



## *Sister Thea Bowman Catholic School*

8213 Church Lane East St. Louis, IL 62203  
Phone (618) 397-0316 /4926 Fax (618) 397-0337

### **Contact Information 2020 - 2021** (Please complete a separate form for each child)

Entering into Grade \_\_\_\_\_ Male / Female (circle one)

Child's Name \_\_\_\_\_

Address \_\_\_\_\_  
Last First Middle Phone (home) \_\_\_\_\_

City/State/Zip \_\_\_\_\_ Phone (cell) \_\_\_\_\_

School District: District 189 District 187 Other \_\_\_\_\_

Date of Birth \_\_\_\_\_ Place of Birth \_\_\_\_\_

Child lives with \_\_\_\_\_ Relationship to child \_\_\_\_\_  
Name of person

Mother's Name: \_\_\_\_\_

Married Divorced Single Deceased

Mother's Address \_\_\_\_\_ Phone (home) \_\_\_\_\_

City/State/Zip \_\_\_\_\_ Phone (cell) \_\_\_\_\_

Mother's Email Address \_\_\_\_\_

Mother's Occupation \_\_\_\_\_ Phone (work) \_\_\_\_\_

Place of Employment \_\_\_\_\_

Father's Name: \_\_\_\_\_

Married Divorced Single Deceased

Father's Address \_\_\_\_\_ Phone (home) \_\_\_\_\_

City/State/Zip \_\_\_\_\_ Phone (cell) \_\_\_\_\_

Father's Occupation \_\_\_\_\_ Phone (work) \_\_\_\_\_

Place of Employment \_\_\_\_\_

Father's Email Address \_\_\_\_\_

(OVER)

Guardian's Name: (If applicable) \_\_\_\_\_

Married

Divorced

Single

Guardian's Address \_\_\_\_\_ Phone (home) \_\_\_\_\_

City/State/Zip \_\_\_\_\_ Phone (cell) \_\_\_\_\_

Guardian's Occupation \_\_\_\_\_ Phone (work) \_\_\_\_\_

Place of Employment \_\_\_\_\_

Guardian Email Address \_\_\_\_\_

Grandparent Name: \_\_\_\_\_

Address \_\_\_\_\_ Phone (home) \_\_\_\_\_

City/State/Zip \_\_\_\_\_ Phone (cell) \_\_\_\_\_

Grandparent Name: \_\_\_\_\_

Address \_\_\_\_\_ Phone (home) \_\_\_\_\_

City/State/Zip \_\_\_\_\_ Phone (cell) \_\_\_\_\_

### **MEDICAL INFORMATION**

List physical/medical problems of which the school should be aware: \_\_\_\_\_

\_\_\_\_\_

Daily Medication \_\_\_\_\_

Physical on file at school? \_\_\_\_\_ Dental on file? \_\_\_\_\_ Immunizations current? \_\_\_\_\_

### **EMERGENCY PHONE NUMBERS (List two other than home)**

Name/Relationship \_\_\_\_\_ / \_\_\_\_\_ Phone \_\_\_\_\_

Name/Relationship \_\_\_\_\_ / \_\_\_\_\_ Phone \_\_\_\_\_

List names/ages/grade levels of all your other children currently at Sister Thea Bowman:

Name \_\_\_\_\_ Age \_\_\_\_\_ Entering Grade \_\_\_\_\_

Name \_\_\_\_\_ Age \_\_\_\_\_ Entering Grade \_\_\_\_\_

Name \_\_\_\_\_ Age \_\_\_\_\_ Entering Grade \_\_\_\_\_

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



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[www.stbcs.com](http://www.stbcs.com)

March 12, 2020

Dear Family Members,

Since the stability of our school and the quality of its programs are of the utmost importance, we are always seeking ways to make improvements to benefit everyone. After much research and investigation, we have partnered with FACTS Management Company to help us manage our tuition payment program and financial aid assessment. FACTS is used by many schools locally and over 6,500 schools nationally. We are excited to be working with them and are confident this program will offer greater efficiency and financial stability for the school while providing convenience to families.

One of our primary goals this year at Sister Thea Bowman is to concentrate our efforts on improving the *business side* of our school. By taking advantage of the security and convenience of payment processing and information technology offered by FACTS, we remain committed to this goal.

You will realize these benefits by using FACTS for your tuition payment plan:

1. **Payment Dates:** You may choose either the 1<sup>st</sup> or the 5<sup>th</sup> of each month as your payment date. Automatic payments can be made from a checking or savings account or from a variety of credit cards, if applicable.
2. **Enrolling in FACTS:** You will receive an invite from FACTS with information necessary to enroll. Included in the invite will be the website you will need to access.
3. **Convenience & Security:** Along with multiple payment plan options, your payments are processed securely through a bank to bank transaction.
4. **Peace of Mind Insurance:** FACTS offers this optional benefit for only \$20 per year per family. In the event of death of the responsible party or spouse, the remaining tuition balance owed for the current school year is paid to the school.
5. **Consumer Account:** You may check your personal account or make payments online from the convenience of your home or office anytime.

With FACTS, the school maintains decision-making control. As always, we will continue to work with families should special circumstances or “hardship” cases arise during the school year.

Thank you for your continued loyalty and support for our school. We depend on your support in our efforts to provide the highest quality of education for your children.

