Child's/Children's Last Name_____

ST. THOMAS ACADEMY

Kindergarten - 8th Grade
New Student
Registration Packet
2023-2024

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 pre-registration.

Placement will be given to those with ***Completed** registration packets, and a $50.00 deposit on or before March 23. The remaining balance ($250.00) is due on or before June 15.

If we do not receive the full registration payment indicated above, your child(ren) will not be considered enrolled for the 2023-2024 school year.

*Many of our classes have waiting lists for 2023-2024.

☐ **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)**

2023-2024 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 2023 - June 2024 (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 2023-2024 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 facebook page 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 Virtue Assemblies.

Family Participation Commitment

2023-2024

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 1st to June 30th 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 1st to June 30th 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

AUTHORIZATION TO ADMINISTER MEDICATION AT SCHOOL

Student Name:_____ Birth Date:_____ Grade:_____

THIS PORTION TO BE COMPLETED BY THE PHYSICIAN/DENTIST

Name of Medication	Dosage	Methods of Administration	Time to be Taken
_____	_____	_____	_____
_____	_____	_____	_____

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_____

FARE Food Allergy Research & Education — FOOD ALLERGY & ANAPHYLAXIS EMERGENCY CARE PLAN

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

LUNG
Short of breath, wheezing, repetitive cough

HEART
Pale, blue, faint, weak pulse, dizzy

THROAT
Tight, hoarse, trouble breathing/ swallowing

MOUTH
Significant swelling of the tongue and/or lips

SKIN
Many hives over body, widespread redness

GUT
Repetitive vomiting, severe diarrhea

OTHER
Feeling something bad is about to happen, anxiety, confusion

OR A COMBINATION of symptoms from different body areas.

1. **INJECT EPINEPHRINE IMMEDIATELY.**
2. **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

NOSE
Itchy/runny nose, sneezing

MOUTH
Itchy mouth

SKIN
A few hives, mild itch

GUT
Mild nausea/ discomfort

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

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

1. Antihistamines may be given, if ordered by a healthcare provider.
2. Stay with the person; alert emergency contacts.
3. 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): _____

_____

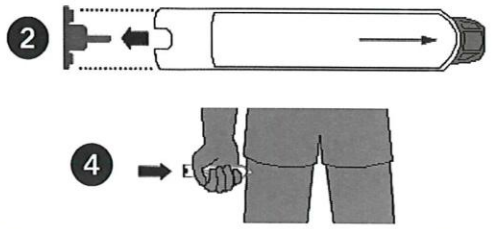
PATIENT OR PARENT/GUARDIAN AUTHORIZATION SIGNATURE DATE PHYSICIAN/HCP AUTHORIZATION SIGNATURE DATE

FORM PROVIDED COURTESY OF FOOD ALLERGY RESEARCH & EDUCATION (FARE) (FOODALLERGY.ORG) 7/2016

FARE Food Allergy Research & Education — FOOD ALLERGY & ANAPHYLAXIS EMERGENCY CARE PLAN

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: _____

FORM PROVIDED COURTESY OF FOOD ALLERGY RESEARCH & EDUCATION (FARE) (FOODALLERGY.ORG) 7/2016

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[2] (Sept-June)
Tuition[1]			
Kindergarten – 5th Grade	□ $6,020.00	□ $6,220.00	□ $622.00
6th – 8th Grade	□ $6,580.00	□ $6,780.00	□ $678.00
Each additional child K-8 Quantity of additional children _____	□ $4,950.00	□ $5,150.00	□ $515.00
Buy Out Options			
Volunteer Hours		□ $500.00	□ $50.00
Scrip		□ $300.00	□ $30.00

For Kindergarten through 8th grade, full tuition is applied for the oldest child.

Price does not include ACH discount. You may fill out the ACH form to have your monthly tuition/fees automatically withdrawn for a total savings of $10.00 per month.

TOTAL TUITION/FEES $_____ □ MONTHLY $_____ or □ ACH PAYMENT $_____

As a school community, St. Thomas Academy continues to thrive and to grow with the continued financial support of all our families. Tuition payments are due by the 15th of each month. Tuition payments must be paid current or written arrangements made with the principal. Arrangements must be made in writing to the principal or a student may be dismissed from school. Under no circumstances will a student with outstanding tuition payments be allowed to re-enter St. Thomas Academy the following year. All Families will be enrolled in our tuition management system called "Smart Tuition" from the Blackbaud company. Before the start of school you will receive a welcome email from Smart Tuition with instructions to set up your secure family portal.

SIGNATURE: _____ DATE: _____

Financial Assistance Application

Please complete this application and return it no later than June 1.

ALL ACCOUNTS MUST BE CURRENT OR AGREEMENTS WITH ADMINISTRATION BEFORE ASSISTANCE WILL BE GRANTED

The following criteria will be used in determining financial assistance:

- Financial need. All applications received will be reviewed. Aid 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 applicant 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.

~over~

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, NOT INCLUDING THE $10 MONTHLY SAVINGS.

PARENT/GUARDIAN SIGNATURE_____ Date_____

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

Must Be Completed Annually

AUTHORIZATION AGREEMENT FOR DIRECT PAYMENTS (ACH DEBITS)

(Savings of $10.00 per month)

Company Name: St. Thomas Academy Company ID Number 52-2387639

I (we) hereby authorize_____, hereinafter called St. Thomas Academy, to initiate debit entries to my (our) Checking Account / Savings Account (select one) indicated below at the depository financial institution named below, hereinafter called First Interstate Bank, and to debit the same to such account. I (we) acknowledge that the origination of ACH transactions to my (our) account must comply with the provisions of U.S. law.

Depository Name: _____ Branch _____

City: _____ State _____ ZIP _____

Routing Number: _____ Account _____

Amount of deduction per month:_____

This authorization is to remain in full force and effect until St. Thomas Academy has received written notification from me (or either of us) of its termination in such time and in such manner as to afford St. Thomas Academy and First Interstate Bank a reasonable opportunity to act on it.

Name(s) _____
(Please Print)

Date: _____ Signature_____

NOTE: ALL WRITTEN DEBIT AUTHORIZATIONS *MUST* PROVIDE THAT THE RECEIVER MAY REVOKE THE AUTHORIZATION ONLY BY NOTIFYING THE ORIGINATOR IN THE MANNER SPECIFIED IN THE AUTHORIZATION. YOUR ACCOUNT WILL BE DEBITED ON THE FIFTH OF EVERY MONTH OR THE FOLLOWING BUSINESS DAY.