

St. Helen Catholic School

2700 East University Avenue

Georgetown, Texas 78626

(512) 868-0744

Fax 512-869-3244

Dear Parent or Guardian:

Enclosed you will find the forms necessary to begin the enrollment process of your child into St. Helen Catholic School. Please remember that submitting this application does not mean your child has been admitted. **All prospective students will be tested.**

Students must be 4, 5 or 6 years of age by September 1, 2010 to enter PreKindergarten, Kindergarten or First Grade, respectively.

Priority in admission is as follows: returning students, siblings of returning students, members of St. Helen Parish; members of neighboring parishes followed by non-Catholics.

Below is a checklist of the documents that are needed in order to begin this process.

_____ Completed Application Form

_____ Survey of Special Needs

_____ Authorization to Release Information

_____ Copy of Birth Certificate* (**Must be the state-issued certificate**)

_____ Copy of Baptism Certificate*
(To qualify for the Catholic Tuition - child must be baptized in the Catholic faith)

_____ Copy of Social Security Card*

_____ Copy of updated Immunization Record. **Diocesan Policy 302.3 regarding Immunizations states that "Immunizations are not in conflict with the Catholic faith. Conscientious objections or waivers, which may be permissible for enrollment in public schools, do not qualify as an exception to this policy."** The complete policy can be found at the end of this Enrollment Packet, as well as online.

_____ Copy of child's most recent Report Card (Grades 1 - 8).

_____ Copy of Standardized Test Results or Academic Record (Grades 1 - 8)

_____ Copy of Custody Agreement (if applicable)

_____ \$150 Non-refundable Application Fee

Please mail all required items to the School Office at 2700 East University Avenue, Georgetown, Texas 78626. Applications will be considered in the order they are received. Thank You.

*You will need to bring in the original copy of these 3 documents for verification by the School Administration.

**ST. HELEN CATHOLIC SCHOOL
NEW STUDENT APPLICATION**

2010 - 2011

ST. HELEN CATHOLIC SCHOOL
2700 E. UNIVERSITY AVENUE
GEORGETOWN, TEXAS 78626
(512) 868-0744
Fax 512-869-3244

FOR OFFICE USE ONLY:	
Date Received:	_____
Grade Entering SHCS:	_____
Application Fee \$	_____ Check #: _____
Processed by:	_____

A non-refundable \$150 application fee and all required documents must accompany this application.

PART I

Grade applying for: _____

(If applying for PreK, child MUST be 4 by September 1, 2010)

(If applying for Kindergarten, child MUST be 5 by September 1, 2010)

(If applying for First Grade, child MUST be 6 by September 1, 2010)

Is this child baptized Catholic? Yes ___ No ___

Child's Name _____
Last Name First Name Middle Name Nickname

_____ Street Address City State Zip Code

_____ Home Phone Child's Birthdate Birthplace (City, State) Social Security Number

Sex ___ M ___ F Age (next September 1, 2010) _____ years _____ months

Are you currently a registered, contributing member of St. Helen Catholic Church? ___ Yes ___ No

Parish in which you are registered if NOT St. Helen? _____

Catholic, but not registered in a parish _____ or non-Catholic _____

(Circle Y or N to indicate if your child has received the following sacraments)

	Baptism	1 st Reconciliation	1 st Eucharist	Confirmation
	Y N	Y N	Y N	Y N
Date:				
Church:				
City/State:				

Ethnic Group (For Diocesan statistical reporting purposes only, please check one - usually mother's Ethnic Group)

_____ American Indian ___ Asian ___ Hispanic ___ Hawaiian/Pacific Islander

_____ Black (non-Hispanic) ___ White (non-Hispanic or other) ___ Multi-racial

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DIOCESE OF AUSTIN
STUDENT HEALTH RECORD

Student Name _____ Date of Birth _____

Family Doctor (name, address, and phone) _____

IMMUNIZATIONS

Please attach a copy of your child's current Immunization Record.

