

PRESCHOOL Application for Enrollment

Saint Gabriel School
 1 Tudor Road, Milford, CT 06460
 (203) 874-3811 / (203) 874-0416 (FAX)

Family Last Name: _____ **New Family** _____ **Returning Family** _____

PRESCHOOL PROGRAM CHOICE: Please Check

Three Year Olds: _____ **Tuesday/Thursday** _____ **Four/Five Year Olds:** _____ **Mon/Wed/Fri** _____
 8:15 a.m. – 11:15 a.m. 8:15 a.m. – 2:45 p.m.

Four Year Olds: _____ **Mon/Wed/Fri** _____ **Four/Five Year Olds:** _____ **Monday – Friday** _____
 8:15 a.m. – 11:15 a.m. 8:15 a.m. – 2:45 p.m.

Family Religious Affiliation: _____ **Parish/Church** _____ **Envelope #** _____

Parental Marital Status: ___ Married ___ Separated ___ Divorced ___ Remarried ___ Single ___ Widowed ___ Other

Students Live With: ___ Both Parents ___ Mother ___ Father ___ Mother/Step ___ Father/Step ___ Grandparents ___ Other

Address at which student lives: _____ **Home Phone** _____
 (Street) City/State/Zip

	Mother's Information	Father's Information	Guardian Information
Parent Name			
Mother's Maiden Name			
Address (if different from child)			
City/State/Zip			
Home Phone			
Work Phone			
Occupation			
Work Place			
Cell Phone			
E-MAIL ADDRESS			
Primary Language At Home			

STUDENT INFORMATION School Year: 20__ - 20__ New Student ___ Current Student___

Last Name: _____ **First name:** _____ **MI** _____ **Preferred Name** _____

Date of Birth: _____ **City and State of Birth :** _____

Gender _____ **What Public School would Your Child Attend:** _____

Ethnic Origin: Amer. Indian ___ Asian ___ Black ___ Caucasian ___ Hispanic ___ Multi-Racial___

Is Your Child Eligible To Ride The Bus? _____ **Who Referred You To Our School?** _____

Please list any relatives attending our school: _____

Sacraments Received:

	Date	Church	City/State/Zip	Certificate
Baptism				
First Confession				
First Communion				
Confirmation				

Payment and Documents Received:

	Date Rec'd		Date Rec'd
Application/Testing Fee \$25.00		Birth Certificate	
Tuition Deposit \$ 200.00 (per child)		Baptismal Certificate	
Tuition Contracts		Release of Records Form	
		Health Form	

PARISH VERIFICATION FORM

Please check off the tuition plan that you are applying for.

Members of Saint Gabriel Parish should return this form to the school office. We will send all parishioner forms to the rectory at one time. **DO NOT BRING IT TO CHURCH OR THE RECTORY.**

Members of all other parishes should get the form signed by their pastor before submitting it to the office.

Family Name: _____
Address: _____
City/State/Zip: _____
Phone #: _____

_____ We are registered at Saint Gabriel Parish (Plan A)
Envelope # _____

_____ We are registered at another Catholic Parish (Plan A).
Name of Parish: _____

_____ We are Catholic but are not affiliated with a
Parish. (Plan B)

_____ We are not Catholic. The church that we attend
is _____ (Plan B)

_____ We are not Catholic and are not affiliated with a church
(Plan B)

Signature of Parent / Guardian: _____

Date: _____

**I certify that the above named family is registered at my parish,
attends Mass consistently and regularly contributes to the parish.**

Name of Parish: _____

Signature of Pastor: _____

(or his designate)

SAINT GABRIEL SCHOOL

TUITION & FUNDRAISING CONTRACT

FAMILY NAME: _____

Parent/Guardian Name: _____

Address: _____

Home Phone: _____ Cell Phone #: _____

City/State/Zip: _____

Work Phone: _____ E-Mail: _____

In consideration for the enrollment of my child/children as student(s) in Saint Gabriel School ("the school"), I hereby agree to pay to the school the tuition and fundraising fees as outlined on the Tuition and Fundraising schedule and in the manner set forth in this Tuition and Fundraising Agreement. **PLEASE FILL OUT ALL SECTIONS COMPLETELY AND BE SURE TO SIGN THIS AGREEMENT.**

TUITION PLAN: ___ A – St. Gabriel Parishioner ___ A – Other Catholic Parish (specify: _____)

Please do not choose Plan A unless you are a Catholic who is registered at a parish, attends Mass regularly and contributes to the parish.

