

Trenton Catholic Academy
At McCorristin Campus
Student Financial Registration 2019-2020
Pre-K

Student Name _____ Date of Birth _____

Parent/Guardian Name _____

Street Address _____ City _____ Zip _____

Telephone Numbers _____

Home

Work

Cell

_____ Will attend Trenton Catholic Academy 2019-2020 school year
_____ \$200.00 family registration fee enclosed **NON-REFUNDABLE**

*Referred to TCA by the _____ Family.
This referral qualifies the referring family for a tuition credit.*

Tuition (select one)

_____ Will pay tuition in full by July 1, 2019. This payment may be made by check, cash, or money order.

_____ Will use automatic debit of checking/savings account beginning August 1 or August 15, 2019, by FACTS, with a one-time \$45.00 start-up fee per year. Monthly payments will be as follows (check one).

3 and 4 year old – ½ day

7:50 – 11:00 am

_____ **5 ½ days \$520.00 per month**

3 and 4 year old – alternate schedule

7:50 – 2:20 pm

_____ **3 full days \$570.00 per month**

3 and 4 year old – full day

7:50 – 2:20 pm

_____ **5 full days \$720.00 per month**

Parent/Guardian Signature _____

Date _____

Please return this form, with all enclosures to: Trenton Catholic Academy
177 Leonard Avenue
Hamilton, New Jersey 08610
Attention: Main Office

Extended Care is available. Please request additional information.

AK



TRENTON CATHOLIC ACADEMY

at McCarristin Campus

177 Leonard Avenue ♦ Hamilton, NJ 08610-4899

P: (609) 586-5888 ♦ F: (609) 631-9295 ♦ www.trentoncatholic.org

January, 2019

Dear Parents/Guardians:

Registration time is here, a time to reflect on your child's education. It is our sincere hope that you will choose the educational experience here at Trenton Catholic Academy for your child/children.

The enclosed materials and a \$200 per family non-refundable tuition deposit are due in the school office before March 15, 2019. All **completed** registrations will be processed on a first come, first serve basis.

Through the support of our fundraising efforts and financial assistance from the Diocese of Trenton, we have been able to keep tuition increases to a minimum. The tuition rates for the new school year are listed on the enclosed form. We expect all families to cooperate with our "50-50 Booklet of Chances" drawing by selling \$100 worth. This amount will automatically be added to your tuition if you choose not to participate in this fundraiser.

Trenton Catholic Academy recommends that families needing financial assistance apply to the Diocese of Trenton. All forms are available on the www.trentoncatholic.org website in English and Spanish. Be mindful that all applications for Diocesan financial assistance are strictly confidential.

If you have registration concerns, call Mrs. Reap at 586-5888, extension 141.

May God graciously bless all of our Trenton Catholic Academy families.

Sincerely,

S. Dorothy Payne, S.S.F.
President

EDUCATIONAL SERVICES COMMISSION of NEW JERSEY

TO: Parent/Guardian
FROM: Private School Principal
RE: Nursing Services; Chapter 226 - Laws of 1991

Existing legislation provides certain nursing services and funding for full time students in private schools.

Included in these services, based on available state aid, is maintenance of student health records, hearing assessment, and scoliosis screening.

In addition, your child will receive emergency nursing services for any school related illness or injury.

Please sign the form below and return it to my office as soon as possible.

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NONPUBLIC NURSING SERVICES

I do give my permission

I do **NOT** give permission

for my child _____, in grade _____ to participate
(Please Print Child's Name)
in nursing services.

School District

Name of School

School Address

Signature of Parent/Guardian Date



Federal Funds Letter and Survey

January, 2019

Dear Parents,

Children in our school are entitled to a variety of programs, materials, and services comparable to those provided to public school students through the use of Federal Funds. **In order for our children to benefit from these additional funds, it is very important for us to know how many children attending our school come from these families.** This information is essential to insure our continued participation in the federal programs, such as Title 1, currently serving your children.

I kindly ask that you review the attached Family Survey and simply indicate a "yes" or "no" to questions 1, 2, and 3. **Please sign the Family Survey, indicate your address, and return the form to my office no later than March 14.** All information will be kept confidential.

Thank you for your assistance with this survey.

Sincerely yours,

A handwritten signature in cursive script that reads 'Mrs. Anne Reap'.

