



**Catholic Tradition.  
Academic Excellence.**

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

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 2017-2018 school year for active members of St. Mary of the Falls Parish is \$3,120.00 for the first child and \$2,995.00 for the 2<sup>nd</sup>, 3<sup>rd</sup>, 4<sup>th</sup> and 5<sup>th</sup> child. For a nonsubsidizing parish, the nonparishioner rate is \$4,600 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 Private School Aid Services (PSAS). Forms are found online at the school website.

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 March 23, 2017. 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). Current preschoolers will be assessed during their school day.
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. Schoolbellies 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 #	CL					
STUDENT INFORMATION						
Last Name	First Name	Middle Name	Sex	Birthdate	Birthplace (City, St, Country)	Date Entered

*Click the box to the left of the current residence.*

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

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

*Check the box(es) to the left of who student resides with.*

STUDENT LIVES WITH		Grade Entering	
<input type="checkbox"/>	Natural Mother (NM)	<input type="checkbox"/>	0
<input type="checkbox"/>	Natural Father (NF)	<input type="checkbox"/>	1
<input type="checkbox"/>	Custodial M (CM)	<input type="checkbox"/>	2
<input type="checkbox"/>	Custodial F (CF)	<input type="checkbox"/>	3
<input type="checkbox"/>	Other	<input type="checkbox"/>	4
<input type="checkbox"/>		<input type="checkbox"/>	5
<input type="checkbox"/>		<input type="checkbox"/>	6
<input type="checkbox"/>		<input type="checkbox"/>	7
<input type="checkbox"/>		<input type="checkbox"/>	8

PARENTS/CUSTODIAL PARENTS		Parent Status		Education	
Natural Mother (NM)	First Name	Maiden Name	Birthplace	Occupation	Employer
Natural Father (NF)					
Custodial M (CM)					
Custodial F (CF)					
Other					
Religion		Catholic, Protestant, Jewish, Other			
Parent Status		<input type="checkbox"/> Married / Separated / Divorced / Remarried / <input type="checkbox"/> Widowed / Single / Deceased <input type="checkbox"/> Under 12 years/High School Graduate/College Non-Graduate/College Graduate/Beyond College			

LEGAL GUARDIAN		OTHER CHILDREN IN THE FAMILY/EST NAME & BIRTHDATES			
Name	Address	City, St, Zip	1.	4.	
			2.	5.	
			3.	6.	
LANGUAGE(S) SPOKEN AT HOME		<input type="checkbox"/> English <input type="checkbox"/> Other (list)			

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

# 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? <input type="checkbox"/> About the same <input type="checkbox"/> Delayed <input type="checkbox"/> 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
<input type="checkbox"/> Allergies	<input type="checkbox"/> Seizure disorder
<input type="checkbox"/> Asthma	<input type="checkbox"/> Sickle cell anemia
<input type="checkbox"/> ADD/ADHD	<input type="checkbox"/> Skin conditions
<input type="checkbox"/> Autism	<input type="checkbox"/> Speech problems
<input type="checkbox"/> Behavior concerns	<input type="checkbox"/> Traumatic brain injury
<input type="checkbox"/> Birth/congenital malformations	<input type="checkbox"/> Vision problems (glasses, contacts)
<input type="checkbox"/> Bone/muscle/joint problems	<input type="checkbox"/> Other _____
<input type="checkbox"/> Blood problems	<input type="checkbox"/> Other _____
<input type="checkbox"/> Bowel/bladder problems	<input type="checkbox"/> Other _____
<input type="checkbox"/> Cancer	<input type="checkbox"/> Other _____
<input type="checkbox"/> Cystic fibrosis	<input type="checkbox"/> Other _____
<input type="checkbox"/> Diabetes	
<input type="checkbox"/> Depression	
<input type="checkbox"/> Ear problem/hearing difficulty	
<input type="checkbox"/> Emotional concerns	
<input type="checkbox"/> Headaches	
<input type="checkbox"/> Heart problems	
<input type="checkbox"/> Hemophilia	
<input type="checkbox"/> Juvenile arthritis	
<input type="checkbox"/> Lead poisoning	
<input type="checkbox"/> Migraines	
<input type="checkbox"/> Neuromuscular disorder	

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.

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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) immunizations against DTP (Diphtheria, Tetanus, Whooping Cough). If received before 4th birthday, a fifth dose is required.
- Receipt of at least three (3) doses of Polio (OPV or IPV individually) is required: if all OPV or all IPV are received. If the third dose was received prior to the fourth birthday, a fourth dose is required. If any combination of IPV or OPV were received, four doses of either vaccine are required.

Effective with the 2010-2011 school year, and progressively thereafter, for all pupils entering Kindergarten, the final dose of polio vaccine must have been administered on or after the fourth birthday, regardless of the number of previous doses.

- Three doses of Hepatitis B vaccine;. The second dose must be given at least 28 days after the first dose, and the third dose at least 8 weeks after the second dose and at least 16 weeks after the first dose. The last dose in the series (3<sup>rd</sup> or 4<sup>th</sup>) must not be administered before 24 weeks of age.
- Two (2) doses of MMR [Measles (Rubeola), Mumps, and Rubella (German Measles)] 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.
- Beginning with the start of the 2010-2011 school year, and progressively thereafter, all children entering Kindergarten are required to have two (2) doses of varicella vaccine. The first (1<sup>st</sup>) dose of vaccine must be given on or after the child's first (1<sup>st</sup>) birthday, and the second (2<sup>nd</sup>) dose at least 28 days following the first dose.
- A tuberculin skin test to determine if your child has been exposed tuberculosis is highly recommended but not required.

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.

Since the school's nurse is required to check the records of all new entrants for compliance with immunization requirements, please have your physician complete the attached School Entrance Medical Record and return it no later than August 1<sup>st</sup>.

If you have any questions, please contact me directly or the building principal.

\*NOTE: Exceptions are provided for under the law. This can be discussed with the school's nurse.

Rev. 4/2010

ONLY FILL OUT  
\*\*IF 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? \_\_\_\_\_