

SAINT PAUL SCHOOL

Education for Tomorrow, Faith for a Lifetime



250 James Street, Burlington, New Jersey 08016
Tel.: (609) 386-1645 • Fax: (609) 386-1345 • www.stpaulbrl.org

Your PreSchool registration packet contains the following forms:

1. Registration Application
2. PreSchool Registration Form
3. Tuition Preference Form...This form **MUST** be completed and signed.
4. Emergency Contact Sheet...This form is completed for both parents' emergency information.
5. Universal Health Form...This form is to be completed and signed by a physician. *ALL PRESCHOOL STUDENTS MUST HAVE A PHYSICAL PRIOR TO THE FIRST DAY OF SCHOOL, SEPTEMBER 2026. ALL PRESCHOOL STUDENTS MUST HAVE A FLU SHOT BY DECEMBER 1, 2026.*
6. Title 1 – Non-public school survey

PLEASE KEEP ALL FORMS TOGETHER AND RETURN ***WITH A COPY OF YOUR CHILD'S BIRTH CERTIFICATE AND BAPTISMAL CERTIFICATE (IF BAPTIZED)*** IN A TIMELY MANNER. YOUR CHILD CANNOT BE REGISTERED UNTIL ALL THIS INFORMATION HAS BEEN RETURNED WITH PAYMENT. YOUR CHILD CANNOT BE ADDED TO A WAITING LIST UNTIL THIS INFORMATION HAS BEEN RETURNED.

Your registration packet checklist:

- Registration Application
- PreSchool Registration Form
- Tuition Preference Form (FACTS)
- Emergency Contact Sheet
- Universal Health Form
- Title1 Non Public School Survey
- Copy of student's birth certificate
- Copy of student's Baptismal certificate (if baptized)
- \$175 Registration Fee (per child)
- \$50 Nurse Fee (per family)

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Registration Application

Student Name: _____
First Middle Last

2024-2025 Incoming Grade: _____

Home Address: _____
Street Address

_____ City State Zip

Phone #: _____

Gender: _____ Male _____ Female

Birth Date: _____

Place of Birth: _____
City State

Religion: _____

Parish: _____

Father's Name: _____

Mother's Name: _____

(Over →)

The following information is used for NCEA (National Catholic Education Association) reporting purposes.

Primary Language: _____

Home Language: _____

- Race: _____ White
_____ Black or African American
_____ American Indian or Alaska Native
_____ Asian
_____ Native Hawaiian or Other Pacific Islander
_____ I choose to not identify with a specific race.

- Ethnicity: _____ Hispanic or Latino
_____ Non-Hispanic or Latino
_____ I choose to not identify with a specific ethnicity.

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Student Registration Form – PreSchool – 4 Year Old Program

Student Name: _____

Address: _____

City, State & Zip Code: _____

Gender: ____ Male ____ Female

Mother's Name: _____

Cell Phone Number (with area code): _____

Email address: _____

Father's Name: _____

Cell Phone Number: _____

Email address: _____

Enrollment Information - Student must be 4 on or before October 1, 2026.

_____ 5 Full Days: Monday to Friday, 8:00 am to 3:00 pm - \$7,300/year

_____ 5 Half Days: Monday to Friday, 8:00 am to 12:00 noon - \$4,000/year

\$175 (per child) Registration Fee and \$50 (per family) Nurse Fee due at time of registration.

_____ paid online at stpaulbrl.org _____ Date

Morning child care is available at 6:30am and afternoon child care is available from 3:00 pm to 6:00 pm at an additional cost.

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ST. PAUL SCHOOL PAYMENT PREFERENCE EVERY PARENT MUST COMPLETE THIS FORM AND RETURN TO SCHOOL BY MARCH 1, 2026

FAMILY NAME: _____

ADDRESS: _____

PHONE: (Include area code and cell numbers) _____

STUDENT(S) NAME: _____

I/we, the undersigned parents/guardians of the students named above agree to pay to the school the total tuition, other charges and fees set forth in the rate schedule published by St. Paul School in January, 2026. All monies owed to the school must be paid by May 1, 2027. Any returned checks, for whatever reason, will incur a \$30 service fee. Registration for the next year will not be accepted unless all tuition, fees, service duty levies are paid for the current calendar year. Fifty percent of the total tuition MUST be received by the school by the end of the first marking period; *otherwise parent access to Genesis will be disabled and the student's enrollment could be jeopardized.* I/we understand in signing this tuition covenant, I/we agree to accept the policies, rules and regulations of St. Paul School, as well as the payment schedule set forth below:

