New Student
K-8 Student Financial Registration 2024-2025

(Please print)
STUDENT NAME _____ GRADE _____

PARENT/GUARDIAN NAME _____ EMAIL _____

STREET ADDRESS _____ CITY _____ ZIP _____

TELEPHONE NUMBERS _____ _____
Home Work Cell

_____**$200.00 PER FAMILY NON-REFUNDABLE REGISTRATION FEE DUE AT REGISTRATION. Check or money order only.**

Tuition for the 2024 – 2025 school year will be:

_____ $5,100.00 **(one child)**
_____ $9,285.00 **(two children)**
_____ $12,545.00 **(three children)**
_____ $16,730.00 **(four children)**

Select one of the below options for tuition payment

1._____ I will pay tuition in full by July 1, 2024. This payment can be made by check or money order.

2._____ FACTS payments will begin June 1 or 15 (12 months) or July 1 or 15 (11 months). FACTS is a financial aid assessment and payment system. There is a $45.00 start-up fee for use of the system for payments and this will be included in your first payment. There is a $40.00 fee at the time of the application for financial aid.

Examples of monthly payments are listed below.

	Select one option	1 Child	2 Children	3 Children	4 Children
Starting July 2024 – 11 months		$463.65	$844.10	$1,140.45	$1,520.90
Starting June 2024 – 12 months		$425.00	$773.75	$1,045.45	$1,394.20

Please read and acknowledge with signature and date, the following:

I agree to pay all fees and tuition owed for the 2024-2025 school year. I acknowledge that failure to do so could result in student removal and delinquencies being sent to collections and further legal actions may be taken.
Signed _____ Date _____

*Trenton Catholic Preparatory Academy, Inc., ("TCPA") is a New Jersey NonProfit Corporation, under New Jersey Statutes TCPA holds a federal tax-exempt EIN number is 86-2805464. It is authorized and existing under IRS Code 26 U.S.C. § 501(c)(3) exclusively for religious or educational purposes.

Trenton Catholic Preparatory Academy*
175 Leonard Avenue Hamilton, NJ 08610
609.586.3705
www.trentoncatholicprep.org

January 2024

Dear Parents/Guardians:

Registration time is here, a time to reflect on your child's education! It is our sincere hope that you will choose the educational experience we provide at Trenton Catholic Preparatory Academy (TCPA) for your child/children.

We want to inform you that the Board of Trustees has submitted an application to convert TCPA to a Charter School, McCorristin Charter School. The state has accepted the application and approved McCorristin Charter School to move to Phase Two Application Status. As of today, the decision has not been made if this transition will take place, but we want you to be aware of the possibility. The reason for the transition is to make sure that our school has a sustainable future based on our mission of educating the entire child and to provide a safe haven for all of our students. If there is a change in status to a Charter School, any student registered through this process is guaranteed a place in the new school. You will be notified when any decisions are made.

The enclosed materials and a $200 per family non-refundable registration fee, check or money order, are due in the school office by March 1, 2024. After that date, the non-refundable registration fee per family goes to $200. All completed registrations will be processed on a first come, first serve basis.

Tuition rates for the 2024/2025 school year are listed on the enclosed form. TCPA uses a financial aid assessment and payment online program, FACTS. We recommend that families needing financial assistance apply through FACTS under Trenton Catholic Preparatory Academy by visiting http://online.factsmgt.com. The FACTS program can also be used to pay your monthly tuition.

If you have registration concerns, please call Mrs. L. Danser 609-586-5888 for K through 8th grade and Ms. R. Rogers 609-586-3704 for 9th through 12th grade.

May God graciously bless all of our Trenton Catholic Preparatory families.

Sincerely,

Margaret Raymond Flood
President, The Board of Trustees

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Permanent Elementary School Record

Trenton Catholic Preparatory Academy
Hamilton NJ

_____ Sex: _____M_____F _____

Last Name **First** **Middle** **Date of Registration**

_____ _____ _____ _____

Address **Zip Code** **Telephone Number** **Public School District**

_____ _____

Parent Email **Parent Work Telephone Number**

_____ _____ _____

Place of Birth (City, State) **Date of Birth** **Country of Citizenship**

_____

Religion **Registered Parish** **City/Town**

Admitted From: School_____ **Date:** _____ **Grade**_____

Baptism: _____ _____ _____
Parish City & State Date

First Penance: _____ _____ _____
Parish City & State Date

First Eucharist: _____ _____ _____
Parish City & State Date

Confirmation: _____ _____ _____
Parish City & State Date

Withdrawal Record
Date: _____
To: _____
Cause: _____

Re-Entry Record
Date: _____
From: _____
Grade: _____

Graduation Date: _____ **High School Entered:** _____ **City/Town:** _____

FAMILY BACKGROUND

Father: _____
Address: _____
Occupation: _____
Religion: _____
Date of Death: _____
Education: ___Elem. ___Coll. ___Sec. ___Adv.