Blessings and Peace,

Dan Nickerson  
Principal



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## ***PARENT/GUARDIAN COMMITMENT FORM 2020 - 2021***

**As educators at Sister Thea Bowman Catholic School, we believe it is our mission to:**

- 1. provide quality education to children who are enrolled in our school**
- 2. teach and provide experience in Catholic doctrine, spirit, and tradition**
- 3. provide opportunities for developing spirituality in students**
- 4. teach children skills for becoming peacemakers at school, at home, and in their communities**
- 5. involve students, parents/guardians, and teachers in the total educational process**
- 6. provide students and parents/guardians the practical, religious, academic, and economic responsibilities that accompany attendance at Sister Thea Bowman Catholic School.**

## ***PARENT/GUARDIAN WITNESS STATEMENT***

**We believe that parents/guardians provide the primary faith formation of their children. We believe that each person has a faith aspect to his/her life and personality.**

**We also believe that the primary purpose of Catholic education is to reinforce, deepen, and enrich the faith that the children experience at home. When the Catholic school clearly and effectively communicates the truths of faith, and when a child sees these truths in practice in the family, there is hope that faith will take root in the heart of that child. A parent's/guardian's own witness is essential to the faith development of the child. Therefore, we ask that:**

- 1. all Catholic families worship weekly at Saturday/Sunday Eucharist and participate in the sacramental preparation of their children**
- 2. all families participate in weekly worship at the church of their choice**
- 3. all parents/ guardians speak to their children about God**
- 4. all parents/guardians make prayer an integral part of their home life**
- 5. all parents/guardians accept responsibility to become familiar with the religion curriculum and become more knowledgeable about the Catholic faith**
- 6. all parents/guardians support the moral teachings of Christian faith in order to not contradict in the home what is taught at school**
- 7. by word and example, all parents/guardians teach their children love and concern for the needs of others, especially the poor.**

**(OVER)**

**Families enrolling their children in Sister Thea Bowman Catholic School must:**

- 1. want their children to receive an education with a strong faith formation emphasis,**
- 2. be willing to make sure their children are on time and ready for school everyday,**
- 3. attend all school related meetings, events, and attend report card conferences with their child,**
- 4. see that their children are at special events: Advent Service and Spring Concert,**
- 5. meet with teachers and administration when requested,**
- 6. be respectful and cooperative with school staff,**
- 7. refrain from using social media to criticize members of the STBCS family,**
- 8. respect confidentiality in parent/guardian/student conferences,**
- 9. support and follow school policies,**
- 10. remain current in tuition/meals/before/after care and extended day fees,**
- 11. agree to participate in fundraising activities or pay the fundraising fee,**
- 12. pledge prayer and/or financial support to the Annual Fund Drive,**
- 13. provide service hours to the school to support the school mission,**
- 14. read weekly newsletter to keep up on current announcements and news.**

**I understand that my presence and participation in my child's school life is critical to his/her success and growth. I have read this Commitment Form and agree to the school's expectations for parents/guardians.**

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**Parent/Guardian Signature**

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**Date**



# Sister Thea Bowman Catholic School

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## Sister Thea Bowman Summer Academy

June 1, 2020 –June 19, 2020

The summer academy program is a collaborative educational experience between the faculty and administration of Sister Thea Bowman Catholic School and ACCESS Academies. The goal of the program is to provide academic enrichment in core subject areas and prepare students for high school and beyond. The summer Academy curriculum is aligned with the common core standards in Math, Science, Reading and Writing, and will feature enrichment classes in Life Skills.

**There is NO cost, however, it is mandatory that rising 6<sup>th</sup> / 7<sup>th</sup> / 8<sup>th</sup> graders attend Summer School Academy.**

### Program Information

1. **Enrollment:** Rising 6<sup>th</sup>, 7<sup>th</sup>, and 8<sup>th</sup>-grade, students enrolled at Sister Thea Bowman Catholic School are required to attend the Summer Academy if they are to return for the Fall. The Summer Academy is counted as 30% of their 1<sup>st</sup> quarter grades for the 2020-2021 school year.
2. **Attendance:** Attendance is mandatory. Any combination of three late arrivals, absences, or late pick-ups will result in the student being dropped from the program.
3. **Behavior:** The Summer Academy will foster a Christian learning environment. Students will behave in ways that are compliant with the teachings of Sister Thea Bowman Catholic School's peacemaker pledge. Behavior issues will be handled by teachers and reported to the Principal. Students who consistently display inappropriate behavior or who are involved in any major discipline offense will be dismissed from the program.
4. **Dress Code:** Students participating in the Summer Academy are required to wear their regular school uniform.
5. **Meals:** Students will have the same lunch options that they have during the regular school year; they may have school lunch or bring lunch from home.
6. **Daily Schedule:** The Summer Academy will start on June 1, 2020 and will end on June 19, 2020. Classes will begin daily at 8:30am and will conclude at 3:00pm Monday through Friday.  
**(8:30-10am: Academics/ 15-minute break / 10:15-11:45am: Academics/ 30-minute Lunch Break / 12:15- 1:45pm: Academics / 15-minute break / 2:00-3:00pm: Enrichment)**

**By signing this form I understand that it is mandatory that my student attend STBA Summer School Academy and acknowledge the consequences if they're dismissed from Summer School. (If a student is dismissed or doesn't attend Summer School Academy they will not be able to return to school in August 2020)**

# **Sister Thea Bowman Academy**

## **2020 Summer Academy Registration Form**

### **Student Information:**

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

### **Parent Information:**

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

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

City/State/Zip: \_\_\_\_\_

Phone: \_\_\_\_\_ cell: \_\_\_\_\_

Email: \_\_\_\_\_

### **Emergency Contact Information:**

Name 1: \_\_\_\_\_ relation: \_\_\_\_\_

Phone: \_\_\_\_\_ cell: \_\_\_\_\_

### **Emergency Contact Information:**

Name 2: \_\_\_\_\_ relation: \_\_\_\_\_

Phone: \_\_\_\_\_ cell: \_\_\_\_\_

### **Daily Departure**

I will pick up my student at 3pm. The following person(s) may sign my child out.

