Admissions Application

Sacred Heart
Early Learning Center

Admissions Office
615 McDade Street
Conroe, Texas 77301

Tel: 936-521-3004
Fax: 936-756-4097

www.sacredheartearlylearningcenter.com

Sacred Heart Early Learning Center
615 McDade Street
Conroe, TX 77301

Admissions Office
Date Received _____
Date Started _____
ELC Grade Level _____

I. APPLICANT INFORMATION

_____

First Name | Middle Name | Last Name | Preferred Name

_____

Street Address | City | State | Zip Code

_____

Home Phone # | Applicant Social Security # | Date of Birth

_____ Male _____Female

_____
Country of Citizenship

_____

Name of Current School | School Phone #

_____

School(s) Previously Attended

II. FAMILY INFORMATION: ____CATHOLIC _____ SACRED HEART PARISHIONERS_____ NON-CATHOLIC

AFFLIATED PARISH: _____ **RELIGIOUS AFFLIATION**: _____

Parent/Guardian

_____

First Name Last Name

_____

Home Address (if different from above)

_____

City State Zip

_____

Home Phone # Cell Phone #

_____

E-mail address

_____

Place of Employment & Position

_____

Work Phone #

_____

If divorced and remarried, spouse's full name

Parent/Guardian

_____

First Name Last Name

_____

Home Address (if different from above)

_____

City State Zip

_____

Home Phone # Cell Phone #

_____

E-mail address

_____

Place of Employment & Position

_____

Work Phone #

_____

If divorced and remarried, spouse's full name

Name of parent/guardian with whom the applicant resides: _____

Who is financially responsible for the applicant's tuition? _____

Names of any relatives who attend (have attended) Sacred Heart:

Name	Relation
_____	_____
_____	_____
_____	_____

III. FAMILY PARTICIPATION

As a school community, Sacred Heart Early Learning Center would like to keep your child's immediate family members, grandparents, and friends informed with our newsletter and various function invitations. Please provide the following information:

Siblings:

Name_____Age_____School_____

Name_____Age_____School_____

Name_____Age_____School_____

Paternal Grandparents

Name_____

Address_____ City_____ State_____ Zip_____

Telephone (_____)_____Email_____

Maternal Grandparents

Name_____

Address_____ City_____ State_____ Zip_____

Telephone (_____)_____Email_____

IV. IDENTIFIED SPECIAL NEEDS OF APPLICANT: Name: _____

Parents are expected to disclose to appropriate school personnel any significant information which may affect their child's education progress or the other students' learning environment. Such information includes but is not limited to academic or medical diagnostic evaluations, medications, or specific family situations. Failure to disclose such significant information during the application process or as the situation changes may result in dismissal of the child.

Applicant has: (Check one that applies)

_____Physical handicap, medical condition, special current or recurrent illness of which school should be informed. Please describe:

_____Diagnosed learning disability: (Diagnosed by & date): _____

Copies of testing results must be submitted.

_____Attention Deficit/Hyperactivity Disorder: (Diagnosed by & date): _____

Description: include types and dosages of medication if applicable and intervention strategies currently being implemented.

Has this applicant ever been tested or counseled by a psychologist or psychiatrist? Yes____ No____ Date: _____
All results of educational/psychological evaluations must be submitted with this application.

Socialization or behavioral problems? Yes____ No____ Date: _____
If yes, please explain. Please provide any other information, regarding the child's educational background or social development that the school should know in order to evaluate its ability to serve the child's needs.

V. PARENTS' GOALS AND ASSESSMENTS

In order for the admissions (Director) to evaluate your child and his/her needs in regard to the programs offered, please answer the following questions. *You may attach an additional page.*

Reason for wishing to enroll student at Sacred Heart Early Learning Center:

Type of Educational Program and Environment Sought for Your Child

Realizing that there are many variables involved in the educational process, please explain the type of educational program/ environment that you desire for your child. What objectives would you like for the teacher to emphasize regarding your child?

Specific Interests

Please provide us with your perspective on your child. Describe your child's strengths and abilities, special areas of interest and/or concerns.

Additional Information

Please provide any additional information regarding your family (adoption, divorce, separation, changes in school, deaths of relatives/friends) or child (fears, social problems, etc.) that would help us know and understand his/her educational or personal needs.

