St. Elizabeth School
Where Knowledge, Truth and Values Meet

99-310 Moanalua Road
Aiea, Hawaii 96701

Ph: (808) 488-5322
www.steliz-hi.org

January 2019

Dear Parents/Guardians:

Thank you for considering St. Elizabeth Preschool. I hope you decide to follow through with this application and we prove to be the school that can best meet your child's educational needs. If you would like to have your child considered for enrollment in our school, it is essential that you return the completed application with the necessary documentation. A registration fee of $300.00 is required which covers Field Trips, Student Insurance, Diocesan Fees, and learning materials. After we have received your application, arrangements will be made for an interview in my office.

Needed documentation/Requirements:

1. Ages 3-5
2. Toilet Trained
3. Application
3. Xerox copy of legal Birth Certificate
4. Xerox copy of Baptismal Certificate (Catholics only)

***5. Department of Education, Student Health Record (Form 14)**
***6. Early Childhood Pre-K Health Record Supplement (Form 908)**

7. Emergency Card
8. Personal Profile Sheet
9. Tuition Contract

***Required by the Department of Health prior to starting Preschool.**

We look forward to meeting with you and being of service to your family.

Sincerely,

Sr. Bernarda Sindol, O.P.
Principal

INFORMATION BULLETIN

Philosophy:
St. Elizabeth School is a Catholic community centered in Christ and committed to the formation of the whole child. We strive for academic excellence through a curriculum that integrates Catholic truths and values. We foster caring, respect, compassion, diversity and student responsibility in accordance with the teachings of Jesus Christ. We promote optimal learning through spiritual, intellectual, psychological, physical and sociological development.

Mission:
St. Elizabeth School is integral to the mission of the Catholic Church. We proclaim the Good News as we encounter the living God who, in Jesus Christ reveals his transforming love, compassion and truth. St. Elizabeth School is committed to provide quality education incorporating Catholic teachings and values in an integrated curriculum designed to enhance life-long learning skills.

History:
St. Elizabeth was established in 1964 under the Sacred Hearts Fathers and staffed by the Dominican Sisters of the Most Holy Rosary. At present, St. Elizabeth is staffed by Diocesan priest, Dominican Sisters and lay instructors. The school has produced more than 1,400 graduates who have successfully entered the job force as graduates from catholic high schools and universities.

School Hours:
Regular attendance and punctuality are encouraged. School begins promptly at 7:50 a.m. with a warning bell at 7:45 a.m. Students arriving before 7:30 a.m. should be enrolled in morning care or in the church at our daily 7:00 a.m. mass. School ends at 2:30 p.m. (Grades K-4) and 2:45 p.m. (Grades 5-8). The 1st and 3rd Fridays of the month are 12:00 p.m. dismissal days. The school calendar is prepared and sent home each year.

Office Hours:
Office hours are from 7:30 a.m. to 3:00 p.m. Monday through Friday with the exception of the 1st and 3rd Fridays of the month when the office closes at 12:00 noon for teacher meetings.

Application Requirements: (Grades K-8)
Applications for new students are processed during the months of January & February. All new students must take an entrance examination. Decisions for acceptance are based on academic performance, school records, test scores and educational needs of the student. Applications must be submitted along with the following. Preschool does not require an entrance exam.

1. Xeroxed copy of child's legal Birth Certificate
2. Xeroxed copy of Baptismal Certificate (Catholics only)
3. Copy of previous school year's report card, and first semester of the current year
4. Standardized Test Results
5. $25.00 Application/Testing Fee (non-refundable)

Curriculum:
Academic Programs:
1. **Religion** – Provides the student with a basic foundation in Catholic teachings and varied opportunities to develop a personal relationship with God. Students are required to participate in Religion classes and church services held during the school day.
2. **Language Arts** – Develops proficiency in Reading, Writing, Listening and Speaking skills which enable communication with others in standard English.
3. **Mathematics** – Develops "mathematical power" so students can apply math beyond the classroom.

4. **Science** – Enhances the discovery and appreciation of the natural environment and promotes the desire of inquiry and discovery.
5. **Social Studies** – Develop global awareness, good citizenship, etc.

Co-Curricular Programs (K-8)

1. Physical Education
2. Health/Human Sexuality
3. Speech
4. Music
5. Computer Literacy
6. Art
7. Robotics

Extra-Curricular Activities

Sports (Grades 4-8)
Educational Excursions
Hula Halau
Student of the Quarter
Altar Servers
Campus Safety Officers
Student Council
Yearbook Staff
Praise Choir

Instruction:
A variety of methods of instructional delivery are utilized in the classroom. They include direct teaching, whole group lectures and discussions, small group activities, hands-on learning activities and use of multi-media.

