ST. THOMAS ACADEMY

Elementary Registration Packet

2019-2020

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 and PAID** registration.

- [ ] **Registration Forms**
- [ ] **Birth Certificate** **(new students only)**
- [ ] **Immunization Records** **(current students, please check their immunization status)**
- [ ] **Confidential Household Income Survey** **(used for Title I funding/qualifying)**
- [ ] **Language Use Survey**

Registration and Tuition

REGISTRATION & INSTRUCTIONAL MATERIALS FEE Includes workbooks, textbooks, classroom materials, and a full zip hooded sweatshirt (4T, YS, YM, YL, YXL)

New Students: 1st child - $500, siblings - $350 **Returning Students** - $300

Registration Fee Total $_____

Non-refundable Registration Fees are Due to guarantee your child's place in a class

LUNCH/SNACK PROGRAM FEE (Optional) **Includes all hot lunches, milk, and snacks for the year**

Preschool – 8TH - $750.00 per child if paid in full or add to your monthly tuition at $80.00/mos. If you opt out, daily hot lunches are available for purchase on a monthly basis via Sycamore at $4.50 per meal. They do not include daily snacks and must be ordered the month prior.

Milk cards for K-8th grade may be purchased in the school office for $10.

TOTAL FEES $_____

Tuition Rates- Full tuition for first child, each additional child is 50% off. Tuition discounts apply to least expensive tuition.

	Pd in full by Aug.1st	Annual	10 Month(Sept.-June)
Kindergarten -5th Grade	$4,550.00	$4,800.00	$480.00
6th, 7th, 8th Grades	$5,250.00	$5,500.00	$550.00
Pre-Kindergarten (must be 4 yrs. by Sept. 1st)			
All Day, M-F	$5,510.00	$5,800.00	$580.00
Pre-School (must be 3yrs. By Sept. 1st)			
All Day, M-F	$6,175.00	$6,500.00	$650.00
All Day MWF	$4,600.00	$4,850.00	$485.00
All Day, T & R	$3,100.00	$3,250.00	$325.00

Volunteer Hour Buy Out Option $375.00 (May be added to monthly tuition payment)

Scrip Buy Out Option $225.00 (May be added to monthly tuition payment)

TOTAL TUITION $ _____ MONTHLY PAYMENT $_____ 10 MOS

Tuition payments are to be kept current. If a family finds themselves in a financial bind, they may contact the Principal or Pastor and make appropriate arrangements.

Signature:_____ Date: _____

2019-2020 Registration Form

Student Information

First: _____ Middle:_____ Last: _____

Gender:_____ Grade:_____ DOB: _____ Shirt Size: 4T, YS, YM, YL, YXL

First: _____ Middle:_____ Last: _____

Gender:_____ Grade:_____ DOB: _____ Shirt Size: 4T, YS, YM, YL, YXL

First: _____ Middle:_____ Last: _____

Gender:_____ Grade:_____ DOB: _____ Shirt Size: 4T, YS, YM, YL, YXL

First: _____ Middle:_____ Last: _____

Gender:_____ Grade:_____ DOB: _____ Shirt Size: 4T, YS, YM, YL, YXL

Family Information

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: _____)

☐ N**on-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 2019 - June 2020 (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 :_____ Phone Number:_____

Emergency Contact :_____ Phone Number:_____

Emergency Contact :_____ Phone Number:_____

LOCAL FIELD TRIP PERMISSION

I/We give permission for our children), _____ to participate in field trips in the local area during the 2019-2020 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.

General Photo Release

☐ I give permission for St. Thomas Academy to use my child's photograph for school-related advertising and publicity on our website. This will not be used for profit, but for promoting the school only.

☐ I give permission for St. Thomas Academy to use my child's photograph for school-related advertising and publicity on our facebook page. This will not be used for profit, but for promoting the school only.

☐ I do not give permission for St. Thomas Academy to use my child's photograph.

Children's Names: _____

Parent/Guardian Signature:_____ Date: _____

Family Participation Commitment

2019-2020

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 on the Academy website and catalogs are available on request. We also have a uniform exchange program available.

Initial: _____

Part II: T.E.A.M. Program

Each **family** must contribute 30 hours of volunteer time to the school. These volunteer hours will be tracked by each family and turned in to the school secretary. 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 done at your home.

Initial: _____

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. If a family chooses not to participate in the Scrip program, you may pay a fee of **$225.00**.

