Pre- K Student Financial Registration 2024-2025

Student Name: _____ Date of Birth: _____

_____ _____ _____
Street Address City Zip

Telephone Numbers:

_____ _____ _____
Home Work Cell

_____ Will attend Trenton Catholic Preparatory Academy 2024-2025 school year. Pre-K for 3 and 4 year old children. 5 days, 7:50am to 2:20pm, with tuition of $7,400 per year.

_____ $200.00 family registration fee enclosed. NON-REFUNDABLE. Please pay by check or money order.

Tuition (select one)
1._____ Will pay tuition of in full ($7,400) by July 1, 2024. This payment may be made by check or money order.

2. _____ Will use automatic debit of checking/savings account through FACTS, with a one-time $45.00 start-up fee per year. Monthly payments will be as follows.

11 months - $672.75/ month
12 months - $616.67/ month

_____ _____
Parent/Guardian Signature Date

Please return this form, with all enclosures to:
Trenton Catholic Preparatory Academy
177 Leonard Avenue
Hamilton, New Jersey 08610
Attention: Main Office

Extended Care is available. Please request additional information.

*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.

Permanent Elementary School Record

Trenton Catholic Preparatory Academy
Hamilton NJ

Last Name _____ First _____ Middle _____ Sex: ____M____F

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: _____

Permanent Elementary School Record

Trenton Catholic Preparatory Academy
Hamilton NJ

Last Name _____ First _____ Middle _____ Sex: _____M_____F

Address _____ Zip Code _____

Telephone Number _____

Date of Registration _____

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: _____

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	

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

IMMUNIZATION REGISTRY NUMBER

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

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.