SPECIAL HEALTH PROBLEMS

Please state any special health concerns of which the school personnel should be made aware of:

HEALTH HISTORY

Please record dates of any disease child has had:

DISEASE	DATE	DISEASE	DATE
Chicken Pox		Measles	
Typhoid Fever		Smallpox	
Mumps		Whooping Cough	
Asthma		Scarlet Fever	
Polio		Convulsions	
Diphtheria		German Measles	

Repeated Ear Infections: Y or N Repeated Tonsillitis: Y or N
 Does child currently have tubes in the ears? Y or N Which ear? L R Both
 Wears Corrective Lenses: Y or N

HEALTH HISTORY (continued)

Please list any drug allergies and type of reaction: _____

Please list any food allergies and type of reaction: _____

Does child wear any special appliance or brace? If yes, explain. _____

List any surgery and/or hospitalization child has had and give date. _____

*Does child need medication daily? _____ If so, list the medication by name, the dosage and why child needs to take it. _____

*The policy of the Diocese of Austin only authorizes Catholic School personnel to administer medication (including over-the-counter medication) by a licensed physician or dentist and labeled by a registered pharmacist. The completion of Form #302b (available online and in the School Office) must be signed by the physician and the parent or guardian. The form is valid only for the current school year and all medication(s) will be returned to parent/guardian on the last day of classes.

**ST. HELEN CATHOLIC SCHOOL
SURVEY OF SPECIAL NEEDS**

We at St. Helen Catholic School are in a partnership with parent(s) or guardian(s), to provide the best education for their child/our student. Any information that assists us in this task ultimately benefits your son or daughter. The following information is requested to ensure that each student's individual learning needs are met to the best of our ability. Failure to provide this information may inhibit the staff's ability to meet the individual needs of your child, and consequently, the school reserves the right to forego acceptance or continuation of the child in our School if such information is not provided.

PLEASE NOTE THAT ALL INFORMATION IS HELD IN THE STRICTEST CONFIDENCE. ALL QUESTIONS MUST BE ANSWERED.

1. Has your child been tested for any special concerns--academic, behavioral or other? Yes No
If yes, please explain: _____

2. Has your child ever been on medication for educational/behavioral purposes? Yes No
If yes, please explain: _____

3. Has your child ever been referred for special educational services? Yes No
If so, what type, by whom and with what results: _____

4. Has your child had special educational services provided? Yes No
If yes, please explain. _____

5. Has your child ever been under the care of a professional counselor, psychologist, or psychiatrist?
 Yes No
If yes, please explain. _____

These next 3 questions must be answered.

6. Are you willing to share all previous and future special education information/tests with the Principal of St. Helen Catholic School? Yes No
7. Would you allow a copy of the special education information/tests to be placed in a confidential student file(s) at St. Helen Catholic School? Yes No
8. Are you willing to sign a release to allow the Principal to speak with the person(s) who conducted any of these services or tests or prepared any information? Yes No

Parent/Guardian Signature

Date

ST. HELEN CATHOLIC SCHOOL
AUTHORIZATION TO RELEASE INFORMATION*

Authorization is hereby granted to:

Name of School Attended by your Child Prior to Enrollment in SHCS

Street Address, City/State/Zip of Previous School

Phone Number of Previous School

to release information from the Educational/Psychological/Medical records of:

Name of Student

Date first Enrolled in Previous School _____

Date of Withdrawal _____

Previous School to send copies of Student Records to:

St. Helen Catholic School
2700 East University Avenue
Georgetown, Texas 78626
Attn: School Administrator

Parent/Guardian Signature

Date: _____

*This form will be mailed to your child's current school by St. Helen Catholic School only **after** the current school year has ended.

