# Sacred Heart School

208 South Market Street - Hudson, MI 49247 - 517-448-6405
www.sacredhearthudson.org

## PRE-SCHOOL REGISTRATION
## 2015-2016

Full Name of Child _____ Age (as of December 1) _____

Address _____ City, State, Zip _____

Date of Birth _____ Place of Birth _____ Phone _____

Father's Name _____ Age _____ State of Birth _____

Father's Address (if different from child) _____

Father's E-mail _____ Father's Cell Phone _____

Father's Employer _____ Father's Work Number _____

Mother's Name _____ Age _____ State of Birth _____

Mother's Address (if different from child) _____

Mother's E-mail _____ Mother's Cell Phone _____

Mother's Employer _____ Mother's Work Number _____

Educational Status: Father _____ Mother _____

Guardian's Name (if other than parent) _____ Allergies _____

Emergency Contact #1 Name & Phone: _____

Emergency Contact #2 Name & Phone: _____

Other children in the family

Name _____ Date of Birth _____ Grade _____
Name _____ Date of Birth _____ Grade _____
Name _____ Date of Birth _____ Grade _____

Are you a registered member of Sacred Heart Parish or any other Catholic Parish? _____ Yes _____ No

Will you use Public School Transportation? _____ Yes _____ No
Please contact the Transportation Department at Hudson Area Schools (448-8912) at least two weeks prior to the start of school. Directions to home: _____

REGISTRATION FEE – $50 per student – must be paid at time of registration.
Please return registration ASAP, as placement is based on a first-come first-serve basis.

Parent Signature _____ Date _____

# Tuition Agreement 2015-2016

**Sacred Heart Pre-School**
**208 South Market Street**
**Hudson, MI 49274**
**517-448-6405**

| | | | |
|---|---|---|---|
| Parent's Last Name: | | First Name: | |
| Street Address: | City: | State: | Zip Code: |
| Home Phone: | Alternate Phone: | | Email: |
| Person responsible for account: | | | |
| Address if different from above: | | | |
| Name of Students: | | | |
| 1. | 2. | | |
| 3. | 4. | | |

**Pre-School Tuition Rates**

**Pre-School tuition rates are as follows:**

$10.50 per day for ½ day (3 hours) of Pre-School
$21.00 per day for full day (7 ¼ hours) of Pre-School.

| | Rate per Week | Rate per month Based on 11 month payment plan | Rate per month Based on 9 month payment plan | Rate per Year |
|---|---|---|---|---|
| Two ½ days per week | $21.00 | $68.73 | $84.00 | $756.00 |
| *Two full days per week* | *$42.00* | $137.46 | $168.00 | *$1,512.00* |
| Three ½ days per week | $31.50 | $103.09 | $126.00 | $1,134.00 |
| *Three full days per week* | *$63.00* | $206.19 | $252.00 | *$2,268.00* |
| Four ½ days per week | $42.00 | $137.46 | $168.00 | $1,512.00 |
| *Four full days per week* | *$84.00* | $274.91 | $336.00 | *$3,024.00* |
| Five ½ days per week | $52.50 | $171.82 | $210.00 | $1,890.00 |
| *Five full days per week* | *$105.00* | $343.64 | $420.00 | *$3,780.00* |

Half Day & Full Day combinations are also available – please contact the school office.

- The 11 month payment plan begins July 1, 2015 and continues through May 2016.
  The 9 month payment plan begins September 1, 2015 and continues through May 2016.
  Payments are due by the 15th of each month. MasterCard and Visa are welcome.
- A registration fee of $70.00 is payable upon registration.
- All outstanding tuition must be paid in full to be able to register for the next year.
- A $25.00 fee will be assessed for any check returned for insufficient funds.

**Date:** _____ **Signature:** _____ **Approved:** _____

# SACRED HEART PRE-SCHOOL ADMISSION POLICY

The following admission policy was adopted by Sacred Heart Education Commission on March 22, 2010.