VI. ADDITIONAL INFORMATION

How did you learn about Sacred Heart Early Learning Center?

Have you previously applied to Sacred Heart Early Center and if so when?

For reporting purposes only, please describe your child's racial/ethnic heritage:

_____Caucasian _____Asian _____American European _____American Latino _____Hispanic American

_____Native American _____Middle Eastern American _____African American Other

VII. FEE AND SIGNATURE

Please send completed form with non-refundable application fee of $35 (make check payable to: Sacred Heart ELC and include the applicant's name on the memo line) to: Sacred Heart ELC - 615 McDade Street, Conroe, TX 77301

I give Sacred Heart Early Learning Center permission to contact applicant's current school for additional information if necessary.

Signature of Parent Guardian_____Date_____

STATEMENT OF ACCURACY AND AUTHENTICITY

I have read and understood this application, and I further certify that the information and attached documents are complete and accurate to the best of my knowledge. I agree to communicate in writing to the director any changes contained herein even if said changes occur after enrollment. I understand that upon discovery of substantial inaccuracy of any information herein, or omission of information requested herein, the school reserves the right to revoke admission of this applicant.

_____

Signature of Parent/Guardian Date

_____

Signature of Parent/Guardian Date

Sacred Heart Early Learning Center admits students of any race, color, national and ethnic origin to all the rights, privileges, programs and activities generally accorded or made available to students at the school. It does not discriminate on the basis of race, color, national and ethnic origin in administration of its educational policies, admission policies, and other school administered programs.

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Early Learning Center

ELC Program Choice

Name: _____**Date of Birth:**_____

Class Registration/Monthly tuition. Class placement for the Two's Class is based on age of child as of September 1st. Enrollment and acceptance is subject to change based on availability. Please check appropriate box for ELC program choice.

6 Weeks to 17 months Infant Class

	2 Day Program Tues/Thur	7:45 am-3:00 pm	$476.00
	2 Day Program Tues/Thur	7:00 am -6:00 pm	$496.00
	3 Day program M/W/F	7:45 am –3:00 pm	$575.30
	3 Day program M/W/F	7:00 am –6:00 pm	$601.30
	5 Day program M-F	7:45 am- 3:00 pm	$825.00
	5 Day program M-F	7:00 am -6:00 pm	$860.00

18 months to 23 months Toddler Class

	2 Day Program Tues/Thur	7:45 am-3:00 pm	$434.00
	2 Day Program Tues/Thur	7:00 am-6:00 pm	$454.00
	3 Day Program M/W/F	7:45 am- 3:00 pm	$575.30
	3 Day Program M/W/F	7:00 am- 6:00 pm	$596.30
	5 Day Program M-F	7:45 am- 3:00 pm	$635.30
	5 Day Program M-F	7:00 am –6:00 pm	$665.30

24 months + Two's Class

	2 Day Program Tues/Thur	7:45 am-3:00 pm	$434.00
	2 Day Program Tues/Thur	7:00 am-6:00 pm	$454.00
	3 Day Program M/W/F	7:45 am- 3:00 pm	$575.30
	3 Day Program M/W/F	7:00 am- 6:00 pm	$596.30
	5 Day Program M-F	7:45 am- 3:00 pm	$635.30
	5 Day Program M-F	7:00 am –6:00 pm	$665.30

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Early Learning Center

SACRED HEART EARLY LEARNING CENTER STUDENT EMERGENCY FORM

_____ ___/___/___ _____ _____ _____
(Student Last Name) (First) (MI) (Date of Birth) (Age) (Sex) (Grade)

Child resides with: _____ Mother & Father _____ Mother _____ Father _____ Other (Relationship) _____

Father/Guardian Name: _____ Mother/Guardian Name: _____

Address: _____ Address: _____

_____ _____
(City) (State) (Zip Code) (City) (State) (Zip Code)

Phone: Home/Cell (_____) _____ Phone: Home/Cell (_____) _____

Work/Cell (_____) _____ Work/Cell (_____) _____

Father's E-Mail: _____ Mother's E-mail: _____

Father's Employer: _____ Mother's Employer: _____

LIST PERSONS TO PICK UP or CONTACT IN CASE OF EMERGENCY WHEN PARENT/GUARDIAN CANNOT BE REACHED

Contact Name	Relationship	Phone	Email
_____	_____	_____	_____
_____	_____	_____	_____

