



**SACRED HEART**  
*Early Learning Center*

**Admissions Application**

**2018/2019**

**Sacred Heart  
Early Learning Center**

Admissions Office  
615 McDade Street  
Conroe, Texas 77301

**Tel: 936-521-3004**

**Fax: 936-756-4097**

**[www.shcstx.com](http://www.shcstx.com)**



**Sacred Heart Early Learning Center**  
 615 McDade Street  
 Conroe, TX 77301

**Admissions Office 2018-2019**  
 Date Received \_\_\_\_\_  
 Date Started \_\_\_\_\_  
 ELC Grade Level \_\_\_\_\_

**I. APPLICANT INFORMATION**

First Name	Middle Name	Last Name	Preferred Name
Street Address	City	State	Zip Code
Home Phone #	Applicant Social Security #	Date of Birth	
_____ Male _____ Female		Country of Citizenship	
Name of Current School		School Phone #	
School(s) Previously Attended			

**II. FAMILY INFORMATION: \_\_\_\_\_ CATHOLIC \_\_\_\_\_ SACRED HEART PARISHIONERS \_\_\_\_\_ NON-CATHOLIC**  
**AFFILIATED PARISH: \_\_\_\_\_ RELIGIOUS AFFILIATION: \_\_\_\_\_**

Parent/Guardian

First Name	Last Name	
Home Address (if different from above)		
City	State	Zip
Home Phone #	Cell Phone #	
E-mail address		
Place of Employment & Position		
Work Phone #		
If divorced and remarried, spouse's full name		

Parent/Guardian

First Name	Last Name	
Home Address (if different from above)		
City	State	Zip
Home Phone #	Cell Phone #	
E-mail address		
Place of Employment & Position		
Work Phone #		
If divorced and remarried, spouse's full name		

Name of parent/guardian with whom the applicant resides: \_\_\_\_\_

Who is financially responsible for the applicant's tuition? \_\_\_\_\_

Names of any relatives who attend (have attended) Sacred Heart:

Name	Relation
_____	_____
_____	_____
_____	_____

**III. FAMILY PARTICIPATION**

As a school community, Sacred Heart Early Learning Center would like to keep your child's immediate family members, grandparents, and friends informed with our newsletter and various function invitations. Please provide the following information:

**Siblings:**

Name \_\_\_\_\_ Age \_\_\_\_\_ School \_\_\_\_\_

Name \_\_\_\_\_ Age \_\_\_\_\_ School \_\_\_\_\_

Name \_\_\_\_\_ Age \_\_\_\_\_ School \_\_\_\_\_

**Paternal Grandparents**

Name \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Telephone (\_\_\_\_\_) \_\_\_\_\_ Email \_\_\_\_\_

**Maternal Grandparents**

Name \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Telephone (\_\_\_\_\_) \_\_\_\_\_ Email \_\_\_\_\_

**IV. IDENTIFIED SPECIAL NEEDS OF APPLICANT:** Name: \_\_\_\_\_

Parents are expected to disclose to appropriate school personnel any significant information which may affect their child's education progress or the other students' learning environment. Such information includes but is not limited to academic or medical diagnostic evaluations, medications, or specific family situations. Failure to disclose such significant information during the application process or as the situation changes may result in dismissal of the child.

Applicant has: (Check one that applies)

\_\_\_\_\_ Physical handicap, medical condition, special current or recurrent illness of which school should be informed. Please describe:

\_\_\_\_\_Diagnosed learning disability: (Diagnosed by & date): \_\_\_\_\_

**Copies of testing results must be submitted.**

\_\_\_\_\_Attention Deficit/Hyperactivity Disorder: (Diagnosed by & date): \_\_\_\_\_

Description: include types and dosages of medication if applicable and intervention strategies currently being implemented.

Has this applicant ever been tested or counseled by a psychologist or psychiatrist? Yes\_\_\_ No\_\_\_ Date: \_\_\_\_\_

**All results of educational/psychological evaluations must be submitted with this application.**

Socialization or behavioral problems? Yes\_\_\_ No\_\_\_ Date: \_\_\_\_\_

If yes, please explain. Please provide any other information, regarding the child's educational background or social development that the school should know in order to evaluate its ability to serve the child's needs.

## **V. PARENTS' GOALS AND ASSESSMENTS**

In order for the admissions (Director) to evaluate your child and his/her needs in regard to the programs offered, please answer the following questions. *You may attach an additional page.*

**Reason for wishing to enroll student at Sacred Heart Early Learning Center:**

### **Type of Educational Program and Environment Sought for Your Child**

Realizing that there are many variables involved in the educational process, please explain the type of educational program/ environment that you desire for your child. What objectives would you like for the teacher to emphasize regarding your child?