Person 1: \_\_\_\_\_

Person 2: \_\_\_\_\_

Signature: \_\_\_\_\_

Date: \_\_\_\_\_

# Sister Thea Bowman Academy Family Contract

As members of Sister Thea Bowman Academy, the students, parents/guardians, and faculty/staff promise to honor this Peace Pledge to the best of our ability.

***We are peacemakers.***

***We are respectful in actions and words to God, self, others, and all creation.***

With this in mind, Sister Thea Bowman Academy offers a joint contract for parents, guardians, students, teachers, and staff. We have high expectations of ourselves, and we also expect a great deal of our students and parents/guardians. To that end, we offer this **Family Contract**. Please carefully read this, sign where appropriate, and return for completion of your registration.

The faculty and staff at Sister Thea Bowman Academy promise, with God's help, to:

- Provide a safe learning environment for students,
- Provide an extended school year for students to enhance performance and learning,
- Provide a full school day (8:00am – 5:00pm, M-Th; 8:00am – 3:30pm, F), ensuring educational enrichment opportunities in the areas of STEM, performing/fine arts, character education/leadership, academic/college/career, and other elective classes,
- Provide proper learning materials and buildings to promote optimal learning,
- Use quality comprehensive curriculum that challenges our students and encourages academic growth,
- Provide parent/guardian meetings to help parents better understand the high school process and subsequent college preparation,
- Follow our graduates into and through a college preparatory high school, providing counseling, support, advocacy, and financial tuition assistance,
- Follow our graduates into whatever post-secondary path they choose, providing guidance, support, advocacy, and college success services,
- Provide funding to our graduates for ACT/SAT preparation, college visits, college applications and other college access and success programs,
- Provide the assistance needed (academic and emotional) for all students to succeed if they choose to do so,
- Provide parent/guardian meetings to promote growth as families.

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Daniel Nickerson, Principal  
(on behalf of STBA faculty and staff)

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Date



# **Sister Thea Bowman Academy Family Contract**

I, the parent(s)/guardian(s), want my child to succeed. I see the program at Sister Thea Bowman Academy as a way to make this happen. I make the commitment, with God's help, to my child and to Sister Thea Bowman Academy to:

- Be attentive to the needs of my child,
- Read weekly school newsletters to be informed about school happenings,
- Read to or with my child daily,
- Take an active interest in my child's education by daily checking agendas, verifying that homework is completed, helping with memory work, signing appropriate homework sheets, and checking grades on-line,
- Monitor my child daily for proper uniform dress and necessary tools for learning,
- Assure my child is on time and attends the full school day,
- Schedule my summer plans after the Academy's extended school year,
- Work with the Graduate Support Director to identify the best college preparatory high school choice for my child,
- Support our teachers and work closely with them to help my child succeed,
- Attend all required programs and meetings,
- Make prompt payments of my school financial obligations.

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Parent/Guardian

---

Date

I, the student, with God's help promise to:

- Faithfully live up to the Peace Pledge,
- Arrive at school in proper school uniform,
- Have all necessary tools for my job as a student,
- Promote a healthy and safe classroom-learning environment by respecting other students and teachers and living in harmony with them,
- Work towards academic success by listening in class, taking notes, participating in class, asking questions, and completing assigned homework and projects,
- Show respect for the adults in charge through my words and actions,
- Be on time and attend the full school day,
- Attend the complete Academy extended school year,
- Keep the school and grounds in clean condition,
- Work with the Graduate Support Director to identify the best college preparatory high school choice for myself,
- Attend all required programs and meetings,
- Take responsibility for my learning by checking grades on-line weekly and proactively working with my teachers to address any issues.

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Student

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Date

**A broken Family Contract may be cause for dismissal from  
Sister Thea Bowman Academy.**



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## **2020-2021 TUITION ASSISTANCE APPLICATION**

(Please Print Clearly)

**DEADLINE** (One week after registration meeting. Must be accompanied by registration fee)

Student (s) Name(s) \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

### **TUITION SCALE**      **Payments: July 1, 2020 – April 1, 2021**

<i>Kindergarten-Grade Eight</i>	<i>10-months</i>	<i>9-months</i>	<i>8-months</i>	<i>7-months</i>
<b>1 Child-</b> \$4500 per year	\$450	\$500	\$563	\$643
<b>2 Children-</b> \$6500 per year	\$650	\$722	\$813	\$929
<b>3 Children-</b> \$7500 per year	\$750	\$833	\$938	\$1071
<b>4 Children-</b> \$8000 per year	\$800	\$889	\$1000	\$1143

### **PARENT/GUARDIAN/STUDENT AGREEMENT**

I request tuition assistance for my child(ren) for the coming school year.

I am able to make 10 monthly payments of \$\_\_\_\_\_ each, beginning July 1 through April 1.

**The TOTAL amount of tuition I am able to pay for the year is \$\_\_\_\_\_.**

**I have submitted a copy of 2 current pay stubs, or my last tax return, or other documentation for verification of income, to include SSI or SSDI.**

***I recognize and understand that tuition assistance may be terminated at the discretion of the principal for: Excessive tardiness and/or absences; Unacceptable behavior in or out of school; Grades falling below a C average; Lack of participation and/or cooperation on the part of the student/parent/guardian; or failure to make tuition payments in a timely manner.***

I understand that if a student who receives tuition assistance withdraws prior to the last day of school, ***no tuition refund is given.***

\_\_\_\_\_  
Parent/Guardian Name (please print)

\_\_\_\_\_  
Parent/Guardian Signature

**Please fill out information on reverse side.**

**Estimated Family Income Based on Attached Pay Stubs or Income Tax Document:**

**Family Income from Wages (Monthly):** \_\_\_\_\_

**SSI or SSDI for Student(s) (Monthly):** \_\_\_\_\_

**Family Unemployment Income (Monthly):** \_\_\_\_\_

**Total estimated Family Monthly Income:** \_\_\_\_\_

**Additional Information needed to determine monthly tuition rate:**



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## **CHURCH/PASTOR INFORMATION**

**2020 - 2021**

We believe that Faith Formation is critical to your student's growth and development. If you have a strong family faith tradition, we encourage you to continue with it, but if you do not, then we encourage you to find a faith community for worship. Please provide information on your current church:

Church \_\_\_\_\_

Street \_\_\_\_\_

City/State/Zip \_\_\_\_\_

Parent/Guardian Name \_\_\_\_\_

\_\_\_\_ I currently do not attend church regularly.