Mother: _____
Address: _____
Occupation: _____
Religion: _____
Date of Death: _____
Education: ___Elem. ___Coll. ___Sec. ___Adv.

Relationship or Guardian to Student _____

Home Situation: **Check All that Apply**

__Two Parents __One Parent __Parents Separated or Divorced
__Father Remarried __Mother Remarried __Other

Child resides with: _____
Parental Rights (in case of separation; attach court order) _____

Language Spoken at Home: _____ **Ethnic Background:** _____

___White ___Black/African American ___American Indian or Alaska Native ___Asian ___Native Hawaiian/Other Pacific Islander

___Hispanic or Latino and ___White ___Black/African American ___American Indian or Alaska Native ___Asian
___Native Hawaiian/Pacific Islander

SIBLINGS/ Complete Name and Date of Birth

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____

TCPA
Trenton Catholic Preparatory Academy

TRENTON RESIDENTS ONLY

Dear Parents:

Please be advised that we have been informed by the TRENTON Department of Transportation that all applications for Private School Transportation MUST BE ACCOMPANIED WITH PROOF OF RESIDENCY. WITHOUT THIS INFORMATION, THE APPLICATION WILL NOT BE ACCEPTED. This can be a copy of a phone bill, PSE&G bill. NO credit card bills.

Thank you in advance for your cooperation in this matter.

Mrs. Anne Reap

Nonpublic School Transportation Application Form

School Year: Resident District Board of Education:

Student Name:
Last First Middle

Date of Birth (mm/dd/yy): Parent/Guardian Name:

Daytime Phone: Email Address:
Area code + number

Home Address: City: Zip:

Mailing Address: City: Zip:

Full name of school to be attended:

Phone: Address of School:
Area code + number

Student's grade for the coming year:

Shortest one-way mileage between home and school:
(shortest route along public roadways or walkways to the nearest tenth of a mile)

Date school opens (mm/dd/yy): Date school closes (mm/dd/yy):

School hours: AM to PM

Name of school of attendance in prior year:

Address:

Signature: Date (mm/dd/yy):

Public School Use Only (Do *not* write below this line)

Your application has been reviewed by the resident district board of education. The following determination has been made:

☐ Transportation will be provided ☐ You are eligible for payment in lieu of transportation ☐ Ineligible

Reason:

Title:

Signature: Date (mm/dd/yy):

New Jersey Department of Education
Office of School Finance

(B6T) Nonpublic School Transportation Application (N.J.A.C 6A:27-2.5)

Instructions

It is the obligation of the parent or guardian of nonpublic school students to annually obtain the Nonpublic School Transportation Application from the administrative office of the nonpublic school for each student for which transportation services are being requested. Submit a separate application for each student.

Note:

- If there is a change of home address, a new application shall be submitted to the public school district of residence.
- If there is a change in the nonpublic school of attendance, a new application shall be submitted to the public school district of residence.
- Complete this application and return it to the nonpublic school on or before March 10th preceding the school year in which transportation is being requested.
- Late applications — Any application received after March 10th will be a late application and must be accompanied by a statement of the reason for lateness. Eligible students will receive transportation or aid in lieu of transportation based on the date the application is received by the public school.
- It is the obligation of the nonpublic school administrator to annually collect the application and submit it to the public school district from which transportation is being requested prior to March 15th.
- It is the obligation of the public school administrator to notify the parent or guardian as the determination of each application by August 1st.
- A district board of education shall pay aid in lieu of transportation to the parent or guardian of an eligible student only after receiving a signed "Nonpublic School Transportation Payment" voucher (B7T) as prescribed by the Commissioner of Education.

APPENDIX H

UNIVERSAL CHILD HEALTH RECORD

Endorsed by: *American Academy of Pediatrics, New Jersey Chapter*
New Jersey Academy of Family Physicians
New Jersey Department of Health

SECTION I - TO BE COMPLETED BY PARENT(S)

Child's Name *(Last)* *(First)*	Gender ☐ Male ☐ Female	Date of Birth / /
Does Child Have Health Insurance? ☐Yes ☐No	If Yes, Name of Child's Health Insurance Carrier	
Parent/Guardian Name	Home Telephone Number ( ) -	Work Telephone/Cell Phone Number ( ) -
Parent/Guardian Name	Home Telephone Number ( ) -	Work Telephone/Cell Phone Number ( ) -

I give my consent for my child's Health Care Provider and Child Care Provider/School Nurse to discuss the information on this form.

