\_\_

**Family Physician:** \_\_\_\_\_ **Phone:** \_\_\_\_\_

**Address:** \_\_\_\_\_

**Medical Insurance Co.:** \_\_\_\_\_ **Identification #:** \_\_\_\_\_

**Family Dentist:** \_\_\_\_\_ **Phone:** \_\_\_\_\_

**Dental Insurance Co.:** \_\_\_\_\_ **Identification #:** \_\_\_\_\_

**Emergency Contact-** In the event that a parent/guardian cannot be reached, we are required to have two people other than parents on the Emergency Contact list.

**Emergency Contact :** \_\_\_\_\_ **Relation to Student** \_\_\_\_\_ **Phone Number:** \_\_\_\_\_

**Emergency Contact :** \_\_\_\_\_ **Relation to Student** \_\_\_\_\_ **Phone Number:** \_\_\_\_\_

**Emergency Contact :** \_\_\_\_\_ **Relation to Student** \_\_\_\_\_ **Phone Number:** \_\_\_\_\_

## LOCAL FIELD TRIP PERMISSION

I/We give permission for our children), \_\_\_\_\_ to participate in field trips in the local area during the school year.

**Each student enrolled at St. Thomas needs permission to leave the school during school hours. This includes all field trips.**

This Permission Slip is for those trips in our local area, which are most often when the class walks to a site in our neighborhood. For each field trip to a site other than local, you will receive a trip specific Permission Slip, giving the destination, time of departure and return, and any other special particulars for that trip.

**Most field trips are class specific. Siblings from another class or from another school are not allowed to attend.**

### **\*General Photo Release**

- I give permission for St. Thomas Academy to use my child's photograph for school-related advertising and publicity on our school's social media feeds and website. This will not be used for profit, but for promoting the school only. Names are not posted or mentioned.
- I do not give permission for St. Thomas Academy to use my child's photograph.

Children's Names: \_\_\_\_\_

Parent/Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_

\*We cannot control the outcome of pictures taken by non-staff during special events, field trips, and/or assemblies.

# **Family Participation Commitment**

**2024-2025**

**Please initial each section below. These are requirements for the school year. Each requirement is per family, not per student.**

## **Part I: Uniforms**

Uniforms are a requirement for students attending St. Thomas Academy. Uniform information is in the Parent Student Handbook available on our website. Catalogs are available on request. We also have a uniform exchange program available to help supplement the school required wardrobe.

Initial: \_\_\_\_\_

## **Part II: T.E.A.M./Volunteer Program**

Each **family** must contribute 20 hours of volunteer time to the school. **If you receive financial assistance, you must contribute 40 hours.** These volunteer hours will be tracked by each family online or in the school office. Volunteer time can include (but is not limited to) participating in school fundraisers, classroom volunteer time, driving students to field trips, school maintenance, or projects for teachers/school done at your home. It also includes any/all donations for fundraisers and class or school items needed for projects or snacks. Every \$20 = 1 volunteer hour. This program runs from July 1<sup>st</sup> to June 30<sup>th</sup> of each school year. If a family chooses not to participate in the T.E.A.M./Volunteer program, you will pay a fee of **\$500.00**

Initial:\_\_\_\_\_ I will participate in the T.E.A.M/Volunteer Program.

Initial:\_\_\_\_\_ I will not participate and will pay the fee of \$500.00

## **Part III: Scrip**

Each **family** will purchase a minimum of **\$1500.00** in Scrip from the school. Scrip is a program where you purchase gift cards for businesses and use them at face value. There is no additional fee involved. If you purchase a Safeway card for \$50, it is worth \$50 at the store. The participating businesses donate a percentage of the value to our school. This program runs from July 1<sup>st</sup> to June 30<sup>th</sup> of each school year. If a family chooses not to participate in the Scrip program, you will pay a fee of **\$300.00**.