\_\_\_\_ I am interested in learning about the Catholic Church.

*For Catholic Students, please provide:*

### **BAPTISM**

Child/Children Name(s)

Name of Church

Date

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_ My child is not baptized.

## **VIDEO/PHOTO PERMISSION**

**2020 - 2021**

I give permission to have my children filmed and photographed for school related activities. I understand that the videos and photographs may be used for marketing purposes to prospective school parents/guardians and possible financial donors.

### **CHILDREN'S NAMES**

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_  
Parent/Guardian Signature



# State of Illinois

## Certificate of Child Health Examination

<b>Student's Name</b>				<b>Birth Date</b>	<b>Sex</b>	<b>Race/Ethnicity</b>	<b>School /Grade Level/ID#</b>	
Last                      First                      Middle				Month/Day/Year				
Address                      Street                      City                      Zip Code				Parent/Guardian                      Telephone # Home                      Work				
<b>IMMUNIZATIONS: To be completed by health care provider. The mo/da/yr for <u>every</u> dose administered is required. If a specific vaccine is medically contraindicated, a separate written statement must be attached by the health care provider responsible for completing the health examination explaining the medical reason for the contraindication.</b>								
<b>REQUIRED Vaccine / Dose</b>	<b>DOSE 1</b>		<b>DOSE 2</b>		<b>DOSE 3</b>		<b>DOSE 4</b>	
	MO	DA	YR	MO	DA	YR	MO	DA
<b>DTP or DTaP</b>								
<b>Tdap; Td or Pediatric DT</b> (Check specific type)	<input type="checkbox"/> Tdap <input type="checkbox"/> Td <input type="checkbox"/> DT		<input type="checkbox"/> Tdap <input type="checkbox"/> Td <input type="checkbox"/> DT		<input type="checkbox"/> Tdap <input type="checkbox"/> Td <input type="checkbox"/> DT		<input type="checkbox"/> Tdap <input type="checkbox"/> Td <input type="checkbox"/> DT	
<b>Polio</b> (Check specific type)	<input type="checkbox"/> IPV <input type="checkbox"/> OPV		<input type="checkbox"/> IPV <input type="checkbox"/> OPV		<input type="checkbox"/> IPV <input type="checkbox"/> OPV		<input type="checkbox"/> IPV <input type="checkbox"/> OPV	
<b>Hib</b> Haemophilus influenza type b								
<b>Pneumococcal Conjugate</b>								
<b>Hepatitis B</b>								
<b>MMR</b> Measles Mumps. Rubella							<b>Comments:</b> * indicates invalid dose	
<b>Varicella</b> (Chickenpox)								
<b>Meningococcal conjugate (MCV4)</b>								
<b>RECOMMENDED, BUT NOT REQUIRED Vaccine / Dose</b>								
<b>Hepatitis A</b>								
<b>HPV</b>								
<b>Influenza</b>								
<b>Other: Specify Immunization Administered/Dates</b>								
<b>Health care provider (MD, DO, APN, PA, school health professional, health official) verifying above immunization history must sign below.</b> If adding dates to the above immunization history section, put your initials by date(s) and sign here.								
<b>Signature</b>				<b>Title</b>		<b>Date</b>		
<b>Signature</b>				<b>Title</b>		<b>Date</b>		
<b>ALTERNATIVE PROOF OF IMMUNITY</b>								
<b>1. Clinical diagnosis (measles, mumps, hepatitis B) is allowed when verified by physician and supported with lab confirmation. Attach copy of lab result.</b> *MEASLES (Rubeola) MO DA YR    **MUMPS MO DA YR    HEPATITIS B MO DA YR    VARICELLA MO DA YR								
<b>2. History of varicella (chickenpox) disease is acceptable if verified by health care provider, school health professional or health official.</b> Person signing below verifies that the parent/guardian's description of varicella disease history is indicative of past infection and is accepting such history as documentation of disease. <b>Date of Disease</b> <b>Signature</b> <b>Title</b>								
<b>3. Laboratory Evidence of Immunity (check one)</b> <input type="checkbox"/> Measles* <input type="checkbox"/> Mumps** <input type="checkbox"/> Rubella <input type="checkbox"/> Varicella <b>Attach copy of lab result.</b>								
*All measles cases diagnosed on or after July 1, 2002, must be confirmed by laboratory evidence. **All mumps cases diagnosed on or after July 1, 2013, must be confirmed by laboratory evidence.								
<b>Completion of Alternatives 1 or 3 MUST be accompanied by Labs &amp; Physician Signature:</b> _____ Physician Statements of Immunity MUST be submitted to IDPH for review.								