Financial Information:
Total cost per student for school year 2018-2019 is $7,000.00 (FACTS-partial monthly payment plan) or $6,850.00 (Paid in Full). Preschool tuition is $700.00 dollars per month for regular day which is 7:30 am- 2:30 p.m. Preschool extended care is $800.00 per month from 7:30 a.m.5:00 p.m. Tuition for school year 2019-2020 has not been determined. In addition, a non-refundable, admission fee of $300.00 is payable upon acceptance. Any tuition increases are kept to a minimum.

Before and After School Care (Grades K-4):
Before school care is provided by Kama'aina Kids from 6:00 - 7:30 a.m.The monthly rate is $50.00 per month. After School Care is also provided by Kama'aina Kids from 2:30 to 5:30 p.m. This monthly rate is $100.00 per month (grades Kindergarten-Fourth). Drop in service is $5.00 a day except for mini days which will be $10.00 a day.

Study Skills Program (Grades 5-8):
The Kama'aina Kids Study Skills Program is an after school service offered to 5th through 8th grade students. It allows students to do their homework in a supervised atmosphere. Cost is $85.00 per month. Drop in service is $10.00 per day.

Cafeteria:
Food service is provided by a local catering company. Lunches served are prepared according to the federal food and nutritional guidelines to insure a healthy and balanced meal. We offer a milk program.

WASC/WCEA Accredited

WASC/WCEA Accredited

ST. ELIZABETH SCHOOL
STUDENT APPLICATION FORM

Last First Name MI Birth Date Student SSN Grade Entering

Home Address City ZIP Sex ( ) Male ( ) Female

Place of Birth If country of birth is other than US, Year of Arrival

US Citizen If not US Citizen, Indicate Status
( ) Yes ( ) No ( ) Immigrant ( ) Refugee ( )Non-Immigrant ( ) US National(Samoa, Etc.)

Number of Siblings: Older Brothers_____ Younger Brothers_____ Older Sisters_____ Younger Sisters_____

If Catholic, Parish____

Baptism Date: __________Church:____City/State:______________

First Communion Date:______ Church:____________________________________City/State:_______________

Ethnic Background (Check Only One)
A ( ) American Indian
B ( ) Black
C ( ) Chinese
D ( ) Filipino
E ( ) Hawaiian
F ( ) Hispanic
G ( ) Indo-Chinese
H ( ) Japanese
I ( ) Korean
J ( ) Multi-Racial/other
K ( ) Pacific Islander
L ( ) Part Hawaiian
M ( ) Portuguese
N ( ) Samoan
O ( ) Tongan
P ( ) White/Caucasian
U ( ) Unknown

Language Spoken at Home
A ( ) English
B ( ) Cantonese
C ( ) Mandarin
D ( ) Ilocano
E ( ) Tagalog
F ( ) Cebuano/Visayan
G ( ) Hawaiian
H ( ) Japanese
I ( ) Korean
J ( ) Samoan
K ( ) Vietnamese
L ( ) Other
M ( ) French
N ( ) German
O ( ) Italian
P ( ) Portuguese
Q ( ) Spanish
T ( ) Tongan

Father's Last Name First MI Ethnicity Religion Occupation

Home Address City Zip Home Phone Cell Phone

Employer / Employer's Address City Zip Business Phone

____E-mail Address

Mother's Last Name First MI Ethnicity Religion Occupation

Home Address City Zip Home Phone Cell Phone

Employer / Employer's Address City Zip Business Phone

____E-Mail Address

Mother's Maiden Name Child Lives with: ( ) Both Parents ( ) Father ( ) Mother ( ) Guardian
Parents are: ( ) Married ( ) Remarried: ( ) Father ( ) Mother Deceased: ( ) Father ( ) Mother

Guardian (If Applicable) First MI Ethnicity Religion Occupation

Home Address City Zip Home Phone Cell Phone

Employer / Employer's Address City Zip Business Phone

____E-mail Address

Other Schools Attended with Address (5 most recent, including Preschool)
Years ________ School___________________________________ City/State___________________
From__________ to ____
From__________ to ____
**How did you hear about St. Elizabeth School: ___Parishioner ___Advertising ___Website___ Recommended by Others
___Other (Please clarify: ______________________________