Initial:\_\_\_\_\_ I will participate in the scrip program

Initial:\_\_\_\_\_ I will not participate and will pay the fee of \$300.00

## **Part IV: Handbook**

Initial:\_\_\_\_\_ I have read the Parent/Student Handbook\*

\* Available at <https://redmondacademy.com/s/Parent-Student-Handbook-24-25.pdf>

**AUTHORIZATION TO ADMINISTER MEDICATION AT SCHOOL**

Student Name: \_\_\_\_\_ Birth Date: \_\_\_\_\_ Grade: \_\_\_\_\_

**THIS PORTION TO BE COMPLETED BY THE PHYSICIAN/DENTIST**

<u>Name of Medication</u>	<u>Dosage</u>	<u>Methods of Administration</u>	<u>Time to be Taken</u>
_____	_____	_____	_____
_____	_____	_____	_____

If given prn, specify the length of time between doses \_\_\_\_\_

Inhalers: \_\_\_\_\_  
Indicate if student must carry on his/her person

Possible side effects of medication \_\_\_\_\_

Emergency procedure in case of serious side effects \_\_\_\_\_

I request and authorize that the above-named student be administered the above-identified oral medication in accordance with the instructions indicated above from \_\_\_\_\_ to \_\_\_\_\_ (not to exceed current school year) as there exists a valid health reason which makes administration of the medication advisable during school hours.

\_\_\_\_\_  
Date of Signature Physician/Dentist Signature

Telephone Number: \_\_\_\_\_ Name(Print) \_\_\_\_\_

**Please note: If samples of medication are to be given, they must be labeled with the name of the student, dosage, and time to be given.**

**THIS PORTION TO BE COMPLETED BY THE PARENT/GUARDIAN**

I request/authorize the school to administer medication to the above identified student in accordance with the doctor's instructions for the period from \_\_\_\_\_ to \_\_\_\_\_ (not to exceed current school year). I understand that every effort will be made by school staff to administer the medication in a timely manner.

Permission to carry inhaler Yes \_\_\_\_\_ No \_\_\_\_\_

\_\_\_\_\_  
Date of Signature Parent/Guardian Signature

Telephone Number: cell \_\_\_\_\_ work \_\_\_\_\_







Name: \_\_\_\_\_ D.O.B.: \_\_\_\_\_

Allergy to: \_\_\_\_\_

Weight: \_\_\_\_\_ lbs. Asthma:  Yes (higher risk for a severe reaction)  No

**PLACE  
PICTURE  
HERE**

**NOTE: Do not depend on antihistamines or inhalers (bronchodilators) to treat a severe reaction. USE EPINEPHRINE.**

**Extremely reactive to the following allergens:** \_\_\_\_\_





**THEREFORE:**

If checked, give epinephrine immediately if the allergen was **LIKELY** eaten, for **ANY** symptoms.




If checked, give epinephrine immediately if the allergen was **DEFINITELY** eaten, even if no symptoms are apparent.

FOR ANY OF THE FOLLOWING:

## SEVERE SYMPTOMS

			
<b>LUNG</b>	<b>HEART</b>	<b>THROAT</b>	<b>MOUTH</b>
Short of breath, wheezing, repetitive cough	Pale, blue, faint, weak pulse, dizzy	Tight, hoarse, trouble breathing/ swallowing	Significant swelling of the tongue and/or lips





  

			<b>OR A COMBINATION of symptoms from different body areas.</b>
<b>SKIN</b>	<b>GUT</b>	<b>OTHER</b>	
Many hives over body, widespread redness	Repetitive vomiting, severe diarrhea	Feeling something bad is about to happen, anxiety, confusion	

↓      ↓      ↓

- INJECT EPINEPHRINE IMMEDIATELY.**
- Call 911.** Tell emergency dispatcher the person is having anaphylaxis and may need epinephrine when emergency responders arrive.
  - Consider giving additional medications following epinephrine:
    - » Antihistamine
    - » Inhaler (bronchodilator) if wheezing
  - Lay the person flat, raise legs and keep warm. If breathing is difficult or they are vomiting, let them sit up or lie on their side.
  - If symptoms do not improve, or symptoms return, more doses of epinephrine can be given about 5 minutes or more after the last dose.
  - Alert emergency contacts.
  - Transport patient to ER, even if symptoms resolve. Patient should remain in ER for at least 4 hours because symptoms may return.

## MILD SYMPTOMS

			
<b>NOSE</b>	<b>MOUTH</b>	<b>SKIN</b>	<b>GUT</b>
Itchy/runny nose, sneezing	Itchy mouth	A few hives, mild itch	Mild nausea/ discomfort

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**FOR MILD SYMPTOMS FROM MORE THAN ONE SYSTEM AREA, GIVE EPINEPHRINE.**

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**FOR MILD SYMPTOMS FROM A SINGLE SYSTEM AREA, FOLLOW THE DIRECTIONS BELOW:**

- Antihistamines may be given, if ordered by a healthcare provider.
- Stay with the person; alert emergency contacts.
- Watch closely for changes. If symptoms worsen, give epinephrine.