**Certificates of Religious Exemption to Immunizations or Physician Medical Statements of Medical Contraindication Are Reviewed and Maintained by the School Authority.**

Last First Middle			Birth Date Month/Day/ Year		Sex	School	Grade Level/ ID
<b>HEALTH HISTORY TO BE COMPLETED AND SIGNED BY PARENT/GUARDIAN AND VERIFIED BY HEALTH CARE PROVIDER</b>							
<b>ALLERGIES</b> (Food, drug, insect, other)		Yes No	List:		<b>MEDICATION</b> (Prescribed or taken on a regular basis.)		Yes No
Diagnosis of asthma?		Yes	No		Loss of function of one of paired organs? (eye/ear/kidney/testicle)		Yes No
Child wakes during night coughing?		Yes	No		Hospitalizations?		Yes No
Birth defects?		Yes	No		When? What for?		
Developmental delay?		Yes	No		Surgery? (List all.)		Yes No
Blood disorders? Hemophilia, Sickle Cell, Other? Explain.		Yes	No		When? What for?		
Diabetes?		Yes	No		Serious injury or illness?		Yes No
Head injury/Concussion/Passed out?		Yes	No		TB skin test positive (past/present)?		Yes* No
Seizures? What are they like?		Yes	No		TB disease (past or present)?		Yes* No
Heart problem/Shortness of breath?		Yes	No		Tobacco use (type, frequency)?		Yes No
Heart murmur/High blood pressure?		Yes	No		Alcohol/Drug use?		Yes No
Dizziness or chest pain with exercise?		Yes	No		Family history of sudden death before age 50? (Cause?)		Yes No
Eye/Vision problems? _____ Glasses <input type="checkbox"/> Contacts <input type="checkbox"/> Last exam by eye doctor _____				Dental <input type="checkbox"/> Braces <input type="checkbox"/> Bridge <input type="checkbox"/> Plate Other			
Other concerns? (crossed eye, drooping lids, squinting, difficulty reading)				Information may be shared with appropriate personnel for health and educational purposes.			
Ear/Hearing problems?		Yes	No		Parent/Guardian Signature		
Bone/Joint problem/injury/scoliosis?		Yes	No		Date		
<b>PHYSICAL EXAMINATION REQUIREMENTS Entire section below to be completed by MD/DO/APN/PA</b>							
HEAD CIRCUMFERENCE if < 2-3 years old		HEIGHT		WEIGHT		BMI	BMI PERCENTILE
							B/P
<b>DIABETES SCREENING</b> (NOT REQUIRED FOR DAY CARE) BMI>85% age/sex Yes <input type="checkbox"/> No <input type="checkbox"/> And any two of the following: Family History Yes <input type="checkbox"/> No <input type="checkbox"/> Ethnic Minority Yes <input type="checkbox"/> No <input type="checkbox"/> Signs of Insulin Resistance (hypertension, dyslipidemia, polycystic ovarian syndrome, acanthosis nigricans) Yes <input type="checkbox"/> No <input type="checkbox"/> At Risk Yes <input type="checkbox"/> No <input type="checkbox"/>							
<b>LEAD RISK QUESTIONNAIRE:</b> Required for children age 6 months through 6 years enrolled in licensed or public school operated day care, preschool, nursery school and/or kindergarten. (Blood test required if resides in Chicago or high risk zip code.)							
<b>Questionnaire Administered?</b> Yes <input type="checkbox"/> No <input type="checkbox"/> <b>Blood Test Indicated?</b> Yes <input type="checkbox"/> No <input type="checkbox"/> <b>Blood Test Date</b> <b>Result</b>							
<b>TB SKIN OR BLOOD TEST</b> Recommended only for children in high-risk groups including children immunosuppressed due to HIV infection or other conditions, frequent travel to or born in high prevalence countries or those exposed to adults in high-risk categories. See CDC guidelines. <a href="http://www.cdc.gov/tb/publications/factsheets/testing/TB_testing.htm">http://www.cdc.gov/tb/publications/factsheets/testing/TB_testing.htm</a> .							
<b>No test needed</b> <input type="checkbox"/> <b>Test performed</b> <input type="checkbox"/> <b>Skin Test: Date Read</b> <b>Result: Positive</b> <input type="checkbox"/> <b>Negative</b> <input type="checkbox"/> <b>mm</b> _____							
<b>Blood Test: Date Reported</b> <b>Result: Positive</b> <input type="checkbox"/> <b>Negative</b> <input type="checkbox"/> <b>Value</b> _____							
<b>LAB TESTS (Recommended)</b>		Date	Results		Date		Results
Hemoglobin or Hematocrit					Sickle Cell (when indicated)		
Urinalysis					Developmental Screening Tool		
<b>SYSTEM REVIEW</b>	Normal	Comments/Follow-up/Needs		Normal	Comments/Follow-up/Needs		
<b>Skin</b>				<b>Endocrine</b>			
<b>Ears</b>		Screening Result:		<b>Gastrointestinal</b>			
<b>Eyes</b>		Screening Result:		<b>Genito-Urinary</b>	LMP		
<b>Nose</b>				<b>Neurological</b>			
<b>Throat</b>				<b>Musculoskeletal</b>			
<b>Mouth/Dental</b>				<b>Spinal Exam</b>			
<b>Cardiovascular/HTN</b>				<b>Nutritional status</b>			
<b>Respiratory</b>		<input type="checkbox"/> Diagnosis of Asthma		<b>Mental Health</b>			
Currently Prescribed Asthma Medication: <input type="checkbox"/> Quick-relief medication (e.g. Short Acting Beta Agonist) <input type="checkbox"/> Controller medication (e.g. inhaled corticosteroid)				<b>Other</b>			
<b>NEEDS/MODIFICATIONS</b> required in the school setting				<b>DIETARY</b> Needs/Restrictions			
<b>SPECIAL INSTRUCTIONS/DEVICES</b> e.g. safety glasses, glass eye, chest protector for arrhythmia, pacemaker, prosthetic device, dental bridge, false teeth, athletic support/cup							
<b>MENTAL HEALTH/OTHER</b> Is there anything else the school should know about this student? If you would like to discuss this student's health with school or school health personnel, check title: <input type="checkbox"/> Nurse <input type="checkbox"/> Teacher <input type="checkbox"/> Counselor <input type="checkbox"/> Principal							
<b>EMERGENCY ACTION</b> needed while at school due to child's health condition (e.g., seizures, asthma, insect sting, food, peanut allergy, bleeding problem, diabetes, heart problem)? <b>Yes</b> <input type="checkbox"/> <b>No</b> <input type="checkbox"/> If yes, please describe.							
On the basis of the examination on this day, I approve this child's participation in (If No or Modified please attach explanation.) <b>PHYSICAL EDUCATION</b> <b>Yes</b> <input type="checkbox"/> <b>No</b> <input type="checkbox"/> <b>Modified</b> <input type="checkbox"/> <b>INTERSCHOLASTIC SPORTS</b> <b>Yes</b> <input type="checkbox"/> <b>No</b> <input type="checkbox"/> <b>Modified</b> <input type="checkbox"/>							
Print Name				(MD,DO, APN, PA) Signature		Date	
Address				Phone			