Signature/Date	This form may be released to WIC. ☐Yes ☐No

SECTION II - TO BE COMPLETED BY HEALTH CARE PROVIDER

Date of Physical Examination:	Results of physical examination normal? ☐Yes ☐No	
Abnormalities Noted:	Weight *(must be taken within 30 days for WIC)*	
	Height *(must be taken within 30 days for WIC)*	
	Head Circumference *(if <2 Years)*	
	Blood Pressure *(if ≥3 Years)*	

IMMUNIZATIONS	☐ Immunization Record Attached ☐ Date Next Immunization Due: _____

MEDICAL CONDITIONS

Chronic Medical Conditions/Related Surgeries • List medical conditions/ongoing surgical concerns:	☐ None ☐ Special Care Plan Attached	Comments
Medications/Treatments • List medications/treatments:	☐ None ☐ Special Care Plan Attached	Comments
Limitations to Physical Activity • List limitations/special considerations:	☐ None ☐ Special Care Plan Attached	Comments
Special Equipment Needs • List items necessary for daily activities	☐ None ☐ Special Care Plan Attached	Comments
Allergies/Sensitivities • List allergies:	☐ None ☐ Special Care Plan Attached	Comments
Special Diet/Vitamin & Mineral Supplements • List dietary specifications:	☐ None ☐ Special Care Plan Attached	Comments
Behavioral Issues/Mental Health Diagnosis • List behavioral/mental health issues/concerns:	☐ None ☐ Special Care Plan Attached	Comments
Emergency Plans • List emergency plan that might be needed and the sign/symptoms to watch for:	☐ None ☐ Special Care Plan Attached	Comments

PREVENTIVE HEALTH SCREENINGS

Type Screening	Date Performed	Record Value	Type Screening	Date Performed	Note if Abnormal
Hgb/Hct			Hearing		
Lead: ☐ Capillary ☐ Venous			Vision		
TB (mm of Induration)			Dental		
Other:			Developmental		
Other:			Scoliosis		

☐ ***I have examined the above student and reviewed his/her health history. It is my opinion that he/she is medically cleared to participate fully in all child care/school activities, including physical education and competitive contact sports, unless noted above.***

Name of Health Care Provider (Print)	Health Care Provider Stamp:
Signature/Date	

Distribution: Original-Child Care Provider Copy-Parent/Guardian Copy-Health Care Provider

Instructions for Completing the Universal Child Health Record (CH-14)

Section 1 - Parent

Please have the parent/guardian complete the top section and sign the consent for the child care provider/school nurse to discuss any information on this form with the health care provider.

The WIC box needs to be checked only if this form is being sent to the WIC office. WIC is a supplemental nutrition program for Women, Infants and Children that provides nutritious foods, nutrition counseling, health care referrals and breast feeding support to income eligible families. For more information about WIC in your area call 1-800-328-3838.

Section 2 - Health Care Provider

1. Please enter the date of the physical exam that is being used to complete the form. Note significant abnormalities especially if the child needs treatment for that abnormality (e.g. creams for eczema; asthma medications for wheezing etc.)
   - **Weight** - Please note pounds vs. kilograms. If the form is being used for WIC, the weight must have been taken within the last 30 days.
   - **Height** - Please note inches vs. centimeters. If the form is being used for WIC, the height must have been taken within the last 30 days.
   - **Head Circumference** - Only enter if the child is less than 2 years.
   - **Blood Pressure** - Only enter if the child is 3 years or older.

2. **Immunization** - A copy of an immunization record may be copied and attached. If you need a blank form on which to enter the immunization dates, you can request a supply of Personal Immunization Record (IMM-9) cards from the New Jersey Department of Health, Vaccine Preventable Diseases Program at 609-826-4860. The Immunization record must be attached for the form to be valid.
   - "Date next immunization is due" is optional but helps child care providers to assure that children in their care are up-to-date with immunizations.