## MEDICATIONS/DOSES

Epinephrine Brand or Generic: \_\_\_\_\_

Epinephrine Dose:  0.15 mg IM     0.3 mg IM

Antihistamine Brand or Generic: \_\_\_\_\_

Antihistamine Dose: \_\_\_\_\_

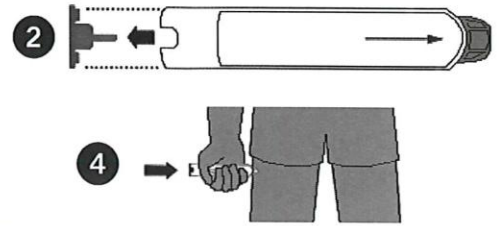
Other (e.g., inhaler-bronchodilator if wheezing): \_\_\_\_\_

\_\_\_\_\_



### EPIPEN® AUTO-INJECTOR DIRECTIONS

1. Remove the EpiPen Auto-Injector from the clear carrier tube.
2. Remove the blue safety release by pulling straight up without bending or twisting it.
3. Swing and firmly push orange tip against mid-outer thigh until it 'clicks'.
4. Hold firmly in place for 3 seconds (count slowly 1, 2, 3).
5. Remove auto-injector from the thigh and massage the injection area for 10 seconds.



### ADRENACLICK® (EPINEPHRINE INJECTION, USP) AUTO-INJECTOR DIRECTIONS

1. Remove the outer case.
2. Remove grey caps labeled "1" and "2".
3. Place red rounded tip against mid-outer thigh.
4. Press down hard until needle enters thigh.
5. Hold in place for 10 seconds. Remove from thigh.



### ADMINISTRATION AND SAFETY INFORMATION FOR ALL AUTO-INJECTORS:

1. Do not put your thumb, fingers or hand over the tip of the auto-injector or inject into any body part other than mid-outer thigh. In case of accidental injection, go immediately to the nearest emergency room.
2. If administering to a young child, hold their leg firmly in place before and during injection to prevent injuries.
3. Epinephrine can be injected through clothing if needed.
4. Call 911 immediately after injection.

### OTHER DIRECTIONS/INFORMATION (may self-carry epinephrine, may self-administer epinephrine, etc.):

Treat the person before calling emergency contacts. The first signs of a reaction can be mild, but symptoms can worsen quickly.

#### EMERGENCY CONTACTS — CALL 911

RESCUE SQUAD: \_\_\_\_\_

DOCTOR: \_\_\_\_\_ PHONE: \_\_\_\_\_

PARENT/GUARDIAN: \_\_\_\_\_ PHONE: \_\_\_\_\_

#### OTHER EMERGENCY CONTACTS

NAME/RELATIONSHIP: \_\_\_\_\_

PHONE: \_\_\_\_\_

NAME/RELATIONSHIP: \_\_\_\_\_

PHONE: \_\_\_\_\_

# Tuition and Fees

**Registration & Instructional Materials Fee:** Includes workbooks, textbooks, classroom materials, and a full zip hooded sweatshirt

**New Students:** 1st child - \$500, Siblings - \$350

**Returning Students:** \$300

**REGISTRATION/INSTRUCTIONAL MATERIALS FEE TOTAL \$** \_\_\_\_\_

**Non-refundable Registration Fees must be paid in advance to guarantee your child's place in a class**

Please mark the applicable charges/payment options below.

	Pd in full by Aug.1st	Annual	10 Months <sup>2</sup> (Sept-June)
<b>Tuition<sup>1</sup></b>			
Kindergarten – 5 <sup>th</sup> Grade	<input type="checkbox"/> \$6,450.00	<input type="checkbox"/> \$6,590.00	<input type="checkbox"/> \$659.00
6 <sup>th</sup> – 8 <sup>th</sup> Grade	<input type="checkbox"/> \$7,040.00	<input type="checkbox"/> \$7,180.00	<input type="checkbox"/> \$718.00
Each additional child K-8* Quantity of additional children _____	<input type="checkbox"/> \$5,145.00	<input type="checkbox"/> \$5,250.00	<input type="checkbox"/> \$525.00
<b>Buy Out Options</b>			
Volunteer Hours	<input type="checkbox"/> \$500.00	<input type="checkbox"/> \$500.00	<input type="checkbox"/> \$50.00
Scrip	<input type="checkbox"/> \$300.00	<input type="checkbox"/> \$300.00	<input type="checkbox"/> \$30.00

\*For Kindergarten through 8<sup>th</sup> grade, full tuition is applied for the oldest child.