Mrs. Anne Reap
Lower School Director

**New Jersey Department of Education
Improving America's Schools Act
LEA Consolidated Formula Subgrant Application
July 1, 2017-June 30, 2018**

Private School Survey
(Title I Only)

Family Survey

1. Find your family size and the annual, monthly or weekly income level listed beside it on the chart below:

Source: Income Eligibility Guidelines

<u>Family Size</u>	<u>Annual</u>	<u>Monthly</u>	<u>Weekly</u>
1	\$22,311	\$1,860	\$430
2	\$30,044	\$2,504	\$578
3	\$37,777	\$3,149	\$727
4	\$45,510	\$3,793	\$876
5	\$53,243	\$4,437	\$1,024
6	\$60,976	\$5,082	\$1,173
7	\$68,709	\$5,726	\$1,322
8	\$76,442	\$6,371	\$1,471
For each additional family member add:	+\$7,733	+\$645	+\$149

Is your family income less than this amount? Yes _____ No _____

2. Are you receiving assistance under the Aid to Families with Dependent Children program? Yes _____ No _____

3. Are any of your children eligible to receive medical assistance under the Medicaid program? Yes _____ No _____

Signature _____

Name (please print) _____

Address _____

**Diocese of Trenton
Permanent Elementary School Record**

School Trenton Catholic Academy
City/Town Hamilton

Last Name _____ First _____ Middle _____ Sex: M F Date of Registration _____

Address _____ ZIP code _____ Telephone _____ Public School District of Residence _____

2. _____

Parent Email _____ Name-Work Telephone _____

Place of Birth (city, state) _____ Date of Birth _____
month day year

Country of Citizenship _____

Religion _____ Registered Parish _____ City/Town _____ Date _____ Grade _____

Admitted from _____ School _____ City, State _____

	Parish	City & State	Date
Baptism			
First Penance			
First Eucharist			
Confirmation			

Withdrawal Record

Date	To	Cause*

**Withdrawal Causes: 1. Illness; 2. Death; 3. Change of Residence; 4. Financial Difficulties; 5. Parent Request; 6. Academics; 7. School Request; 8. Other Reasons*

Re-entry Record

Date	From	Grade

Graduation Date _____ High School Entered _____ City/Town _____

FAMILY BACKGROUND

Name	Address	Occupation	Religion	Date of Death	Education
Father					<input type="checkbox"/> Elem. <input type="checkbox"/> Coll. <input type="checkbox"/> Sec. <input type="checkbox"/> Adv.
Mother <small>(include maiden name)</small>					<input type="checkbox"/> Elem. <input type="checkbox"/> Coll. <input type="checkbox"/> Sec. <input type="checkbox"/> Adv.
Guardian					<input type="checkbox"/> Elem. <input type="checkbox"/> Coll. <input type="checkbox"/> Sec. <input type="checkbox"/> Adv.

Relationship of guardian to student _____

Home situation: Two parents One parent Parents separated or divorced

(Check all that apply) Restructured-mother/stepfather Father remarried Mother remarried

Restructured-stepmother/father Other

Child resides with _____

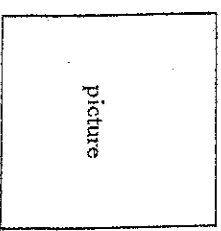
Parental rights (in case of separation; attach court order) _____

Language spoken at home _____ Ethnic background _____

SIBLINGS

Complete Name	Date of Birth

OTHER PERTINENT INFORMATION:



UNIVERSAL CHILD HEALTH RECORD

Endorsed by: American Academy of Pediatrics, New Jersey Chapter
New Jersey Academy of Family Physicians
New Jersey Department of Health

SECTION I - TO BE COMPLETED BY PARENT(S)

Child's Name (Last) _____ (First) _____		Gender <input type="checkbox"/> Male <input type="checkbox"/> Female	Date of Birth ____ / ____ / ____
Does Child Have Health Insurance? <input type="checkbox"/> Yes <input type="checkbox"/> No	If Yes, Name of Child's Health Insurance Carrier _____		
Parent/Guardian Name _____		Home Telephone Number _____	Work Telephone/Cell Phone Number _____
Parent/Guardian Name _____		Home Telephone Number _____	Work Telephone/Cell Phone Number _____
I give my consent for my child's Health Care Provider and Child Care Provider/School Nurse to discuss the information on this form.			
Signature/Date _____		This form may be released to WIC. <input type="checkbox"/> Yes <input type="checkbox"/> No	

SECTION II - TO BE COMPLETED BY HEALTH CARE PROVIDER

Date of Physical Examination: _____	Results of physical examination normal? <input type="checkbox"/> Yes <input type="checkbox"/> No
Abnormalities Noted: 	Weight (must be taken within 30 days for WIC) _____
	Height (must be taken within 30 days for WIC) _____
	Head Circumference (if <2 Years) _____
	Blood Pressure (if ≥3 Years) _____

IMMUNIZATIONS	<input type="checkbox"/> Immunization Record Attached <input type="checkbox"/> Date Next Immunization Due: _____
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MEDICAL CONDITIONS