## PROOF OF SCHOOL DENTAL EXAMINATION FORM

Illinois law (Child Health Examination Code, 77 Ill. Adm. Code 665) states all children in kindergarten and the second, sixth and ninth grades of any public, private or parochial school shall have a dental examination. The examination must have taken place within 18 months prior to May 15 of the school year. A licensed dentist must complete the examination, sign and date this Proof of School Dental Examination Form. If you are unable to get this required examination for your child, fill out a separate Dental Examination Waiver Form.

This important examination will let you know if there are any dental problems that need attention by a dentist. Children need good oral health to speak with confidence, express themselves, be healthy and ready to learn. Poor oral health has been related to lower school performance, poor social relationships, and less success later in life. For this reason, we thank you for making this contribution to the health and well-being of your child.

### To be completed by the parent or guardian (please print):

Student's Name:	Last	First	Middle	Birth Date: (Month/Day/Year)
Address:	Street	City	ZIP Code	
Name of School:	ZIP Code	Grade Level:	Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female	
Parent or Guardian:	Last Name	First Name		
Student's Race/Ethnicity: <input type="checkbox"/> White <input type="checkbox"/> Black/African American <input type="checkbox"/> Hispanic/Latino <input type="checkbox"/> Asian <input type="checkbox"/> Native American <input type="checkbox"/> Native Hawaiian/Pacific Islander <input type="checkbox"/> Multi-racia <input type="checkbox"/> Unknown <input type="checkbox"/> Other _____				

### To be completed by dentist:

Date of Most Recent Examination: \_\_\_\_\_ (Check all services provided at this examination date)  
☐ Dental Cleaning ☐ Sealant ☐ Fluoride treatment ☐ Restoration of teeth due to caries

#### Oral Health Status (check all that apply)

☐ Yes ☐ No **Dental Sealants Present on Permanent Molars**

☐ Yes ☐ No **Caries Experience / Restoration History** — A filling (temporary/permanent) OR a tooth that is missing because it was extracted as a result of caries OR missing permanent 1st molars.

☐ Yes ☐ No **Untreated Caries** — At least 1/2 mm of tooth structure loss at the enamel surface. Brown to dark-brown coloration of the walls of the lesion. These criteria apply to pit and fissure cavitated lesions as well as those on smooth tooth surfaces. If retained root, assume that the whole tooth was destroyed by caries. Broken or chipped teeth, plus teeth with temporary fillings, are considered sound unless a cavitated lesion is also present

☐ Yes ☐ No **Urgent Treatment** — abscess, nerve exposure, advanced disease state, signs or symptoms that include pain, infection, or swelling.

**Treatment Needs (check all that apply). For Head Start Agencies, please also list appointment date or date of most recent treatment completion date.**

☐ **Restorative Care** — amalgams, composites, crowns, etc.

Appointment Date: \_\_\_\_\_

☐ **Preventive Care** — sealants, fluoride treatment, prophylaxis

Appointment Date: \_\_\_\_\_

☐ **Pediatric Dentist Referral Recommended**

Treatment Completion Date: \_\_\_\_\_

Additional comments: \_\_\_\_\_

Signature of Dentist \_\_\_\_\_ License #: \_\_\_\_\_ Date: \_\_\_\_\_





# State of Illinois Eye Examination Report

Illinois law requires that proof of an eye examination by an optometrist or physician (such as an ophthalmologist) who provides eye examinations be submitted to the school no later than October 15 of the year the child is first enrolled or as required by the school for other children. The examination must be completed within one year prior to the first day of the school year the child enters the Illinois school system for the first time. The parent of any child who is unable to obtain an examination must submit a waiver form to the school.

Student Name \_\_\_\_\_  
(Last) (First) (Middle Initial)  
Birth Date \_\_\_\_\_ Gender \_\_\_\_\_ Grade \_\_\_\_\_  
(Month/Day/Year)  
Parent or Guardian \_\_\_\_\_  
(Last) (First)  
Phone \_\_\_\_\_  
(Area Code)  
Address \_\_\_\_\_  
(Number) (Street) (City) (ZIP Code)  
County \_\_\_\_\_

## To Be Completed By Examining Doctor

### Case History

Date of exam \_\_\_\_\_  
Ocular history: ☐ Normal or Positive for \_\_\_\_\_  
Medical history: ☐ Normal or Positive for \_\_\_\_\_  
Drug allergies: ☐ NKDA or Allergic to \_\_\_\_\_  
Other information \_\_\_\_\_

### Examination

	Distance			Near
	Right	Left	Both	Both
Uncorrected visual acuity	20/	20/	20/	20/
Best corrected visual acuity	20/	20/	20/	20/

Was refraction performed with dilation? ☐ Yes ☐ No

	Normal	Abnormal	Not Able to Assess	Comments
External exam (lids, lashes, cornea, etc.)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Internal exam (vitreous, lens, fundus, etc.)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Pupillary reflex (pupils)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Binocular function (stereopsis)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Accommodation and vergence	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Color vision	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Glaucoma evaluation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Oculomotor assessment	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Other _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____

NOTE: "Not Able to Assess" refers to the inability of the child to complete the test, not the inability of the doctor to provide the test.

