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 _____
Last First Middle

Address _____ 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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Phone (618) 397-0316/ 4926 Fax (618) 397-0337 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 1st or the 5th 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.

_____ _____

Parent/Guardian Signature **Date**

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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**

Kindergarten-Grade Eight	***10-months***	***9-months***	***8-months***	***7-months***
1 Child- $4500 per year	$450	$500	$563	$643
2 Children- $6500 per year	*$650*	*$722*	*$813*	*$929*
3 Children- $7500 per year	$750	$833	$938	$1071
4 Children- $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

Student's Name Last First Middle	**Birth Date** Month/Day/Year	**Sex**	**Race/Ethnicity**	**School /Grade Level/ID#**
Address Street City Zip Code	Parent/Guardian	Telephone # Home		Work

IMMUNIZATIONS: To be completed by health care provider. The mo/da/yr for *every* 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.

REQUIRED Vaccine / Dose	**DOSE 1** MO DA YR	**DOSE 2** MO DA YR	**DOSE 3** MO DA YR	**DOSE 4** MO DA YR	**DOSE 5** MO DA YR	**DOSE 6** MO DA YR
DTP or **DTaP**						
Tdap; **Td** or Pediatric **DT (**Check specific type)	☐Tdap☐Td☐DT	☐Tdap☐Td☐DT	☐Tdap☐Td☐DT	☐Tdap☐Td☐DT	☐Tdap☐Td☐DT	☐Tdap☐Td☐DT
Polio (Check specific type)	☐ IPV ☐ OPV	☐ IPV ☐ OPV	☐ IPV ☐ OPV	☐ IPV ☐ OPV	☐ IPV ☐ OPV	☐ IPV ☐ OPV
Hib Haemophilus influenza type b						
Pneumococcal Conjugate						
Hepatitis B						
MMR Measles Mumps. Rubella				**Comments:** * indicates invalid dose		
Varicella (Chickenpox)						
Meningococcal conjugate (MCV4)						
RECOMMENDED, BUT NOT REQUIRED Vaccine / Dose						
Hepatitis A						
HPV						
Influenza						
Other: Specify Immunization Administered/Dates						

Health care provider (MD, DO, APN, PA, school health professional, health official) verifying above immunization history must sign below.
If adding dates to the above immunization history section, put your initials by date(s) and sign here.

Signature **Title** **Date**

Signature **Title** **Date**

ALTERNATIVE PROOF OF IMMUNITY

1. Clinical diagnosis (measles, mumps, hepatitis B) is allowed when verified by physician and supported with lab confirmation. Attach copy of lab result.
***MEASLES (Rubeola)** MO DA YR ****MUMPS** MO DA YR **HEPATITIS B** MO DA YR **VARICELLA** MO DA YR

2. History of varicella (chickenpox) disease is acceptable if verified by health care provider, school health professional or health official.
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.

Date of Disease **Signature** **Title**

3. Laboratory Evidence of Immunity (check one) ☐Measles* ☐Mumps ☐Rubella ☐Varicella Attach copy of lab result.**

*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.

Completion of Alternatives 1 or 3 MUST be accompanied by Labs & Physician Signature: _____
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

HEALTH HISTORY **TO BE COMPLETED AND SIGNED BY PARENT/GUARDIAN AND VERIFIED BY HEALTH CARE PROVIDER**

ALLERGIES (Food, drug, insect, other)	Yes No	List:		**MEDICATION** (Prescribed or taken on a regular basis.)	Yes No	**List:**	
Diagnosis of asthma? Child wakes during night coughing?	Yes No Yes No			Loss of function of one of paired organs? (eye/ear/kidney/testicle)	Yes No		
Birth defects?	Yes No			Hospitalizations? When? What for?	Yes No		
Developmental delay?	Yes No						
Blood disorders? Hemophilia, Sickle Cell, Other? Explain.	Yes No			Surgery? (List all.) When? What for?	Yes No		
Diabetes?	Yes No			Serious injury or illness?	Yes No		
Head injury/Concussion/Passed out?	Yes No			TB skin test positive (past/present)?	Yes* No	*If yes, refer to local health department.	
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 ☐ Contacts ☐ Last exam by eye doctor _____ Other concerns? (crossed eye, drooping lids, squinting, difficulty reading)				Dental ☐ Braces ☐ Bridge ☐ Plate Other			
Ear/Hearing problems?	Yes No			Information may be shared with appropriate personnel for health and educational purposes. **Parent/Guardian Signature** **Date**			
Bone/Joint problem/injury/scoliosis?	Yes No						

PHYSICAL EXAMINATION REQUIREMENTS **Entire section below to be completed by MD/DO/APN/PA**

HEAD CIRCUMFERENCE if < 2-3 years old **HEIGHT** **WEIGHT** **BMI** **BMI PERCENTILE** **B/P**

DIABETES SCREENING **(NOT REQUIRED FOR DAY CARE)** **BMI>85% age/sex** Yes☐ No☐ And any two of the following: **Family History** Yes ☐ No ☐
Ethnic Minority Yes☐ No ☐ **Signs of Insulin Resistance** (hypertension, dyslipidemia, polycystic ovarian syndrome, acanthosis nigricans) Yes☐ No ☐ **At Risk** Yes ☐ No ☐

LEAD RISK QUESTIONNAIRE: 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.)