**Specific Interests**

Please provide us with your perspective on your child. Describe your child's strengths and abilities, special areas of interest and/or concerns.

**Additional Information**

Please provide any additional information regarding your family (adoption, divorce, separation, changes in school, deaths of relatives/friends) or child (fears, social problems, etc.) that would help us know and understand his/her educational or personal needs.

**VI. ADDITIONAL INFORMATION**

How did you learn about Sacred Heart Early Learning Center?

Have you previously applied to Sacred Heart Early Center and if so when?

For reporting purposes only, please describe your child's racial/ethnic heritage:

\_\_\_\_Caucasian    \_\_\_\_Asian    \_\_\_\_American European    \_\_\_\_American Latino    \_\_\_\_Hispanic American  
\_\_\_\_Native American    \_\_\_\_Middle Eastern American    \_\_\_\_African American Other

**VII. FEE AND SIGNATURE**

Please send completed form with non-refundable application fee of \$35 (make check payable to: Sacred Heart ELC and include the applicant's name on the memo line) to: Sacred Heart ELC - 615 McDade Street, Conroe, TX 77301

I give Sacred Heart Early Learning Center permission to contact applicant's current school for additional information if necessary.

Signature of Parent Guardian \_\_\_\_\_ Date \_\_\_\_\_

**STATEMENT OF ACCURACY AND AUTHENTICITY**

I have read and understood this application, and I further certify that the information and attached documents are complete and accurate to the best of my knowledge. I agree to communicate in writing to the director any changes contained herein even if said changes occur after enrollment. I understand that upon discovery of substantial inaccuracy of any information herein, or omission of information requested herein, the school reserves the right to revoke admission of this applicant.

\_\_\_\_\_  
Signature of Parent/Guardian      Date

\_\_\_\_\_  
Signature of Parent/Guardian      Date

Sacred Heart Early Learning Center admits students of any race, color, national and ethnic origin to all the rights, privileges, programs and activities generally accorded or made available to students at the school. It does not discriminate on the basis of race, color, national and ethnic origin in administration of its educational policies, admission policies, and other school administered programs.



**ELC Program Choice 2018-2019**

Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Class Registration/Monthly tuition. Class placement is based on age of child as of September 1, 2018 and subject to change based on availability. Please check appropriate box.

Three Days Mon/Wed/Fri (18 mos. – 4 Year Olds) \$575.30/month (July - April) 7:45 a.m. – 3:00 p.m.

Five Days Monday through Friday (18 mos-4 Year Olds) \$635.30/month (July – April) 7:45 a.m. – 3:00 p.m.

**\*Please note children must be potty trained to attend 3 and 4-year-old classes.**



**SACRED HEART EARLY LEARNING CENTER STUDENT EMERGENCY FORM 2018/2019**

\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_  
 (Student Last Name) (First) (MI) (Date of Birth) (Age) (Sex) (Grade)

Child resides with: \_\_\_\_\_ Mother & Father \_\_\_\_\_ Mother \_\_\_\_\_ Father \_\_\_\_\_ Other (Relationship) \_\_\_\_\_

Father/Guardian Name: \_\_\_\_\_ Mother/Guardian Name: \_\_\_\_\_

Address: \_\_\_\_\_ Address: \_\_\_\_\_

\_\_\_\_\_  
 (City) (State) (Zip Code)

\_\_\_\_\_  
 (City) (State) (Zip Code)

Phone: Home/Cell (\_\_\_\_\_) \_\_\_\_\_

Phone: Home/Cell (\_\_\_\_\_) \_\_\_\_\_

Work/Cell (\_\_\_\_\_) \_\_\_\_\_

Work/Cell (\_\_\_\_\_) \_\_\_\_\_

Father's E-Mail: \_\_\_\_\_

Mother's E-mail: \_\_\_\_\_

Father's Employer: \_\_\_\_\_

Mother's Employer: \_\_\_\_\_

**LIST PERSONS TO PICK UP or CONTACT IN CASE OF EMERGENCY WHEN PARENT/GUARDIAN CANNOT BE REACHED**

Contact Name	Relationship	Phone	Email
_____	_____	_____	_____
_____	_____	_____	_____

**MEDICAL INFORMATION**

Doctor's Name: \_\_\_\_\_ Office Phone: (\_\_\_\_\_) \_\_\_\_\_

Insurance Carrier: \_\_\_\_\_ Group Policy # \_\_\_\_\_

Allergies (drugs, food, environmental): \_\_\_\_\_

Medical Conditions (ex. diabetes, asthma) \_\_\_\_\_ Medication (taken daily or as needed) \_\_\_\_\_ YES \_\_\_\_\_ NO

