



Mary of the Falls School
8262 Columbia Road
Olmsted Falls, Ohio 44138
440-235-4580
Fax: 440-235-6833

**Catholic Tradition.
Academic Excellence.**

Dear Kindergarten Parents,

We are pleased that you have chosen St. Mary of the Falls School for your child's education. We are committed to providing a quality education based on Catholic values. We look forward to working with you and count on your support in continuing our strong Catholic traditions and academic excellence.

Tuition for the 2020-2021 school year for active members of St. Mary of the Falls Parish is \$3,350 for the first child and \$3,100 for the 2nd, 3rd, 4th and 5th child. For a nonsubsidizing parish, the nonparishioner rate is \$4,900 per child. Tuition is payable in ten monthly installments beginning July 1. An active parishioner attends Sunday Mass on a weekly basis and supports the parish through weekly use of their church envelopes. Applications for financial assistance are made through FACTS at the following link: <https://online.factsmgt.com>

The following procedures will be followed for Kindergarten registration:

1. Registration: You will receive all necessary forms, complete the registration sheet and pay the \$100.00 registration fee.
2. Kindergarten screening will be held on April 2, 2020. Please sign up for a screening time. (The screening process is designed to assess your child's visual, auditory, language and motor development. It gives an indication of your child's learning strengths and areas that need reinforcement. The process takes about 60 minutes. Refreshments are provided for parents in the school library while they wait).
3. Immunization records need to be turned in to the school office.

St. Mary of the Falls School gives priority to families who are active parishioners of St. Mary of the Falls Parish. If more children apply than can be accommodated, they will be placed on a waiting list. The school day begins at 7:55a.m. and ends at 2:30p.m. Kindergarten students follow the St. Mary of the Falls uniform code. Schoolbelles provides our school uniforms. Catalogs are available online. St. Mary of the Falls offers before and aftercare. Information is available in the School Office.

We look forward to meeting you and your child at the screening. If you have any questions, please contact the school office at 440-235-4580.

God Bless you,

Annemarie Rajnicek,
Principal

OFFICE OF CATHOLIC EDUCATION - DIOCESE OF CLEVELAND - PERMANENT RECORD CARD
Saint Mary of the Falls School
Olmsted Falls, OH 44138



STUDENT INFORMATION		ENT #	CLASS OR (Year)
Last Name	First Name	Middle Name	Sex
			Birthdate
			Birthplace (City, St, Country)
			Date Entered

Click the box to the left of the current residence.

mm/dd/yyyy

Date student entered school.

Residence Address		City	County	Zip	Home Phone	Student Parish / City
Ethnicity (Optional)		<input type="radio"/> Amer Indian/Alaskan Native <input type="radio"/> Black/African Amer <input type="radio"/> Native Hawaiian/Other Pacific Islands <input type="radio"/> Multiracial <input type="radio"/> Asian <input type="radio"/> Hispanic <input type="radio"/> White				

SACRAMENTS		BAPTISM CERTIFICATE		STUDENT ENTERED FROM	
Baptism Date	Verified by	School from	Parochial	Other	
Reconciliation Date	Church	School from City			
Communion Date	Rite	School from State			
Confirmation Date	City, St, Zip	Grade Entering			

Check the boxes to the left of who student resides with.

STUDENT LIVES WITH					
<input type="checkbox"/> Natural Mother (NM)	Last Name	First Name	Maiden Name	Birthplace	Occupation
<input type="checkbox"/> Natural Father (NF)					Employer
<input type="checkbox"/> Custodial M (CM)					Work Phone
<input type="checkbox"/> Custodial F (CF)					
<input type="checkbox"/> Other					

PARENTS/CUSTODIAL PARENTS		Religion		Parent Status		Education	
Natural Mother (NM)		Catholic, Protestant, Jewish, Other		Married / Separated / Divorced / Remarried / Widowed / Single / Deceased		Under 12 years/High School Graduate/College Non-Graduate/College Graduate/Beyond College	
Natural Father (NF)							
Custodial M (CM)							
Custodial F (CF)							
Other							

LEGAL GUARDIAN		OTHER CHILDREN IN THE FAMILY LAST NAME & BIRTHDATES			
Name		1.	4.		
Address		2.	5.		
City, St, Zip		3.	6.		

LANGUAGE SPOKEN AT HOME English Other (list) _____

The design of the Permanent Record Card is the property of the Diocese of Cleveland and may not be altered.

Revised 2007

Ohio Department of Health • School and Adolescent Health

Health History

Student's name	Sex <input type="checkbox"/> Male <input type="checkbox"/> Female	Date of birth / /
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Family Health History Please list allergies, heart problems, diabetes, cancer or other serious health conditions.

Father
Mother
Brothers and Sisters

Birth and Developmental History No unusual birth or developmental history

Did the mother have any unusual physical or emotional illness during this pregnancy?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Was infant born full term? <input type="checkbox"/> Yes <input type="checkbox"/> No	Did the infant have any sickness or problems?	<input type="checkbox"/> Yes <input type="checkbox"/> No

Briefly explain illness or problems.