MEDICAL INFORMATION

Doctor's Name: _____ Office Phone: (_____) _____

Insurance Carrier: _____ Group Policy # _____

Allergies (drugs, food, environmental): _____

Medical Conditions (ex. diabetes, asthma) Medication (taken daily or as needed) _____YES _____NO

_____ _____
Medication Name Dosage

I, _____, do hereby authorize the school administration to render first aid for illness or injury to my child named above. In the event of a medical emergency, I authorize the school administration to have my child transported to the nearest hospital/emergency care center for emergency medical or surgical treatment and to contact my child's physician and one of the persons listed above. I further authorize the release of the above medical information to all medical personnel providing treatment. I agree to be solely responsible for the payment of all expenses incurred in such an emergency. I do hereby release, hold harmless, and indemnify most Reverend Daniel N. DiNardo, Archbishop of the Archdiocese of Galveston-Houston and his successors in office, the Archdiocese of Galveston-Houston, Sacred Heart School and any other of their officers, agents, employees or representatives from any and all liability, claims, losses, or expenses arising from personal injury, death, or loss of or damage to property arising from any medical treatment received and/or transportation to the nearest hospital/emergency care center.

_____ _____
Signature of Parent/Guardian **Date Signed**

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Early Learning Center

STUDENT TB QUESTIONNAIRE

Name of Child _____Date of Birth_____

Tuberculosis (TB) is a disease caused by TB germs and is usually transmitted by an adult person with active TB lung disease. It is spread to another person by coughing or sneezing TB germs into the air. These germs may be breathed in by the child. Adults who have active TB disease usually have many of the following symptoms: cough for more than two weeks duration, loss of appetite, weight loss of ten or more pounds over a short period of time, fever, chills and night sweats.

A person can have TB germs in his or her body but not have active TB disease (this is called latent TB infection or **LTBI).** Tuberculosis is preventable and treatable. TB skin testing (often called the PPD or Mantoux test) is used to see if your child has been infected with TB germs. No vaccine is recommended for use in the United States to prevent tuberculosis. The skin test is not a vaccination against TB.

We need your help to find out if your child has been exposed to tuberculosis.

Place a mark in the appropriate box:	Yes	No	Don't Know
TB can cause fever of long duration, unexplained weight loss, a bad cough (lasting over Two weeks), or coughing up blood. As far as you know: has your child been around anyone with any of these symptoms or problems? or has your child had any of these symptoms or problems? or has your child been around anyone sick with TB?			
Was your child born in Mexico or any other country in Latin America, the Caribbean, Africa, Eastern Europe or Asia?			
Has your child traveled in the past year to Mexico or any other country in Latin America, the Caribbean, Africa, Eastern Europe or Asia for longer than 3 weeks? If so, specify which country/countries? _____ _____			
To your knowledge, has your child spent time (longer than 3 weeks) with anyone who is/has been an intravenous (IV) drug user, HIV-infected, in jail or prison or recently came to the United States from another country?			

Has your child been tested for TB? Yes____(if yes, specify date ____ / ___) No____

Has your child ever had a positive TB skin test? Yes____(if yes, specify date ____ / ___) No_____

For school/healthcare provider use only

PPD administered Yes_____ No_____

Date administered _____ / ____ / _____ Date read _____ / _____ Result of PPD test_____mm response

Type of service provider (i.e. school, Health Steps, other clinics) _____

PPD provider _____

Print Name Address

Provider phone number _____

SACRED HEART
Early Learning Center

Statement of Child's Health

Admission Requirement: The following must be presented when your child (under the age of 5 years) is admitted to the day care facility within one week of admission. Please take to your child's health care provider.

Child Name:_____ DOB: _____

Health Care Provider Information:

Name of Health Care Organization (Printed): _____

Name of Health Care Provider (Printed): _____

Complete Address (Printed): _____

_____

Contact Number: _____

_____Health-Care Professionals Statement: I have examined the above-named child within the past year and find that he/she is physically able to take part in the day care program.

_____ _____

Health Care Providers Signature Date