St. Louise de Marillac Catholic Preschool

REGISTRATION FORM 2022-2023

Registration Date: _____

Student Name _____ M ◯ F ◯ Date of Birth _____
Last First Middle

Father's Name _____ Mother's Name _____
Last First Last First

Home Address _____ City _____ State _____

Zip Code _____

Home Phone: _____ Mom's Cell: _____ Dad's Cell: _____

Mom email: _____ Dad email: _____

St. Catherine Laboure Parishioner? _____

If not, which church do you attend? _____

Please Indicate Session:

( ) Tuesday – Thursday – AM 3 YEAR OLD
( ) Tuesday – Thursday – PM 3 YEAR OLD
( ) Monday – Wednesday – Friday – AM 4 YEAR OLD
( ) Monday – Wednesday – Friday – PM 4 YEAR OLD
( ) Monday – Tuesday – Wednesday – Thursday – Friday – Transition, PM Only

_____ _____
Parent/Guardian Signature Date

St. Louise de Marillac School
310 McMurray Road, Upper St. Clair, PA 15241
Phone: 412.835.0600 Fax: 412.835.2898
www.stlouiseschoolpa.org

St. Louise de Marillac Catholic Preschool
TUITION AGREEMENT

WHEREAS, St. Louise de Marillac School operates under the South Region Catholic Elementary Schools (SRCES), and WHEREAS, the undersigned parents/guardians desire their child(ren) to be enrolled in said school. NOW THEREFORE, with intent to be legally bound hereby, the parties agree as follows:

1. The school will accept _____ as a student(s) for the 2022-2023 school year, subject to the school's rules and regulations regarding behavior and academic matters.

2. In exchange for the school's agreement to accept said child/children as a student(s), the parents/guardians agree to pay tuition in the amount of $_____for the 2022-2023 school year.

   ___◯___ I/We will pay in full, **in advance**, by April 30, 2022.

   ___◯___ I/We agree to enroll in FACTS, our Tuition Management System for tuition payment (Payments are made over a 9 month period; May and then September through April 2023).

3. I/We have included the non-refundable $55 registration fee

1-5-22

_____ _____

Parent/Guardian Signature Date Principal Signature Date

Upper St. Clair Township School District

HEALTH HISTORY

Name: _____ Date of Birth: _____

Address: _____ Telephone Number: _____

Name of Parent: Father: _____ Mother: _____

MEDICAL HISTORY

(Give details where applicable)

	Yes	No	More Information
Allergies ……..	☐	☐	_____
Asthma ……..	☐	☐	_____
Cardiac Problems……..	☐	☐	_____
Diabetes ……..	☐	☐	_____
Gastrointestinal Disorder……..	☐	☐	_____
Headaches/Migraines……..	☐	☐	_____
Hearing Disorder……..	☐	☐	_____
Hospitalizations/Operations……..	☐	☐	_____
Neuromuscular Disorder……..	☐	☐	_____
Orthopedic Condition……	☐	☐	_____
Seizure Disorder……..	☐	☐	_____
Skin Disorder……..	☐	☐	_____
Vision Disorder……..	☐	☐	_____
Other (medical issues/concerns)……..	☐	☐	_____

Are there any special medical problems or chronic conditions which require medication, restriction of activity or which might affect his/her education? If so, specify _____

_____

Parent's Signature _____ Date: _____