___ B - Non Catholic ___ B –Catholic Not Registered At A Parish

I choose ___ **OPTION 1: Full Payment** or ___ **OPTION 2: FACTS TUITION MANAGEMENT**

Total Tuition Due For Family: _____ Less Deposit of _____ Book Fee Amount: _____ Monthly Payment : _____

Student Name _____ Grade _____ Student Name _____ Grade _____

Option 1: Full Payment

The entire tuition is paid in full in accordance with the attached Tuition and Fundraising Policies as outlined in the school handbook. This payment is due on or before May 1. Please note: If you choose Option 1 and payment is not received by the due date then monthly payments will have to be set up through the FACTS plan. **NO MONTHLY PAYMENTS CAN BE ACCEPTED IN THE OFFICE.**

Option 2: FACTS Tuition Management Program

Payments will be made according to guidelines and regulations set forth by FACTS and the Tuition and Fundraising Policies of Saint Gabriel School. Payment is budgeted over 10 months from May – Feb. Payments must be deducted from a checking or savings account.

If you choose Option 2 please complete the FACTS Automatic Tuition Payment Agreement form. Please return this form immediately so that you can have the full 10 months to make payments. If you used FACTS last year, the bank information is already on the renewal form. If this information has changed, please be sure to make the corrections. Fill in all tuition information and be sure to sign the agreement. Note : The signature on the form must match the name on the bank account.

In all of the above options it is understood that each family has a fundraising obligation to the school. The fundraising obligation will be as follows: Kindergarten – Grade 8 - 500 points. Each family will receive 5 points for each hour worked at an event (including Bingo). Families will also receive 1 point for every dollar raised in fundraisers such as the Fall Brochure. (This is the dollar amount of the profit – not gross sales). **THIS 500 POINTS MUST INCLUDE AT LEAST 5 NIGHTS WORKED AT BINGO.** Families who choose not to work at Bingo have the option of paying an additional \$ 1,350.00 in tuition. Such fundraising obligations may be fulfilled through participation in our fundraisers or direct payment (of \$1.00 per point not worked off) to the school. In all cases, this obligation must be fulfilled by **May 15** in accordance with the Tuition and Fundraising policies of the school. In addition, if my parish does not indicate (by signing the parish verification form) that I meet the requirements as established (registered Catholic, attending Mass on a regular basis and contributing to my parish), I am responsible for the \$250.00 difference which will be charged to my account on **March 1.**

Unconditional Obligation

I realize that the overhead expenses of the school do not diminish with the departure of any student during the course of the year and that my obligation to pay all fees for the full academic year is unconditional after return of this signed agreement by Saint Gabriel School. Registration fees, deposits and all fundraising monies are non-refundable. If a child leaves the school during the year, the tuition is prorated on a daily basis (based on a 180 school year). The number of days enrolled times the daily rate is the tuition owed the school at the time of withdrawal. Any refunds will be based on that formula. I also understand that late charges on unpaid balances will be incurred and that in the event of collection by any attorney or other agency, I accept responsibility for, and agree to pay, all additional charges, including a reasonable attorney's fee.