Chronic Medical Conditions/Related Surgeries • List medical conditions/ongoing surgical concerns:	<input type="checkbox"/> None <input type="checkbox"/> Special Care Plan Attached	Comments _____
Medications/Treatments • List medications/treatments:	<input type="checkbox"/> None <input type="checkbox"/> Special Care Plan Attached	Comments _____
Limitations to Physical Activity • List limitations/special considerations:	<input type="checkbox"/> None <input type="checkbox"/> Special Care Plan Attached	Comments _____
Special Equipment Needs • List items necessary for daily activities	<input type="checkbox"/> None <input type="checkbox"/> Special Care Plan Attached	Comments _____
Allergies/Sensitivities • List allergies:	<input type="checkbox"/> None <input type="checkbox"/> Special Care Plan Attached	Comments _____
Special Diet/Vitamin & Mineral Supplements • List dietary specifications:	<input type="checkbox"/> None <input type="checkbox"/> Special Care Plan Attached	Comments _____
Behavioral Issues/Mental Health Diagnosis • List behavioral/mental health issues/concerns:	<input type="checkbox"/> None <input type="checkbox"/> Special Care Plan Attached	Comments _____
Emergency Plans • List emergency plan that might be needed and the sign/symptoms to watch for:	<input type="checkbox"/> None <input type="checkbox"/> Special Care Plan Attached	Comments _____

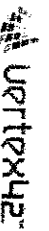
PREVENTIVE HEALTH SCREENINGS

Type Screening	Date Performed	Record Value	Type Screening	Date Performed	Note if Abnormal
Hgb/Hct			Hearing		
Lead: <input type="checkbox"/> Capillary <input type="checkbox"/> Venous			Vision		
TB (mm of induration)			Dental		
Other:			Developmental		
Other:			Scoliosis		

I have examined the above student and reviewed his/her health history. It is my opinion that he/she is medically cleared to participate fully in all child care/school activities, including physical education and competitive contact sports, unless noted above.

Name of Health Care Provider (Print) _____	Health Care Provider Stamp: _____
Signature/Date _____	

Immunization Record



LAST NAME

FIRST NAME

M.I.

BIRTHDATE (mm/dd/yy)

MEDICAL NOTES (allergies, vaccine reactions, etc.)

INSTRUCTIONS

Record the Type (HeptB) and the Date (m/d/yy) for each vaccination given. For combination vaccines (like Hib-HeptB), complete a row under each separate antigen in the combination. Take a copy of your immunization record with you when you visit a healthcare professional. Have them assist you in completing the form. For information about the vaccines and recommended immunization schedules, see the Center for Disease Control and Prevention website at <http://www.cdc.gov/vaccines>

Vaccine	Type	Date Given (m/d/yy)	Administered By (clinic, doctor, etc.)	Next Dose Date
Hepatitis B (3) (HeptB, Hib-HeptB, HepA-HeptB, DTaP-HeptB-IPV)				
Diphtheria, Tetanus, Pertussis (5) (DTaP, DTP, DT, Td, Tdap, DTaP-HeptB-IPV, DTaP-IPV/Hib, DTaP-IPV, DTaP/Hib)				
Haemophilus type b Hib (3) (Hib, Hib-HeptB, DTaP-IPV/Hib, DTaP/Hib)				
Pneumococcal (PCV7, PCV13, PPSV23)				
Polio (4-5) (IPV, OPV, DTaP-HeptB-IPV, DTaP-IPV/Hib, DTaP-IPV)				
Measles, Mumps, & Rubella (MMR, MMRV) (2)				
Varicella (chickenpox) (2) (VAR, MMRV)				

Vaccine	Type	Date Given (m/d/yy)	Administered By (clinic, doctor, etc.)	Next Dose Date
Hepatitis A (2) (HepA, HepA-HeptB) *optional*				
Meningococcal (2) (MCV4, MPSV4)				
Human papillomavirus (3) (HPV4, HPV2) *optional*				
Tdap (1)				
Influenza (Yearly) (IV, LAIV)				
Other				

Lower School Registration Information Sheet

Thank you for your interest in Trenton Catholic Academy. We have instituted this form to help ease you through the registration process. Please feel free to call our Main Office, 586-5888 ext. 141, with any questions. The following items must be received/completed in order to finalize your registration:

PreKindergarten Students:

- Registration Form
- Non Refundable Registration Fee
- Copy of Official Birth Certificate
- Copy of Baptismal Certificate
- Completed Health Form
- Immunization Record (Immunizations must be up to date)

Final Acceptance is issued for incoming Pre-Kindergarten students following submission of above.

Students Entering Kindergarten through 8th Grade:

- Registration Form
- Non Refundable Registration Fee
- Copy of Official Birth Certificate
- Copy of Baptismal Certificate
- Completed Health Form
- Immunization Record (Immunizations must be up to date)

Plus:

- Student Interview with the Lower School Director
- Report Cards from past two years
- Standardized Test results from the past two years
- Discipline Report from sending school
- Copy of latest Child Study report if applicable

Final Acceptance is issued for incoming K through 8th grade students following submission of above, review of report cards, standardized testing and Director interview.