All Saints Academy

Transforming the world through excellence, prayer, and diversity.

All Saints Academy Preschool

2017-2018 School Year Registration

All Saints Academy * 2855 E. Livingston Avenue, Columbus, Ohio 43209

* Phone: (614) 231-3391 *

Dear Parents and Caregivers,

Thank you for your interest in our Preschool Program at All Saints Academy! We offer full and half-day preschool. Please see the following sheet for times and fees. Enclosed you will find an application, emergency form, information sheet, and medical statement that needs to be signed by your child's physician after a medical check-up. Accompanying this medical form, we will need a copy of your child's shot records. Medical records need to be turned in within 30 days of enrollment.

The completed application packet and $60.00 registration fee must be returned to our office before your child is considered enrolled. Please remember, there is a limited number of students we can accept into the program in order to maintain a high quality teacher to child ratio. Our enrollment policy is first come, first serve. Incomplete forms will be returned and will delay enrollment, possibly losing your spot, so please be sure to fill out all of the forms included in the registration packet.

It is mandatory that all tuition payments be made on a monthly basis through FACTS payment services online. Payments begin in September and end in May. Other payments, such as registration and supply fees may be paid in cash or money order to the director or office staff.

We are looking forward to meeting you and having your child become a part of our All Saints Academy "family!" If you have any questions, please call our office and we will be glad to help you.

Sincerely,
Courtney Jones
Director

2017-2018 Preschool Tuition

	Half Day **8:00 am- 11:30 am**	**Full Day** **8:00 am-2:30 pm**
5 Days/Week **(Monday-Friday)**	$323/month	$540/month
3 Days/Week	$194/month	$387/month
2 Days/Week	$129/month	$257/month

Fall Information

All Saints Academy Preschool

- Fall session begins September 5, 2017.
- Students must have the attached Ohio Department of Education **medical form signed and completed by a physician with a copy of their shot records**. The medical statement must be **on file within the first 30 days** of child's start date.
- Preschool is open from 8:00am to 2:30 pm, Monday-Friday.
- Students must be 3-5 years old and completely toilet trained.
- The class environment, activities, and lesson plans are planned and taught by a degreed teacher and director. There is also a teaching aide for preschool. A 12 to 1 children to staff ratio is maintained for this age group.
- Parents/caregivers will take turns providing morning snacks for the class.
- Children who stay full day will have a free school lunch provided for them, unless the caregiver chooses to pack their lunch.

FEES: An annual Non-Refundable registration fee of $60.00

Annual $30 supply fee ($15 due in September, $15 due in February)

Tuition: Preschool tuition fees are listed on attached chart

Tuition will be paid through online system, FACTS (see website www.asacatholic.org for a link to sign up.)

Scholarships/Financial Aid

- We have an Early Childhood Education Grant with limited spots for eligible 4 year old students (must be 4 by September 30th, 2017.)
- We accept Title XX funding.
- Please call the office for more information on these state funded programs.

*Discount: 2 siblings who come full time receive a -$10.00/week from tuition

Other Fees: Late pick-ups will be charged $1/minute starting at 11:35 am for half day students and at 2:35 pm for full day students.

All Saints Academy Preschool Application Form

2017-2018

Child's Name: _____ Birthday: _____

Street Address: _____

City: _____ Zip:_____

Phone Number: _____

Will attend **part-time** 8:00am-11:30am Yes___ No___

Will attend **full-time** 8:00am-2:30 pm Yes___No___

Please check days of the week child will be attending: Mon___Tues___Wed___Thurs___Fri____

For Office Use Only **$60 Registration Fee Paid: _____**

Permissions for School Year Programs:

- During the school year program, I give my child permission to take routine walks with their class outside of the school. The walks will be contained withing the area bound by James (east), Roosevelt (west), Livingston (north), and Dover (south.)
  Yes____ No____
- I give my permission for my home phone number to be included in the class roster to be available for other parents of children in the class.
  Yes____No_____

Signature_____ Date_____

Persons permitted to pick up my child from school and who may be contacted in case of an emergency:

Name	**Relationship to child**	**Phone #**

Statement of responsibility for payment of child's tuition

Person accepting responsibility for payment, please fill out form and sign below:

Name: _____

Address: _____

City: _____ State: _____ Zip:_____

Home phone: _____ Cell phone: _____

Signature: _____ Date: _____

Please note that due to high fees charged to our account when payments are returned NSF, we are unable to accept payments made with personal checks.

EMERGENCY MEDICAL AUTHRORIZATION

Purpose: To enable caregivers to authorize treatment for children who become ill or injured while under school authority when caregivers cannot be reached.

STUDENT'S FULL NAME: _____BIRTH DATE_____ LAST 4 S.S. # _____

PARENT/GUARDIAN NAME:_____ PARENT/GUARDIAN NAME:_____

STUDENT'S ADDRESS: _____

PARENT/GUARDIAN PHONE NUMBERS

NAME:_____

☐ CELL:_____ _____

☐ HOME:_____

☐ WORK:_____

Please indicate 1, 2 and 3 in boxes to set order in which to call

PARENT/GUARDIAN PHONE NUMBERS

NAME:_____

☐ CELL_____

☐ HOME:_____

☐ WORK:_____

Please indicate 1, 2 and 3 in boxes to set order in which to call

I HEREBY GIVE CONSENT FOR THE FOLLOWING MEDICAL CARE PROVIDERS AND LOCAL HOSPITALS TO BE CALLED:

Name of Physician or Clinic: _____Phone:_____

Address: _____

Name of Dentist or Clinic:_____Phone:_____

Medical Specialist:_____Phone:_____

Local Hospital: _____Emergency Room Phone:_____

In the event reasonable attempts to contact me have been unsuccessful, I hereby give consent for (1)the administration of any treatment deemed necessary by above-named doctors, or, in the event the designated preferred practitioner is not available, by another licensed physician or dentist; and (2) the transfer of my child to any hospital reasonably accessible. This authorization does not cover major surgery unless medical opinions of two other licensed physicians or dentists, concurring in the necessity of such surgery, are obtained prior to the performance of each surgery.

Allergies, medical conditions, or other facts concerning child's medical history (include any allergies, medications being taken, and any physical impairments to which physician should be alerted of):

_____

_____

PARENT/GUARDIAN SIGNATURE:_____ DATE:_____

CHILD'S HEALTH INFORMATION

Child's Chronic Medical/Health Needs

Child's Allergies/Treatment

Child's Dietary Needs/Restrictions

Child's History of Hospitalization and Disease History

Child's Medications (NOTE: A MEDICATION FORM MUST BE COMPLETED FOR EACH MEDICATION ADMINISTERED WHILE IN PROGRAM ATTENDANCE)

IMPORTANT INFORMATION REGARDING THE MEDICAL STATEMENT FORM:

*****THE FOLLOWING PAGE IS THE OHIO DEPARTMENT OF EDUCATION MEDICAL STATEMENT FORM THAT MUST BE FILLED OUT AND SIGNED BY A PHYSICIAN. YOU MAY DETACH THE FOLLOWING FORM TO TAKE TO YOUR CHILD'S DOCTOR. BE SURE TO BRING THE COMPLETED FORM AND SHOT RECORDS BACK WITHIN 30 DAYS OF YOUR CHILD'S FIRST DAY OF SCHOOL, PER LICENSING REGULATIONS. AFTER 30 DAYS, WITHOUT A MEDICAL STATEMENT ON FILE, YOUR CHILD WILL NOT BE ABLE TO ATTEND SCHOOL.*****

Thank you!