_____ I will participate in the scrip program

_____ I will not participate and will pay the fee of $225.00

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): _____

_____

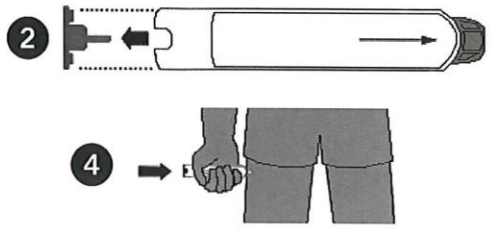
PATIENT OR PARENT/GUARDIAN AUTHORIZATION SIGNATURE DATE PHYSICIAN/HCP AUTHORIZATION SIGNATURE DATE

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

Survey Number: _____
(For School Use Only)

Household Income Survey 2019-2020

Even if your income does not meet these Income Eligibility Guidelines, you must return the survey in order for the school's survey to be valid.

Your Address: _____ **City** _____ **ST** _____ **Zip** _____

1. Circle your household size below, and then answer the following questions:

Household Size (Circle One)	Est. Annual Income (As Reported to IRS)	Monthly Income	If Paid Two times per mo.	If Paid Every Two Weeks	Weekly Income
-1-	22,311	1,860	930	859	430
-2-	30,044	2,504	1,252	1,156	578
-3-	37,777	3,149	1,575	1,453	727
-4-	45,510	3,793	1,897	1,751	876
-5-	53,243	4,437	2,219	2,048	1,024
-6-	60,976	5,082	2,541	2,346	1,173
-7-	68,709	5,726	2,863	2,643	1,322
-8-	76,442	6,371	3,186	2,941	1,471
For each additional family member add	7,733	645	323	298	149

Is your income equal to or less than any of the amounts listed next to the number you circled? ☐ Yes ☐ No

Is your family participating in the Supplemental Nutrition Assistance Program (SNAP) - Oregon Trail Card? ☐ Yes ☐ No

Is your family participating in Temporary Aid to Needy Families (TANF)? ☐ Yes ☐ No

Is your family receiving Food Distribution Program on Indian Reservations (FDPIR)? ☐ Yes ☐ No

Do your students receive migrant, homeless or runaway education services? ☐ Yes ☐ No

2. Please list all students in your household that attend school. (Enter the grade they will be entering in Fall, 2019. Write on back to list more than 5 students)

Name	Grade	School

3. Certification: I certify that the above information is, to the best of my knowledge, true and complete.

Signed:_____ **Date:**_____

OR –Aug 2017

Language Use Survey

The purpose of this survey is to determine if your child's current language exposure and use might make your child eligible to receive support in academic English instruction.

Student Name: _____ Grade Level: _____

School: _____ Date of Birth: _____

1. What language(s) does your child **hear or use** regularly in your household (i.e. spoken, media, music, literature, etc.)? hear_____ use (i.e., American Sign Language (ASL)) _____

2. Describe the language(s) your child **understands**.

   - ☐ No English
   - ☐ Mostly another language and a little English
   - ☐ English and another language equally
   - ☐ Mostly English and a little of another language
   - ☐ Tribal/Heritage/Native Language (i.e. languages spoken by American Indian/Alaska, Native Hawaiians, and citizens of U.S. Territories)
   - ☐ Only English

3. What language(s) do **adults** most frequently **use** when speaking/conversing to your child?

   Parent/Guardian: _____ Parent/Guardian: _____

   Other Adults in the Home: _____ Child-care Providers: _____

4. What language(s) does your **child CURRENTLY speak/express** most frequently ***outside of school***?

   _____

5. Does your child frequently participate in cultural activities that are in a language other than English? Please list the activity and how often your child participates in the activity (for example: once/week, 2 times/week, once a month, etc.).

   _____

6. Is there anything else you think the school should know about your child's language use (i.e., what language did your child speak/express from ages 0-4; did your child have speech classes; did your child attend a bilingual pre-school, etc.)?

   _____

Parent Questions: In what language(s) do you want to receive information from the school (if available)?

Parent/Guardian:

Oral _____ Written _____ American Sign Language_____

Parent/Guardian:

Oral _____ Written _____ American Sign Language_____

Parent or Guardian Signature _____ **Date** _____

What is your relationship to the student? _____ **(i.e., parent, grandparent, etc.)**

ST. THOMAS ACADEMY

REDMOND, OREGON

FOR OFFICE USE ONLY
REGISTRATION FEE PAID ____
DATE RECEIVED _____
F.A. AWARDED _____

Financial Assistance Application

Please complete this application and return it no later than August 1, 2019.

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 _____

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 attach an additional sheet if necessary.

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.

AMOUNT OF ASSISTANCE REQUESTED..... $_____

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.

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) o Checking Account / o 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.