ALL payment options **MUST** be made through **FACTS**. Tuition for the 2026-2027 school year will be paid:

_____ FACTS single payment, due July 1, 2026 (no FACTS service fee, 2% discount will apply).

_____ FACTS payment plan 10 equal payments (beginning July 2026)

_____ FACTS payment plan 4 quarterly payments (beginning July 2026)

_____ FACTS payment plan 2 payments (July 2026 & November 2026)

Father's/Guardian signature and date _____

Mother's/Guardian signature and date _____

***Please note: If you choose the single payment option and payment is not received by the due date, you will be required to use the FACTS payment plan. This must be done before your child/children can begin school in September.**

ALL FINANCIAL CORRESPONDENCE MUST BE SENT TO THE PARISH OFFICE: 223 E UNION STREET, BURLINGTON, NJ 08016. PLEASE CALL EILEEN KELLY, 609-386-0163 x211, WITH ANY QUESTIONS.

2026-2027 EMERGENCY CONTACT

Student Last Name _____

Family Last Name _____

Student(s) First Name(s) _____

	FATHER	MOTHER
NAME	_____	_____
HOME PHONE	_____	_____
CELL PHONE	_____	_____
EMPLOYER	_____	_____
WORK PHONE	_____	_____

Email address most used to receive student information. *Only one email address will be assigned to the Genesis parent access account.*

E-mail address: _____

EMERGENCY CONTACTS (Parents are *always* the first call for an emergency. These are backup.)

1. _____ **Relationship to Student:** _____

Home Phone: _____ **Cell Phone:** _____

2. _____ **Relationship:** _____

Home Phone: _____ **Cell Phone:** _____

FAMILY PHYSICIAN AND DENTIST INFORMATION:

Doctor's/Practice Name: _____

Phone Number: _____

Dentist's/Practice Name: _____

Phone Number: _____

Allergies/Medical conditions: _____

Parent/Guardian Signature: _____

Parent/Guardian please print name: _____

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 <input type="checkbox"/> Male <input type="checkbox"/> Female	Date of Birth ____ / ____ / ____
Does Child Have Health Insurance? <input type="checkbox"/> Yes <input type="checkbox"/> 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. <input type="checkbox"/> Yes <input type="checkbox"/> No	

SECTION II - TO BE COMPLETED BY HEALTH CARE PROVIDER

Date of Physical Examination: _____	Results of physical examination normal? <input type="checkbox"/> Yes <input type="checkbox"/> 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	<input type="checkbox"/> Immunization Record Attached <input type="checkbox"/> Date Next Immunization Due: _____
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MEDICAL CONDITIONS

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

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January, 2026

Dear Parents,

The *No Child Left Behind Act of 2001, (NCLB)*, reauthorized federal legislation to continue to provide a variety of programs, materials, and services to children and teachers in non-public schools similar to those provided to public school students and teachers. These activities are enhanced by additional federal funds provided for school attendance areas with families whose income falls below specific levels or who benefit from other federal assistance programs. *In order for our children to benefit from these additional funds, it is very important for us to know how many children attending our school are members of these families.*

Please review the enclosed survey and simply indicate whether you meet the criteria by checking YES or NO. Additionally, identify the public school district where your child(ren) would attend if not attending a non-public school. **This information is essential to ensure our continued participation in the federal programs such as Title I. It is an important benefit that we do not want to lose. Please return this form by March 1, 2026. All information will be kept confidential.**

Thank you for your assistance with this survey.