### Diagnosis

☐ Normal ☐ Myopia ☐ Hyperopia ☐ Astigmatism ☐ Strabismus ☐ Amblyopia

Other \_\_\_\_\_





# State of Illinois Eye Examination Report

## Recommendations

1. Corrective lenses: ☐ No ☐ Yes, glasses or contacts should be worn for:  
☐ Constant wear ☐ Near vision ☐ Far vision  
☐ May be removed for physical education

2. Preferential seating recommended: ☐ No ☐ Yes

Comments \_\_\_\_\_  
\_\_\_\_\_

3. Recommend re-examination: ☐ 3 months ☐ 6 months ☐ 12 months  
☐ Other \_\_\_\_\_

4. \_\_\_\_\_

5. \_\_\_\_\_

Print name \_\_\_\_\_

Optometrist or physician (such as an ophthalmologist)  
who provided the eye examination ☐ MD ☐ OD ☐ DO

License Number \_\_\_\_\_

Address \_\_\_\_\_  
\_\_\_\_\_

Phone \_\_\_\_\_

Signature \_\_\_\_\_

Date \_\_\_\_\_

### Consent of Parent or Guardian

I agree to release the above information on my child  
or ward to appropriate school or health authorities.

\_\_\_\_\_  
(Parent or Guardian's Signature)

\_\_\_\_\_  
(Date)

(Source: Amended at 32 Ill. Reg. \_\_\_\_\_, effective \_\_\_\_\_)



# *Sister Thea Bowman Catholic School*

8213 Church Lane East St. Louis, IL 62203  
Phone (618) 397-0316/4926 Fax (618) 397-0337

## Records Release Form

I hereby authorize Sister Thea Bowman Catholic to release the records of:

\_\_\_\_\_  
Student's Name

\_\_\_\_\_  
Birth date

\_\_\_\_\_ Academic Records

\_\_\_\_\_ Health Records

\_\_\_\_\_ Standardized Test Scores

\_\_\_\_\_ I.E.P.

\_\_\_\_\_ Psychological Records

\_\_\_\_\_ Birth Certificate

To: \_\_\_\_\_ School Name

\_\_\_\_\_ Street Address

\_\_\_\_\_ City/State/Zip

\_\_\_\_\_  
Parent/Guardian Signature

\_\_\_\_\_  
Date

"It's what we do TODAY, not someday that matters."  
Sr. Thea Bowman, FSPA



# *Sister Thea Bowman Catholic School*

8213 Church Lane East St. Louis, IL 62203  
Phone (618) 397-0316/4926 Fax (618) 397-0337

To the Principal/Registrar:

\_\_\_\_\_ has enrolled in the \_\_\_\_\_ grade at  
(Student Name)

Sister Thea Bowman Catholic School. Please send a copy of academic, attendance, testing, health, behavior, and any other pertinent records. Thank you for your cooperation.

Sincerely,

*Dan Nickerson*  
Principal

.....  
I hereby authorize Sister Thea Bowman Catholic School to obtain the records of:

\_\_\_\_\_  
Student Name

\_\_\_\_\_ Academic Records

\_\_\_\_\_ Health Records

\_\_\_\_\_ Standardized Test Scores

\_\_\_\_\_ I.E.P.

\_\_\_\_\_ Psychological Records

\_\_\_\_\_ Birth Certificate

From: \_\_\_\_\_ School Name

\_\_\_\_\_ Street Address

\_\_\_\_\_ City/State/Zip

\_\_\_\_\_ (Phone)

\_\_\_\_\_  
Parent/Guardian

\_\_\_\_\_  
Date



# *Sister Thea Bowman Catholic School*

8213 Church Lane East St. Louis, IL 62203  
Phone (618) 397-0316/4926 Fax (618) 397-0337

## **Behavior and Information Form**

(to be completed by personnel at the school presently attended)

This form is for a student attending your school who has applied to attend Sister Thea Bowman Catholic for Fall, 2015. To be eligible for transfer, a student must be in good behavioral standing. The individual completing this form should have personal knowledge about this student (teacher, counselor, administrator).

The answers to the questions on this form serve as an important factor in determining a student's eligibility to attend Sister Thea Bowman Catholic School. It is crucial that all questions are answered accurately and completely. Any activity in violation of the Safe Schools Act must be included, including the student's conduct involving weapons, drugs, alcohol, willful infliction of injury to another person at your school or any other school. This law further states: "Any person who knowingly submits false information to satisfy any requirement of subsection 2 of this section is of a class A misdemeanor."

School: \_\_\_\_\_

Student's Name: \_\_\_\_\_

Date: \_\_\_\_\_

Class of: \_\_\_\_\_

Disruptive behavior is defined as behavior that disrupts the continuity of instruction and, hence learning. It sets into motion an act or a series of actions which bring about disorganization and distraction from learning, and may threaten, or be perceived to threaten, the safety of those in the learning environment. Please provide the following information for the current school year and the previous school year.