How does the child's development compare to other children, such as his or her brothers/sisters or playmates?
 About the same Delayed Advanced

Student Health Conditions

<input type="checkbox"/> YES , my child receives regular medical/health care for the following conditions:	<input type="checkbox"/> NO medical conditions
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<input type="checkbox"/> Allergies	<input type="checkbox"/> Diabetes	<input type="checkbox"/> Seizure disorder
<input type="checkbox"/> Asthma	<input type="checkbox"/> Depression	<input type="checkbox"/> Sickle cell anemia
<input type="checkbox"/> ADD/ADHD	<input type="checkbox"/> Ear problem/hearing difficulty	<input type="checkbox"/> Skin conditions
<input type="checkbox"/> Autism	<input type="checkbox"/> Emotional concerns	<input type="checkbox"/> Speech problems
<input type="checkbox"/> Behavior concerns	<input type="checkbox"/> Headaches	<input type="checkbox"/> Traumatic brain injury
<input type="checkbox"/> Birth/congenital malformations	<input type="checkbox"/> Heart problems	<input type="checkbox"/> Vision problems (glasses, contacts)
<input type="checkbox"/> Bone/muscle/joint problems	<input type="checkbox"/> Hemophilia	<input type="checkbox"/> Other _____
<input type="checkbox"/> Blood problems	<input type="checkbox"/> Juvenile arthritis	<input type="checkbox"/> Other _____
<input type="checkbox"/> Bowel/bladder problems	<input type="checkbox"/> Lead poisoning	<input type="checkbox"/> Other _____
<input type="checkbox"/> Cancer	<input type="checkbox"/> Migraines	<input type="checkbox"/> Other _____
<input type="checkbox"/> Cystic fibrosis	<input type="checkbox"/> Neuromuscular disorder	<input type="checkbox"/> Other _____

Please explain any conditions above or any reasons for hospitalizations.

Please indicate any allergies your child may have.

Allergy type	Reaction	School restrictions or recommended actions
<input type="checkbox"/> Bee/Insect		
<input type="checkbox"/> Food		
<input type="checkbox"/> Medication		
<input type="checkbox"/> Other		

Health History continued

Please list any prescription and over the counter medication that your child takes on a regular basis.

Medication and dose	Time	Reason

Do any health and/or medical conditions require school restrictions, modifications, and/or intervention?
 Yes No If YES, please explain.

Does the student require any special procedures and/or treatments for their health condition(s)?
 Yes No If YES, please explain.

Please indicate any other information about your child's health or development that you think would be helpful for the school to know.

Form completed by	Relationship to student	Date / /
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LETTER TO PARENTS REQUIRED IMMUNIZATIONS

TO: Parents of Children Entering Kindergarten
FROM: School Health Clinic
DATE: _____
SUBJECT: Immunizations

In order to attend school in August, your child must have completed the following immunizations which are required under Ohio Law Sections 3313.671 and 3701.13 of the Ohio Revised Code:*

- Four (4) or more doses of DTaP or DT, or any combination. If all four (4) doses were given before the fourth birthday, a fifth dose (5) is required. If the fourth dose was administered at least six months after the third dose, and on or after the 4th birthday, a fifth (5) dose is not required.
- Three (3) or more doses of Polio (IPV). The FINAL dose must be administered on or after the 4th birthday regardless of the number of doses. If a combination of IPV or OPV was received, four (4) doses of either vaccine are required.
- Three doses of Hepatitis B vaccine. The second dose must be given at least 28 days after the first dose. The third dose must be given at least 16 weeks after the first dose and at least 8 weeks after the second dose. The last dose in the series (3rd or 4th) must not be administered before 24 weeks of age.
- Two (2) doses of MMR (Measles, Mumps, and Rubella) vaccine are required. The first dose must have been received on or after the 1st birthday and the second dose at least 28 days after the first dose.
- Two (2) doses of Varicella vaccine. The first (1st) dose of vaccine must be given on or after the first (1st) birthday. The second (2nd) dose should be administered at least three (3) months after dose one (1); however, if the second dose is administered at least 28 days after the first dose, it is considered valid.

According to Section 3313.671, on the 15th day after school entrance it will be necessary to exclude all students from school who do not meet the above requirements.

Medical authorities and school educators urge that every child have a complete medical examination before entering school in order that defects, if present, may be corrected and the child be physically ready to accept all the advantages which education has to offer.

The school clinic staff is required to check the records of all new entrants for compliance with immunization requirements. Please have your physician complete the attached Physical Examination form and return it along with a copy of the child's Immunization record no later than August 1st.

If you have any questions, please contact the school clinic or the building principal.

*NOTE: Exceptions are provided for under the law. This can be discussed with the school clinic staff.

(ONLY FILL OUT IF YOU ARE DIVORCED)

**St. Mary of the Falls School
Information Regarding Legal Custody**
to be completed as part of the registration/reregistration agreement

Date: _____

Child's Name: _____ Grade: _____

Address of child's residence: _____

Child lives with: _____ both parents
_____ mother as custodial parent
_____ father as custodial parent
_____ grandparent(s) with legal custody
_____ other (Please explain.) _____

Residential parent/guardian:

Name: _____
Address: _____
City, Zip: _____
Phone: _____

Is there a court order (or pending order) affecting the custody and/or residence of the child?

Please attach a certified copy of the entire court order including the case number and those sections referring to visitation rights and contacts with the school. Also include the page bearing the judge's signature and court seal. This copy should include any and all modifications made as of the date of registration of the child in the school. It is also the responsibility of the parents to inform the principal of any subsequent modifications during the child's tenure at the school.

Non-residential parent:

Name: _____
Address: _____
City, Zip: _____
Phone: _____

Does the non-residential parent have visitation rights? _____

Is there a court decision that states that the non-residential parent should NOT receive school information or attend school activities? _____

Is the non-residential parents responsible for paying tuition? _____