Sacred Heart Pre-Kindergarten is open to any child who will be three years of age by December 1st of the school year for which they are enrolling, regardless of race, color or creed. The child must be toilet trained and be able to communicate with others.

Further, and above this, the policy adopted by the Education Commission reads that admission will be subject to the following:

1. Priority will be given in the following order:
    a. Children of parents who are parishioners of Sacred Heart Church or any other parent that has other children attending Sacred Heart School
    b. Children of other parishioners
    c. Children of other Catholic parents
    d. A child of other parents who choose to register

2. All tuition and fees need to be current and registration and book fees need to be paid at the time of registration. Regular monthly tuition payments will begin in July and all payments are non-refundable.

3. Attendance to the Pre-School does not automatically qualify your child for admittance to our Kindergarten.

The above priority list will only apply for two weeks after the start of registration. Any late registrations will be place upon a waiting list and will receive a telephone call if a position is available for your child.

You will be notified of your child's admission into our Pre-School program on or before May 1st.

A copy of your child's birth certificate, a completed health history and a physical examination are required. Both sides of the green health appraisal must be filled on completely by August 20.

Revised 11/22/04

# SACRED HEART SCHOOL
# HEALTH HISTORY

Family Doctor _____ Phone _____

Address _____

Does your child have any previous school experience? _____ yes _____ no

_____

School Address Year attended

Is English the main language used in your home? _____ yes _____ no Other _____

Date of last eye exam _____ Date of last dental exam _____ Date of last medical exam _____

Does your child wear glasses? _____ Date lenses were last changed _____

Does your child have any allergies? _____

Is your child on any medication? _____ If so, what medication and reason _____

How often is the medication taken? _____

Does your child have any activity restrictions? _____ If yes, please explain _____

Does your child have any special physical or emotional problems? (vision, hearing, epilepsy, bone problems, birth defects, etc.) _____

Nature of handicap _____

Unusual physical characteristics _____

Unusual food habits _____

Birth weight _____ Was your child full term? _____

Mother's health problems during pregnancy _____

Please check all diseases child has had:

| Disease | Age | Disease | Age | Disease | Age |
|---|---|---|---|---|---|
| Measles | _____ | Polio | _____ | Rheumatic Fever | _____ |
| Mumps | _____ | Tonsillitis | _____ | Heart Disease | _____ |
| Chicken Pox | _____ | Enlarge Lymph Gl | _____ | Diabetes | _____ |
| German Measles | _____ | Pleurisy | _____ | Epilepsy | _____ |
| Whooping Cough | _____ | Pneumonia | _____ | Bone/Joint Disease | _____ |
| Scarlet Fever | _____ | Hay Fever | _____ | Ear Infection | _____ |
| Diphtheria | _____ | Bronchitis | _____ | Mastoiditis | _____ |
| Smallpox | _____ | Asthma | _____ | Appendicitis | _____ |
| Typhoid Fever | _____ | Eczema | _____ | Convulsions | _____ |
| Meningitis | _____ | Allergies | _____ | | |

Explain _____ Explain _____ Explain _____

In case my child becomes ill at school or in case of an accident, please take my child to our family doctor or to any available doctor in an emergency.

Parent Signature _____ Date _____

# State of Michigan - Department of Social Services

| **Sacred Heart Pre-Kindergarten**<br>**209 South Market Street, Hudson, Michigan 49247** | | Date of Registration |
|---|---|---|
| Name of Child (Last, First, Middle Initial) | Birth Date | Date of Discharge |
| Name of Parents | Home Address | Home Phone Number |
| Name of Mother's Employer | | Hours of Employment |
| Employer's Address | | Business Phone Number |
| Name of Father's Employer | | Hours of Employment |
| Employer's Address | | Business Phone Number |

PERSON OTHER THAN PARENT TO BE NOTIFIED IN
EMERGENCY SITUATION WHEN PARENT IS NOT AVAILABLE

| Name | Home Address | Phone Number |
|---|---|---|
| | | |

NAMES OF PERSONS OTHER THAN PARENTS TO WHOM CHILD MAY BE RELEASED

| | |
|---|---|
| 1.) | 3.) |
| 2.) | 4.) |

I hereby give permission to Sacred Heart Pre-Kindergarten, licensed by the Department of Social Services to secure emergency medical and/or emergency surgical treatment for the above named minor child while in their care.