\_\_\_\_\_  
 Medication Name Dosage

I, \_\_\_\_\_, do hereby authorize the school administration to render first aid for illness or injury to my child named above. In the event of a medical emergency, I authorize the school administration to have my child transported to the nearest hospital/emergency care center for emergency medical or surgical treatment and to contact my child's physician and one of the persons listed above. I further authorize the release of the above medical information to all medical personnel providing treatment. I agree to be solely responsible for the payment of all expenses incurred in such an emergency. I do hereby release, hold harmless, and indemnify most Reverend Daniel N. DiNardo, Archbishop of the Archdiocese of Galveston-Houston and his successors in office, the Archdiocese of Galveston-Houston, Sacred Heart School and any other of their officers, agents, employees or representatives from any and all liability, claims, losses, or expenses arising from personal injury, death, or loss of or damage to property arising from any medical treatment received and/or transportation to the nearest hospital/emergency care center.

\_\_\_\_\_  
**Signature of Parent/Guardian**

\_\_\_\_\_  
**Date Signed**



# SACRED HEART

## Early Learning Center

### STUDENT TB QUESTIONNAIRE 2018/2019

Name of Child \_\_\_\_\_ Date of Birth \_\_\_\_\_

Tuberculosis (TB) is a disease caused by TB germs and is usually transmitted by an adult person with active TB lung disease. It is spread to another person by coughing or sneezing TB germs into the air. These germs may be breathed in by the child. Adults who have active TB disease usually have many of the following symptoms: cough for more than two weeks duration, loss of appetite, weight loss of ten or more pounds over a short period of time, fever, chills and night sweats.

A person can have TB germs in his or her body but not have active TB disease (this is called latent TB infection or **LTBI**). Tuberculosis is preventable and treatable. TB skin testing (often called the PPD or Mantoux test) is used to see if your child has been infected with TB germs. No vaccine is recommended for use in the United States to prevent tuberculosis. The skin test is not a vaccination against TB.

We need your help to find out if your child has been exposed to tuberculosis.

Place a mark in the appropriate box:	Yes	No	Don't Know
TB can cause fever of long duration, unexplained weight loss, a bad cough (lasting over Two weeks), or coughing up blood. As far as you know: has your child been around anyone with any of these symptoms or problems? or has your child had any of these symptoms or problems? or has your child been around anyone sick with TB?			
Was your child born in Mexico or any other country in Latin America, the Caribbean, Africa, Eastern Europe or Asia?			
Has your child traveled in the past year to Mexico or any other country in Latin America, the Caribbean, Africa, Eastern Europe or Asia for longer than 3 weeks? If so, specify which country/countries? _____ _____			
To your knowledge, has your child spent time (longer than 3 weeks) with anyone who is/has been an intravenous (IV) drug user, HIV-infected, in jail or prison or recently came to the United States from another country?			

Has your child been tested for TB? Yes \_\_\_ (if yes, specify date \_\_\_ / \_\_\_ ) No \_\_\_

Has your child ever had a positive TB skin test? Yes \_\_\_ (if yes, specify date \_\_\_ / \_\_\_ ) No \_\_\_

For school/healthcare provider use only



PPD administered Yes \_\_\_ No \_\_\_

Date administered \_\_\_ / \_\_\_ / \_\_\_ Date read \_\_\_ / \_\_\_ Result of PPD test \_\_\_ mm response

Type of service provider (i.e. school, Health Steps, other clinics) \_\_\_\_\_

PPD provider \_\_\_\_\_  
Print Name
Address

Provider phone number \_\_\_\_\_





### Statement of Child's Health 2018/2019

**Admission Requirement:** The following must be presented when your child (under the age of 5 years) is admitted to the day care facility within one week of admission. Please take to your child's health care provider.

Child Name: \_\_\_\_\_

DOB: \_\_\_\_\_

**Health Care Provider Information:**

Name of Health Care Organization (Printed): \_\_\_\_\_

Name of Health Care Provider (Printed): \_\_\_\_\_

Complete Address (Printed): \_\_\_\_\_  
\_\_\_\_\_

Contact Number: \_\_\_\_\_

\_\_\_\_\_ Health-Care Professionals Statement: I have examined the above-named child within the past year and find that he/she is physically able to take part in the day care program.

\_\_\_\_\_  
Health Care Providers Signature

\_\_\_\_\_  
Date