**TOTAL ANNUAL TUITION/BUY OUT \$** \_\_\_\_\_  **MONTHLY \$** \_\_\_\_\_

As a school community, St. Thomas Academy continues to thrive and grow with the continued financial support of all our families. Tuition payments are due by the 15<sup>th</sup> of each month. Tuition payments must be paid current or written arrangements must be made with the principal. Arrangements must be made in writing to the principal or a student may be dismissed from school. Under most circumstances, a student with outstanding tuition payments will not be allowed to re-enter St. Thomas Academy the following year. All Families will be enrolled in our tuition management system called "Blackbaud Tuition Management" from the Blackbaud company. Before the start of school, you will receive a welcome email from Blackbaud with instructions to set up your secure family portal.

**SIGNATURE:** \_\_\_\_\_

**DATE:** \_\_\_\_\_





## Financial Assistance Application

Please complete this application and return it no later than May 15.

**ALL ACCOUNTS MUST BE CURRENT OR AGREEMENTS WITH ADMINISTRATION BEFORE ASSISTANCE WILL BE CONSIDERED.**

The following criteria will be used in determining financial assistance:

- Financial need. All applications received will be reviewed. Assistance is dispersed according to need. A set amount of funding is available each year. Not all applicants will qualify for financial aid; previous recipients are not automatically guaranteed aid.
- Student applicants must abide by all rules of St. Thomas Academy.
- Financial Assistance may be revoked if terms of the Tuition Contract are not maintained and kept current.
- Financial Assistance may be revoked if confidentiality is not maintained.

### STUDENT INFORMATION:

Name \_\_\_\_\_ Grade \_\_\_\_\_

Name \_\_\_\_\_ Grade \_\_\_\_\_

Name \_\_\_\_\_ Grade \_\_\_\_\_

Name \_\_\_\_\_ Grade \_\_\_\_\_

### PARENT INFORMATION:

Name \_\_\_\_\_

Name \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ Zip \_\_\_\_\_

Home Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_

Father's Place of Employment \_\_\_\_\_

Mother's Place of Employment \_\_\_\_\_

### DIVORCED OR SEPARATED PARENTS:

This form is to be completed by the parent responsible for the student's educational expenses. Shared responsibility requires an application from both parents.

**FINANCIAL INFORMATION:**

Gross Wages, Salaries, Tips.....\$ \_\_\_\_\_

Interest and Dividends Income..... \$ \_\_\_\_\_

Other Income (alimony, child support, pension)..... \$ \_\_\_\_\_

**TOTAL HOUSEHOLD INCOME** \$ \_\_\_\_\_

**EDUCATION EXPENSES:**

Total elementary, middle school, high school, and college tuition to be paid for dependent children listed as family members.

Name \_\_\_\_\_ School \_\_\_\_\_ Tuition \_\_\_\_\_

Name \_\_\_\_\_ School \_\_\_\_\_ Tuition \_\_\_\_\_

Name \_\_\_\_\_ School \_\_\_\_\_ Tuition \_\_\_\_\_

**MEDICAL/DENTAL EXPENSES:**

Total anticipated medical/dental expenses this year not covered by insurance \$ \_\_\_\_\_

**EXPLANATION/SPECIAL CIRCUMSTANCES:** Use this space to explain any unusual expenses or special circumstances (student loans, high debt to income ratio, etc..). You may attaché an additional sheet if necessary.

Please indicate how much you CAN contribute to tuition for your child(ren) \$ \_\_\_\_\_.

**APPLICATIONS THAT ARE NOT COMPLETED OR MISSING INFORMATION WILL NOT BE PROCESSED.** Fees not covered under Financial Aid: Registration/Material fees, BASP, milk/lunch program, yearbook, and elective fees.

**IF I'M APPROVED FOR FINANCIAL AID, I WILL CONTRIBUTE 40 HOURS OF VOLUNTEER TIME. I ALSO AGREE TO HAVE MY MONTHLY TUITION PAYMENTS AUTOMATICALLY DEDUCTED VIA ACH DEBIT.**

PARENT/GUARDIAN SIGNATURE \_\_\_\_\_ Date \_\_\_\_\_

Thank you for completing this application. All information is kept confidential and will only be reviewed by Mrs. Schulte, Father Saji, and the bookkeeper. You may be contacted if clarification is needed.