Questionnaire Administered? Yes ☐ No ☐ **Blood Test Indicated?** Yes ☐ No ☐ **Blood Test Date** **Result**

TB SKIN OR BLOOD TEST 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. http://www.cdc.gov/tb/publications/factsheets/testing/TB_testing.htm.

No test needed ☐ **Test performed ☐** **Skin Test: Date Read** **Result: Positive ☐ Negative ☐** **mm_____**
Blood Test: Date Reported **Result: Positive ☐ Negative ☐** **Value**

LAB TESTS (Recommended)	Date	Results		Date	Results
Hemoglobin or Hematocrit			Sickle Cell (when indicated)		
Urinalysis			Developmental Screening Tool		

SYSTEM REVIEW	**Normal**	**Comments/Follow-up/Needs**		**Normal**	**Comments/Follow-up/Needs**
Skin			**Endocrine**		
Ears		Screening Result:	**Gastrointestinal**		
Eyes		Screening Result:	**Genito-Urinary**		LMP
Nose			**Neurological**		
Throat			**Musculoskeletal**		
Mouth/Dental			**Spinal Exam**		
Cardiovascular/HTN			**Nutritional status**		
Respiratory		☐ Diagnosis of Asthma	**Mental Health**		
Currently Prescribed Asthma Medication: ☐ Quick-relief medication (e.g. Short Acting Beta Agonist) ☐ Controller medication (e.g. inhaled corticosteroid)			**Other**		

NEEDS/MODIFICATIONS required in the school setting

DIETARY Needs/Restrictions

SPECIAL INSTRUCTIONS/DEVICES e.g. safety glasses, glass eye, chest protector for arrhythmia, pacemaker, prosthetic device, dental bridge, false teeth, athletic support/cup

MENTAL HEALTH/OTHER 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: ☐ Nurse ☐ Teacher ☐ Counselor ☐ Principal

EMERGENCY ACTION needed while at school due to child's health condition (e.g., seizures, asthma, insect sting, food, peanut allergy, bleeding problem, diabetes, heart problem)?
Yes ☐ No ☐ 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.)
PHYSICAL EDUCATION Yes ☐ No ☐ Modified ☐ **INTERSCHOLASTIC SPORTS Yes ☐ No ☐ Modified ☐**

Print Name (MD,DO, APN, PA) **Signature** **Date**

Address **Phone**

State of Illinois
Illinois Department of Public Health

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: ☐ Male ☐ Female

Parent or Guardian: Last Name	First Name

Student's Race/Ethnicity:

☐ White ☐ Black/African American ☐ Hispanic/Latino ☐ Asian
☐ Native American ☐ Native Hawaiian/Pacific Islander ☐ Multi-racia ☐ Unknown
☐ 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:_____

Illinois Department of Public Health, Division of Oral Health
217-785-4899 • TTY (hearing impaired use only) 800-547-0466 • www.dph.illinois.gov

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.)	❑	❑	❑	_____
Internal exam (vitreous, lens, fundus, etc.)	❑	❑	❑	_____
Pupillary reflex (pupils)	❑	❑	❑	_____
Binocular function (stereopsis)	❑	❑	❑	_____
Accommodation and vergence	❑	❑	❑	_____
Color vision	❑	❑	❑	_____
Glaucoma evaluation	❑	❑	❑	_____
Oculomotor assessment	❑	❑	❑	_____
Other _____	❑	❑	❑	_____

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 _____

Continued on back

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 _____ License Number _____

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

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)

Address _____
_____

Phone _____

Signature _____ Date _____

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

Printed by Authority of the State of Illinois
6/09

IOCI1271-09

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

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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

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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:

( ) Autism
( ) Deaf/Blindness
( ) Mental Retardation
( ) Other Health Impairment
( ) Specific Learning Disability
( ) Blindness
( ) Emotional Disturbance
( ) Multiple disabilities
( ) Partial Sight
( ) Traumatic Brain Injury
( ) Deafness
( ) Hearing Impairment
( ) Orthopedic Impairment
( ) Speech/Language
( ) 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.

_____ Date: _____
Parent/Guardian Signature

_____ Date: _____
Student Signature

_____ Date: _____
Student Signature

_____ Date: _____
Student Signature