3. **Medical Conditions** - Please list any ongoing medical conditions that might impact the child's health and well being in the child care or school setting.

   a. Note any significant medical conditions or major surgical history. **If the child has a complex medical condition, a special care plan should be completed and attached for any of the medical issue blocks that follow.** A generic care plan (CH-15) can be downloaded at www.nj.gov/health/forms/ch-15.dot or pdf. Hard copies of the CH-15 can be requested from the Division of Family Health Services at 609-292-5666.

   b. **Medications** - List any ongoing medications. Include any medications given at home if they might impact the child's health while in child care (seizure, cardiac or asthma medications, etc.). Short-term medications such as antibiotics do not need to be listed on this form. Long-term antibiotics such as antibiotics for urinary tract infections or sickle cell prophylaxis should be included.

   PRN Medications are medications given only as needed and should have guidelines as to specific factors that should trigger medication administration. *Please be specific about what over-the-counter (OTC) medications you recommend, and include information for the parent and child care provider as to dosage, route, frequency, and possible side effects. Many child care providers may require separate permissions slips for prescription and OTC medications.*

   c. **Limitations to physical activity** - Please be as specific as possible and include dates of limitation as appropriate. Any limitation to field trips should be noted. Note any special considerations such as avoiding sun exposure or exposure to allergens. Potential severe reaction to insect stings should be noted. Special considerations such as back-only sleeping for infants should be noted.

   d. **Special Equipment** – Enter if the child wears glasses, orthodontic devices, orthotics, or other special equipment. Children with complex equipment needs should have a care plan.

   e. **Allergies/Sensitivities** - Children with life-threatening allergies should have a special care plan. Severe allergic reactions to animals or foods (wheezing etc.) should be noted. Pediatric asthma action plans can be obtained from The Pediatric Asthma Coalition of New Jersey at www.pacnj.org or by phone at 908-687-9340.

   f. **Special Diets** - Any special diet and/or supplements that are medically indicated should be included. Exclusive breastfeeding should be noted.

   g. **Behavioral/Mental Health issues** – Please note any significant behavioral problems or mental health diagnoses such as autism, breath holding, or ADHD.

   h. **Emergency Plans** - May require a special care plan if interventions are complex. Be specific about signs and symptoms to watch for. Use simple language and avoid the use of complex medical terms.

4. **Screening** - This section is required for school, WIC, Head Start, child care settings, and some other programs. This section can provide valuable data for public heath personnel to track children's health. Please enter the date that the test was performed. Note if the test was abnormal or place an "N" if it was normal.
   - For lead screening state if the blood sample was capillary or venous and the value of the test performed.
   - For PPD enter millimeters of induration, and the date listed should be the date read. If a chest x-ray was done, record results.
   - Scoliosis screenings are done biennially in the public schools beginning at age 10.

   This form may be used for clearance for sports or physical education. As such, please check the box above the signature line and make any appropriate notations in the Limitation to Physical Activities block.

5. Please sign and date the form with the date the form was completed (note the date of the exam, if different)
   - Print the health care provider's name.
   - Stamp with health care site's name, address and phone number.

STATE OF NEW JERSEY
HEALTH HISTORY AND APPRAISAL

Name of Child (Last, First, M.I.) | IMMUNIZATION REGISTRY NUMBER

Date of Birth (Mo/Day/Yr) | Sex ☐ Male ☐ Female

PARENT OR GUARDIAN NAME | TELEPHONE NO.

ADDRESS

VACCINE TYPE	1st Dose Mo/Day/Yr	2nd Dose Mo/Day/Yr	3rd Dose Mo/Day/Yr	4th Dose Mo/Day/Yr	5th Dose Mo/Day/Yr
DIPHTHERIA, TETANUS, PERTUSSIS (DTaP) or any combination *(If Td or DT, indicate in corner box)*					
Tdap					
POLIO – INACTIVATED POLIO VACCINE (IPV) *If oral vaccine, indicate (OPV) in corner box*					
MEASLES, MUMPS, RUBELLA (MMR)					
HAEMOPHILUS B (HIB)**					
HEPATITIS B					
VARICELLA					
PNEUMOCOCCAL CONJUGATE **					
MENINGOCOCCAL					
HEPATITIS A ***					
HPV (HUMAN PAPILLOMAVIRUS) ***					
OTHER					
OTHER					

LEAD SCREENING	
Test Date	Result

Document below single antigen vaccine receipt, serology titers, or varicella disease history

Hepatitis B	Date:	Titer:
Varicella	Date:	Titer:
Measles	Date:	Titer:
Mumps	Date:	Titer:
Rubella	Date:	Titer:

☐ Provisional admission attached–Date Granted: _____ ☐ Medical exemption attached ☐ Religious exemption attached