Sincerely,

Ron Trampe

Mr. Ron Trampe
Principal

Enclosure

INCOME ELIGIBILITY GUIDELINES

48 CONTIGUOUS STATES, DISTRICT OF COLUMBIA, GUAM AND TERRITORIES

Federal Poverty Guidelines		Reduced Price Meals – 185%			Free Meals – 130%		
Household size	Annual	Annual	Month	Week	Annual	Month	Week
1	\$ 15,650	\$ 28,953	\$ 2,413	\$ 557	\$ 20,345	\$ 1,696	\$ 392
2	\$ 21,150	\$ 39,128	\$ 3,261	\$ 753	\$ 27,495	\$ 2,292	\$ 529
3	\$ 26,650	\$ 49,303	\$ 4,109	\$ 949	\$ 34,645	\$ 2,483	\$ 667
4	\$ 32,150	\$ 59,478	\$ 4,957	\$ 1,144	\$ 41,795	\$ 3,380	\$ 804
5	\$ 37,650	\$ 69,653	\$ 5,805	\$ 1,340	\$ 48,945	\$ 4,079	\$ 942
6	\$ 43,150	\$ 79,828	\$ 6,653	\$ 1,536	\$ 56,095	\$ 4,675	\$ 1,079
7	\$ 48,650	\$ 90,003	\$ 7,501	\$ 1,731	\$ 63,245	\$ 5,271	\$ 1,217
8	\$ 54,150	\$ 100,178	\$ 8,349	\$ 1,927	\$ 70,395	\$ 5,867	\$ 1,354
Each additional family member add	\$ 5,500	\$ 10,175	\$ 848	\$ 196	\$ 7,150	\$ 596	\$ 138

SAINT PAUL SCHOOL

TITLE I NON-PUBLIC SCHOOL SURVEY

1. Use the attached Income Eligibility Guidelines chart to answer the questions in Item 1.

Is your family income less than the amount in column 2 (Federal Poverty Guidelines)?

YES _____ NO _____

Is your family income less than the amount in columns 3 to 5 (Reduced Price Meals)?

YES _____ NO _____

Is your family income less than the amount in columns 6 to 8 (Free Meals)?

YES _____ NO _____

Are you receiving assistance under the Temporary Assistance to Needy Families (TANF) program?

YES _____ NO _____

Are any of your children eligible to receive medical assistance under the Medicaid Program?

YES _____ NO _____

Identify the Public School District and grade that your child(ren) would attend if not attending a non-public school.

NAME OF PUBLIC SCHOOL DISTRICT (REQUIRED) GRADE LEVEL

1. _____

2. _____

3. _____

4. _____

5. _____

Home address (required) _____

Saint Paul School

2026-2027 Tuition Rates

PreK-3 or 4 Tuition - Full-time M-F 8:00 am - 3:00 pm	\$ 7,300
PreK-3 or 4 Tuition - Part-time M-F 8:00 am - 12:00 pm	\$ 4,000
PreK-3 Tuition - M/W/F Full-time (3 year olds only) 8:00 am - 3:00 pm	\$ 4,500
PreK-3 Tuition - M/W/F Part-time (3 year olds only) 8:00 am - 12:00 pm	\$ 2,400
Kindergarten - 8th Grade - Catholic	
One Child	\$ 6,000
Two Children	\$ 10,000
Three Children	\$ 13,500
Four Children	\$ 14,000
Kindergarten – 8th Grade - Non-Catholic	
One Child	\$ 7,700
Two Children	\$ 11,700
Three Children	\$ 16,900
Four Children	\$ 17,500



PreSchool Uniform Information

All uniforms are to be purchased from:

Flynn & O'Hara Uniform Company
10905 Dutton Road
Philadelphia, PA 19154
www.flynnohara.com/register

Warm weather: The PE uniform (yellow t-shirt and green shorts with St. Paul School silkscreen) is worn by all students in PreK every day.

Cold weather: Students will wear the yellow PE t-shirt with PE uniform sweatpants and sweatshirt (both with St. Paul School silkscreens).

All students are to wear an *all-black* Velcro-close sneaker.

Optional item: Green 1/4 zip sweatshirt with school crest.



St. Paul School

Child Care

Child Care is available before and after school every day. Billing of Child Care will be sent home on a bi-weekly basis. We ask that each bill be paid in a timely manner before the next billing cycle. Payment should be made online at: stpaulbrl.org/child-care.



Child Care Fee Schedule

Mornings 6:45-7:45am	\$5/day - \$20 per 5 consecutive days
Afternoons 3:00-3:30pm	\$5/day - \$20 per 5 consecutive days
Afternoons 3:00-6:00pm	\$25 per day - \$100 per 5 consecutive days
Half Days 12:00-3:00pm	\$25 per day
Half Days 12:00-6:00pm	\$30 per day

*Pickup AFTER 6:00pm - \$30 charge.