1. STUDENT DISCIPLINE PROFILE: (If applicable, give specific reasons and dates for each incident.)

A. Number of office referrals for disciplinary reasons \_\_\_\_\_

\_\_\_\_\_

B. Number of out-of-school suspensions (past/present) \_\_\_\_\_

\_\_\_\_\_

C. Number of in-school suspensions (past/present) \_\_\_\_\_

\_\_\_\_\_

D. Number of incidents exhibiting aggressive behavior toward peers/adults which resulted in physical contact, such as pushing, shoving, grabbing, etc. \_\_\_\_\_ (Please indicate if weapon was involved or if serious injury resulted.) \_\_\_\_\_

\_\_\_\_\_

**OVER**

- E. Has the student been expelled or is he a candidate for expulsion pending a hearing (for any reason, including conduct involving weapons, drugs, alcohol, or willful infliction of injury to another person) YES \_\_\_\_\_ NO \_\_\_\_\_

Do you certify that the transferring student is in good behavioral standing? YES \_\_\_\_\_ NO \_\_\_\_\_

Is the student currently enrolled at your school? YES \_\_\_\_\_ NO \_\_\_\_\_

**SPECIAL EDUCATION DATA:**

Does the student receive special education services? YES \_\_\_\_\_ NO \_\_\_\_\_

Has the classroom teacher requested that the student be evaluated by the Special Education Department? YES \_\_\_\_\_ NO \_\_\_\_\_

Have the parents/guardians ever refused a Special Education Referral? YES \_\_\_\_\_ NO \_\_\_\_\_

**If the student is receiving Special Education Services, this portion is to be completed by the Special Education Teacher.** (Please check appropriate current placement and diagnosis.)

**PLACEMENT:**

Ages 3-5

- ☐ Early Childhood setting
- ☐ Early childhood special education
- ☐ Itinerant services outside of the home
- ☐ Part-time early childhood/part-time early Childhood special education
- ☐ Home
- ☐ Separate School
- ☐ Residential Facility

Grades K-8

- ☐ Outside the regular class for less than 21% of the time
- ☐ Outside the regular class 21-60% of the time
- ☐ Outside the regular class for more than 60% of the time
- ☐ Public separate school day facility
- ☐ Private separate school day facility
- ☐ Homebound/hospital instruction
- ☐ Public/private residential facility

**DIAGNOSIS:**

- |   |   |   |
|---|---|---|
| <input type="checkbox"/> Autism                       | <input type="checkbox"/> Blindness              | <input type="checkbox"/> Deafness               |
| <input type="checkbox"/> Deaf/Blindness               | <input type="checkbox"/> Emotional Disturbance  | <input type="checkbox"/> Hearing Impairment     |
| <input type="checkbox"/> Mental Retardation           | <input type="checkbox"/> Multiple disabilities  | <input type="checkbox"/> Orthopedic Impairment  |
| <input type="checkbox"/> Other Health Impairment      | <input type="checkbox"/> Partial Sight          | <input type="checkbox"/> Speech/Language        |
| <input type="checkbox"/> Specific Learning Disability | <input type="checkbox"/> Traumatic Brain Injury | <input type="checkbox"/> Young Child Dev. Delay |

☐ Other (please identify: \_\_\_\_\_)

\_\_\_\_\_  
Signature of Teacher Completing this portion of the form

\_\_\_\_\_  
Date Completed

\_\_\_\_\_  
Signature and Title of Person completing this form who has knowledge of this student

\_\_\_\_\_  
Date completed

\_\_\_\_\_  
Signature of Principal

\_\_\_\_\_  
Name of current school

\_\_\_\_\_  
School telephone number

This completed form should be returned immediately to:

Sister Thea Bowman Catholic School  
8213 Church Lane  
East St. Louis, IL 62203  
618/397-0316/4926 618/397-0337 (fax)



# *Sister Thea Bowman Catholic School*

8213 Church Lane East St. Louis, IL 62203  
Phone (618) 397-0316 / 4926 Fax (618) 397-0337

## **BUS REQUEST FORM** **2020 - 2021**

- I am requesting bus service as a District 189 resident.
- My house or apartment is within District 189 school limits.
- I understand that bus service is a privilege, and my student's eligibility for Bus Service will be determined by the District 189 Transportation Office.
- All kindergarten students must have an adult with them at the bus stop for pick-up and must be met by an adult at the bus stop at drop-off time.
- Bus Service is not door-to-door; however, the bus company tries to stop in the safest location close to the residence of the student.

### **ADDRESS:**

Street \_\_\_\_\_

City/State/Zip \_\_\_\_\_

Student name(s) and grade(s):

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Parent/Guardian Name \_\_\_\_\_

### **FOR OFFICE USE:**

\_\_\_\_\_ Date submitted to District 189

\_\_\_\_\_ Date Student(s) Added to Bus Route

\_\_\_\_\_ Date Family Notified of Bus Route Assignment

**BUS ROUTE #** \_\_\_\_\_

**BUS STOP** \_\_\_\_\_



# *Sister Thea Bowman Catholic School*

8213 Church Lane East St. Louis, IL 62203

Phone (618) 397-0316 / 4926

Fax (618) 397-0337

stbcs.com

## **Parent Acknowledgement and Agreement form**

Dear Families,

This is your copy of the "Family Handbook" for the 2019-2020 school year.

In order that you might better understand the philosophy and requirements of Sister Thea Bowman Catholic School, it is important that you and your student(s) thoroughly read this handbook.

Please sign and return the slip below which indicates that you have read and accept the rules, regulations and policies stated in the "Family Handbook," including, but not limited to:

- Concussion Protocol
- Internet Use Policy
- That the School, the employees and agents of the school, the Diocese of Belleville, and the Bishop of Belleville are to incur no liability, as a result of any injury arising from the administration of asthma medication, anaphylaxis medication, use of an undesignated epinephrine auto-injector, the use of an opioid antagonist, or the use of undesignated asthma medication.

This is due by the first day of school.

Dan Nickerson  
Principal

We have read and will support the rules and regulations as presented in this handbook, including, but not limited to, The Concussion Protocol and The Internet Use Policy.

\_\_\_\_\_  
Parent/Guardian Signature

Date: \_\_\_\_\_

\_\_\_\_\_  
Student Signature

Date: \_\_\_\_\_

\_\_\_\_\_  
Student Signature

Date: \_\_\_\_\_

\_\_\_\_\_  
Student Signature

Date: \_\_\_\_\_