HISTORY	YEAR	HISTORY	YEAR	HISTORY	YEAR	HISTORY	YEAR
FOOD ALLERGIES		DIABETES		LYME DISEASE		JUVENILE RHEUMATOID ARTHRITIS	
NON-FOOD/NON-DRUG ALLERGIES		INFLUENZA (FLU)		MONONUCLEOSIS		AUTISM SPECTRUM DISORDERS	
		OTHER		NEUROMUSC. DISORDER		HEMATOLOGICAL DISORDERS	
ASTHMA		DRUG ALLERGIES		CHRONIC OTITIS MEDIA		ADD/ADHD	
CONGENITAL DISORDER		HEART DISEASE		AUTO IMMUNE DISORDERS		CONCUSSION/TBI	
CONVULSIVE DISORDER		HEPATITIS		STREP INFECTIONS			

HEALTH SCREENING CODE: N = Normal; R = Referred; T = Under Treatment; C = See Comments

Grade/Age																
Date																
Height																
Weight																
BMI***																
Blood Pressure																
VISION With correction	R															
	L															
	BOTH															
VISION Without correction	R															
	L															
	BOTH															
Muscle Balance																

Color Perception Date Results

HEARING Date																
Pure Tone	R															
	L															

BIENNIAL SCOLIOSIS SCREENING (Beginning at Age 10) Date Date Date Date Date

Referred for abnormal result ☐ ☐ ☐ ☐ ☐

TB Screening (Mantoux or IGRA Test)

	Date	Date
Tested		
Read		
Mantoux Result (MM) or IGRA Result		

Chest X-Ray

Date	Result: Normal	Result: Abnormal

Medication
Reactor No Rx ☐
Date Started _____
Date Completed _____

**REQUIRED FOR DAY/CHILD CARE ENROLLEES (2 Months-5th Birthday Only) ***Not Required

TCPA
Trenton Catholic Preparatory Academy

EDUCATIONAL SERVICES COMMISSION of NEW JERSEY

TO: Parent/Guardian

FROM: Mrs. Anne Reap, Lower School Director

Nursing Services: Chapter 226 - Laws of 1991

Existing legislation provides certain nursing services and funding for full time students in private schools.

Included in these services, based on available state aid, is maintenance of student health records, hearing assessment, and scoliosis screening.

In addition, your child will receive emergency nursing services for any school related illness or injury.

Please sign the form below and return it to my office as soon as possible.

NONPUBLIC NURSING SERVICES

___ I do give my permission

____ I do NOT give permission

for _____, my child, in grade_____to participate in
(Please print child's name)
nursing services.

_____
School District

_____
Name of School

_____
School Address

_____ _____
Signature of Parent/Guardian Date

TCPA
Trenton Catholic Preparatory Academy

RECORD RELEASE

The Student identified below has been accepted at Trenton Catholic Preparatory Academy. They have my permission for you to release a copy of the complete school records, including but not limited to grades, attendance, testing records, child study evaluation information, etc. for my child to Trenton Catholic Preparatory Academy:

_____
School Name

_____
School Address

PLEASE PRINT
Student Name: _____ Current Grade: _____

Address: _____
City State Zip Apt. No.

Telephone Number: _____

_____
Parent/Guardian Signature

_____
PRINT Parent/Guardian Name

_____
Date

TRENTON CATHOLIC PREPARATORY ACADEMY
Lower School
Registration Information Sheet

Thank you for your interest in Trenton Catholic Preparatory Academy. We have instituted this form to help ease you through the registration process. Please feel free to call our Main Office, 609-8586-5888 ext. 141, with any questions.

The following items must be received/completed in order to finalize your registration:

PreKindergarten Students:

- Registration Form
- Non Refundable Registration Fee
- Copy of Official Birth Certificate
- Copy of Baptismal Certificate
- Completed Health Form Immunization Record (Immunizations must be up to date)

Final Acceptance is issued for incoming Pre-Kindergarten students following submission of above,

Students Entering Kindergarten through 8th Grade:

- Registration Form
- Non Refundable Registration Fee
- Copy of Official Birth Certificate
- Copy of Baptismal Certificate
- Completed Health Form
- Immunization Record (Immunizations must be up to date)
- Plus:
  - Student Interview with the Lower School Director
  - Report Cards from past two years
  - Standardized Test results from the past two years
  - Discipline Report from sending school
  - Copy of latest Child Study report if applicable

Final Acceptance is issued for incoming K through 8th grade students following submission of above, review of report cards, standardized testing, and Director interview.