The **deposit is \$ 200.00 per child (All Grades).** The **Book Fee is \$ 100.00 per child (K-8).** The **Supply Fee for Preschool is \$ 30.00 per child.** Deposits and Book or Supply Fees are payable directly to the school office and **must accompany this form.** This form and the deposits/fees **must be received in the school office by March 10** in order for us to have the account set up to begin in May. (Grades K-8 totals \$ 300.00 per child and Preschool totals \$ 230.00 per child). If your child will be graduating in June, a \$ 150.00 Graduation Fee is also due at registration in March. **On April 1, all slots not secured by a deposit and signed agreement will be opened to those on our waiting list.**

I HAVE READ THE TUITION POLICY AND CONTRACT AND AGREE TO ALL OF ITS CONTENTS:

DATE: _____ PARENT/GUARDIAN SIGNATURE: _____

DATE: _____ PARENT/GUARDIAN SIGNATURE: _____



State of Connecticut Department of Education Health Assessment Record



To Parent or Guardian:

In order to provide the best educational experience, school personnel must understand your child's health needs. This form requests information from you (Part I) which will also be helpful to the health care provider when he or she completes the medical evaluation (Part II).

State law requires complete primary immunizations and a health assessment by a legally qualified practitioner of medicine, an advanced practice registered nurse or registered nurse, a physician assistant or the school medical advisor prior to school entrance in Connecticut (C.G.S. Secs. 10-204a and 10-206). An immunization update and additional health assessments are required in the 6th or 7th grade and in the 10th or 11th grade. Specific grade level will be determined by the local board of education.

Please print

Name of Student (Last, First, Middle)		Social Security Number	Birth Date	Sex
Address (Street)		Race/Ethnicity		
(Town and ZIP code)		<input type="checkbox"/> American Indian	<input type="checkbox"/> White, not of Hispanic origin	
		<input type="checkbox"/> Asian	<input type="checkbox"/> Hispanic/Latino	
		<input type="checkbox"/> Black, not of Hispanic origin	<input type="checkbox"/> Other	
Home Telephone Number	School	Grade		
Name of Parent/Guardian (Last, First, Middle)				
Health Care Provider		Health Insurance Company/Number* or Medicaid/Number*		

* If applicable

If your child does not have health insurance, call 1-877-CT-HUSKY

Part I — To be completed by parent

**Important: Complete Part I before your child is examined.
Take this form with you to the health care provider's office.**

Please check answers to the following questions in columns on the left.
(Explain all "yes" answers in the space provided below.)

- | | Yes | No | |
|-----|--------------------------|--------------------------|---|
| 1. | <input type="checkbox"/> | <input type="checkbox"/> | Do you have any concerns about your child's general health (overall eating and sleeping habits, teeth, etc.)? |
| 2. | <input type="checkbox"/> | <input type="checkbox"/> | Has your child been diagnosed with any chronic disease <input type="checkbox"/> asthma <input type="checkbox"/> diabetes <input type="checkbox"/> seizure disorder <input type="checkbox"/> other _____ |
| 3. | <input type="checkbox"/> | <input type="checkbox"/> | Does your child have any allergies (food, insects, medication, latex, etc.)? |
| 4. | <input type="checkbox"/> | <input type="checkbox"/> | Does your child take any medications (daily or occasionally)? |
| 5. | <input type="checkbox"/> | <input type="checkbox"/> | Does your child have any problems with vision, hearing or speech (glasses, contacts, ear tubes, hearing aids)? |
| 6. | <input type="checkbox"/> | <input type="checkbox"/> | Has your child had any hospitalization, operation, major illness or injury, or significant accident? (Please specify.) |
| 7. | <input type="checkbox"/> | <input type="checkbox"/> | In the last 12 months, has your child experienced any difficulty with wheezing, excessive coughing or excessive night waking? (Please specify.) |
| 8. | <input type="checkbox"/> | <input type="checkbox"/> | In the last 12 months, has your child experienced any difficulty with excessive weight loss or weight gain, or excessive thirst or urination? (Please specify.) |
| 9. | <input type="checkbox"/> | <input type="checkbox"/> | Does your child have health insurance? (If your child does not have health insurance, call 1-877-CT-HUSKY) |
| 10. | <input type="checkbox"/> | <input type="checkbox"/> | Does your child have dental insurance? |
| 11. | <input type="checkbox"/> | <input type="checkbox"/> | Would you like to discuss anything about your child's health with the school nurse? |

Please explain any "yes" answers here. For illnesses/injuries/etc., include the year and/or your child's age at the time.