Non-emergency medical treatment or elective surgery is not included in this authorization.

Date _____ Signature of Parent or Guardian _____

| Physician Preferred for Emergency Treatment | City | Phone Number | Office Hours |
|---|---|---|---|
| | | | |

| Hospital Preferred for Emergency Treatment | Health Insurance Identification Information |
|---|---|
| | (Company Name - Group # - Contract or ID#) |

MICHIGAN DEPARTMENT OF COMMUNITY HEALTH

County _____ Screening Location _____ MEDICAID: Y N Number: _____

## KINDERGARTEN ENTRY/PRESCHOOL HEARING AND VISION SCREENING RECORD

CHILD'S NAME _____ Male Female DOB _____ AGE _____

Name Used _____ School Attending _____

PARENT/GUARDIAN'S NAME _____ Telephone _____ H/W/C

Address _____ City _____ Zip _____

### BRIEF HISTORY

HEARING

1. Has your child been seen by a doctor for any ear problems? Y N
   Date of Exam _____ Doctor _____
2. Is your child on any cold or allergy medications? Y N
3. As a parent, do you have any concerns regarding your child's hearing? Y N

VISION

1. Has your child ever been examined by an eye doctor? Y N
   Date of Exam _____ Doctor _____
2. Has your child ever confused colors? Y N
3. When your child is ill or tired, do the eyes appear crossed or does one eye wander when looking at an object? Y N

DO NOT WRITE BELOW THIS LINE

HEARING SCREENING

| | | |
|---|---|---|
| Screening | Pass | Fail |
| Threshold | Pass | Fail |
| Audiogram | | |

RESULTS
- ☐ Pass
- ☐ Refer
- ☐ Under Care
- ☐ Retest

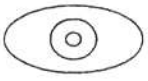
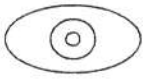
VISION SCREENING

1. Visual Acuity/2-Line Difference

| | 20/40 | 20/25 |
|---|---|---|
| Both eyes | 0 1 2 3 4 5 6 | |
| Right eye | 0 1 2 3 4 5 6 | 0 1 2 3 4 5 6 |
| Left eye | 0 1 2 3 4 5 6 | 0 1 2 3 4 5 6 |

2. Cover/Uncover Test:

| | Near | | Far | |
|---|---|---|---|---|
| Right eye movement | Pass | Fail | Pass | Fail |
| Left eye movement | Pass | Fail | Pass | Fail |

3. Corneal Reflection L  R  Pass Fail

4. Eye History Pass Fail

5. Symptom(s): _____ Pass Fail

RESULTS
- ☐ Pass
- ☐ Refer
  - ☐ 2-Line
  - ☐ 20/50
- ☐ Symptom
- ☐ Fail; no refer
- ☐ Under Care
- ☐ Permanent difficulty
- ☐ Retest

ATTENTION PARENT(S): Your child was given the health department hearing and vision screening tests:

Hearing
- ☐ Passed
- ☐ Failed (an examination by your local health department or your doctor is required)

Vision
- ☐ Passed
- ☐ Failed (an eye examination by an ophthalmologist or optometrist is required)

Please present this certificate when enrolling your child in school for the first time (Michigan Public Health Code; Act 368 or 1978). Retain this statement with other health records of your child.

Child's Name Date of Screening Qualified Hearing/Vision Technician

Health Department

DCH-0479 (1/2010)