ST. HELEN CATHOLIC SCHOOL

AFTER SCHOOL PROGRAM GENERAL INFORMATION

On-site staff coordinates this program and billing is handled through the School Office. The program is an extension of the regular school day, and because some structure is necessary for order and control, the students are primarily encouraged to use this time to complete homework assignments. *Only students enrolled at St. Helen Catholic School are eligible for this program*

PROGRAM HOURS

3:30pm to 6pm
(regular school days)

After School Care is not provided on Early Dismissal Days. Any student that is not picked up by 3:45pm will be placed in the After School Care Program. Billing begins at 3:45pm. Snacks are provided.

FEES PER STUDENT

Monthly Rate: \$176 per child will apply if your child(ren) is/are in the program for 6 days or more (whether consecutive or not).

Daily Rate: \$17 per child will apply if your child(ren) is/are in the After School Program anywhere from one to five days (consecutive or not).

302.3

Immunization Policy

Every student enrolled in a Catholic school in the Diocese of Austin shall be immunized against vaccine preventable diseases caused by infectious agents in accordance with the immunization schedule adopted by the Texas Department of State Health (commonly known as the “Minimum State Vaccine Requirements for Texas School Entrance/Attendance”). Each year, every student must present evidence of the required immunizations from a physician or health care provider authorized to administer immunizations to the school before the first day of school. The immunizations must be current. A student who fails to present the required evidence shall not be accepted for enrollment.

There are no exceptions to the foregoing requirement unless the student presents a written statement signed by the student’s physician (M.D. or D.O.) who is authorized to practice in the State of Texas, stating that:

- (1) the physician has examined the student;*
- (2) the physician has determined that the student has either:
 - (a) an allergy to the vaccination(s) identified in the statement and will suffer the severe allergic reaction(s) described in the statement;
 - (b) an immunodeficiency described in the statement and will suffer a serious health risk(s), which is also described in the statement, if the student receives the vaccination(s) specifically identified in the statement; or
 - (c) a neurological disorder described in the statement and will suffer a serious health risk(s), which is also described in the statement, if the student receives the vaccination(s) specifically identified in the statement; and
- (3) it is the physician’s judgment that the student will pose no serious health risk to the rest of the school community if admitted to the school without receiving the identified vaccination(s).

Exceptions under this policy apply only to the vaccine(s) specifically identified in the physician’s statement as causing a severe allergic reaction or a serious health risk to the student.

The physician’s statement under this policy shall be in a form that is acceptable to the Superintendent of Catholic Schools of the Diocese of Austin. The Superintendent shall make acceptable forms available. [sample statement follows this policy]

Immunizations are not in conflict with the Catholic faith. Conscientious objections or waivers, which may be permissible for enrollment in public schools, do not qualify as an exception to this policy (Atty. Gen. Op. GA-0420). [<http://www.oag.state.tx.us/opinions/opinions/50abbott/op/2006/pdf/ga0420.pdf>]

*A physician’s exam and renewal of exemption are required upon entrance to elementary, middle school, and high school.

[Sample Physician's Statement – Must be typed on Physician's Letterhead]

Date: _____

Name of Patient: _____

Age of Patient: _____

Name of School: _____

Address of School: _____

On _____ I, the undersigned physician, examined the patient named above.

Based on my examination, it is my judgment that the patient will face the following serious health risk(s) if the Patient receives the following vaccination(s):

Identify Vaccination(s): _____

Identify Serious Health Risk(s):

The Patient has the following allergy to the vaccination(s) listed above: _____ and will suffer the following severe allergic reaction if the Patient receives the vaccination: _____

I have diagnosed the Patient with the following immunodeficiency: _____ and if the Patient receives the vaccination the Patient will face the following serious health risk: _____

I have diagnosed Patient with the following neurological disorder: _____ and if the Patient receives the vaccination the Patient will face the following serious health risk: _____

It is also my judgment that admitting the Patient to the School named above will pose no serious health risk to the rest of the school community, children or staff.

(Signature of Physician)

Print Name: _____

This statement is to be typed on the physician's letterhead and signed by the physician. The physician may attach additional sheets for further explanation.