I give permission for release of information on this form for confidential use in meeting my child's health and educational needs in school.

Signature of Parent/Guardian	Date
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To the Health Care Provider: Please complete and sign.

_____ has had a complete history and physical exam on _____
 Student's Name Birth Date Month/Day/Year

Findings for this student are as follows:

Screening/Test Results			Immunization Record					
Note: * Mandated Screening/Test under Connecticut State Law			Vaccine (Month/Day/Year) Note: * Minimum requirements prior to school enrollment. At subsequent exams, note booster shots only.					
* Height:		BMI:	Dose 1	Dose 2	Dose 3	Dose 4	Dose 5	Dose 6
* Weight:		* Postural:	DTP	*	*	*	*	
* Blood Pressure:		<input type="checkbox"/> Normal	DTP/Hib					
Pulse:		<input type="checkbox"/> Abnormal	DTaP					
* HCT/HGB:		Min. _____	DT/Td					
Urinalysis:		Slight _____	OPV	*	*	*		
* Gross dental:		Mod. _____	IPV	*	*	*		
Lead (Date/Result)		Marked _____	MMR					
TB and Other Test Results (Sickle Cell, etc.)			Measles	*	*		Booster for entry into K and 7th grade	
			Mumps	*				
TB: In high-risk group? <input type="checkbox"/> Yes <input type="checkbox"/> No			Rubella	*				
Test	Date	Results	HIB	*			Students under age 5	
			Hep B	*	*	*	Req. for entry into K and 7th grade.	
* Vision/ Type of Screening		* Auditory/ Type of Screening		Varicella	*		Students born 1/1/97 or later. Required for 7th grade entry.	
With glasses	R L 20/ 20/	Pass/Fail R	PCV				Pneumococcal conjugate vaccine	
Without glasses	R L 20/ 20/	L	Other Vaccines (Specify)					
* Chronic Disease Assessment:			Disease Hx of above _____ (Specify) _____ (Date) _____ (Confirmed by)					
Yes No								
<input type="checkbox"/> Asthma: <input type="checkbox"/> mild <input type="checkbox"/> moderate <input type="checkbox"/> severe			Exemption					
<input type="checkbox"/> exercise induced <input type="checkbox"/> unclassified								
<input type="checkbox"/> Diabetes: <input type="checkbox"/> Type I <input type="checkbox"/> Type II			Religious _____ Medical: Permanent _____ Temporary _____ Date _____					
<input type="checkbox"/> Anaphylactic Reaction: <input type="checkbox"/> food <input type="checkbox"/> insect <input type="checkbox"/> latex			Recertify Date _____ Recertify Date _____ Recertify Date _____					
<input type="checkbox"/> Seizure Disorder								
<input type="checkbox"/> Other: Please specify _____								

This student has the following problems which may adversely affect his or her educational experience:

- Vision Auditory Speech/Language Physical Dysfunction Emotional/Social Behavior
- The pupil has a health condition which may require emergency action at school, e.g., seizures, allergies, anaphylaxis. *Specify below.*
- The pupil is on long-term medication. *Specify below.*

Comments and recommendations (additional information about any of the above health assessment): _____

- This student may participate fully in the school program, including physical education activities.
- This student may participate in the school program and physical education with the following restriction/adaptation. *(Specify reason and restriction.)* _____

- Yes No Based on this comprehensive health history and physical examination, this student has maintained his/her level of wellness.
- I would like to discuss information in this report with the school nurse.

Signature of health care provider	Name/Group Practice (Please type or print.)	Phone Number
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