Department of Education

Student's Health Record

Student Address Label

Name ______________________ (Last) ______________________ (First) ______________________ (Middle Initial)

Female ❑ Male ❑

Preschool: Entry Date ___/___/___
Elementary: Entry Date ___/___/___
Intermediate/Middle: Entry Date ___/___/___
High: Entry Date ___/___/___

Birthdate [|] [|] [| | |]
Month Day Year

Parent's Name ______________________ (Mother/Legal Guardian) ______________________ (Father/Legal Guardian)

Allergies: ______________________

Please complete the following sections **(CHECK IF YES)**

Medical Status

Allergy (type) ❑	Cancer/Leukemia ❑	Hearing Problems ❑	Hypertension ❑	Seizures ❑	Vision Problem ❑
Asthma ❑	Chronic Cough/Wheezing ❑	Heart Disease ❑	JRA Arthritis ❑	Sickle Cell Anemia ❑	
Behavioral Problems ❑	Diabetes ❑	Hemophilia ❑	Rheumatic Heart ❑	Skin Problems ❑	

Physician's Examination Code: N-Normal; A-Abnormal; C-Corrected; R-Receiving Care

Date	Grade	Height	Weight	BMI	Blood Pressure	Vision R	Vision L	Hearing R	Hearing L	Eyes	Ears	Nose	Throat	Teeth	Heart	Lungs	Abdomen	Nervous System	Skin	Scoliosis	Extremities	Nutrition	Varicella Immunity Secondary to Disease (DATE)	Reviewed Immunization Record (Check if Yes)	Completed PPD Screening (Check if Yes) See Results Below	Provider's Signature	Provider's Stamp or Printed Name
/ /																							/ /				
/ /																							/ /				

Tuberculosis Examination
Mantoux Test (Intradermal)

Date Given	Date Read	Results (mm)	Physician, APRN, PA or Clinic
/ /	/ /		
/ /	/ /		

Chest X-Ray

Date	Results	Location

Dental Examination

Dental Check-Up	/ /

Immunizations (Vaccines, Dates Given: Month/Day/Year)

Vaccine							
DTaP, DTP, DT, Tdap or Td	Type						
	Date	/ /	/ /	/ /	/ /	/ /	/ /
Polio (IPV or OPV)	Type						
	Date	/ /	/ /	/ /	/ /	/ /	/ /
Hib (*Haemophilus influenzae* type b)	Type						
	Date	/ /	/ /	/ /	/ /	/ /	/ /
Pneumococcal Conjugate	Type						
	Date	/ /	/ /	/ /	/ /	/ /	/ /
Hepatitis B	Type						
	Date	/ /	/ /	/ /	/ /	/ /	/ /
MMR	Date	/ /	/ /	/ /	Varicella	/ /	/ /
Hepatitis A	Date	/ /	/ /				
Other	Type						
	Date	/ /	/ /	/ /	/ /	/ /	/ /
Other	Type						
	Date	/ /	/ /	/ /	/ /	/ /	/ /

*OFFICE USE ONLY (Rev. 2010)

Physician, APRN, PA or Clinic ______________________

State of Hawaii
Department of Human Services

Benefit, Employment & Support Services Division

Early Childhood Pre-K Health Record Supplement*

Name of Child: | **Name of Child Care Facility:**

Child's DOB: | **To Be Completed By The Physician**

1. Type Screening	2. Date Completed	3. Results	4. Recommendations/Follow up
Head Circumference (up to 2yrs old)		☐ Normal ☐ Abnormal	
Hgb/Hct		☐ Normal ☐ Abnormal	
Lead		☐ Normal ☐ Abnormal	
BMI (≥ 2 years old)		☐ Normal ☐ Counsel	
Developmental Screening Tool: ☐ PEDS ☐ ASQ ☐ Other ____		☐ No Concern ☐ Concern	

5. Medical Conditions	6. Special Care Plan Needed	7. Recommendations	8. EC Provider Use Only
Allergies/Sensitivities ☐ None • List:	☐ Yes ☐ No		☐ Special Care Plan completed
Medications/Treatments ☐ None • List:	☐ Yes ☐ No		☐ Special Care Plan completed
Special Diet prescribed by physician ☐ None • List:	☐ Yes ☐ No		☐ Special Care Plan completed
Behavioral Issues/Social Emotional Concerns ☐ None • List:	☐ Yes ☐ No		☐ Special Care Plan completed
Medical Conditions/Related Surgeries ☐ None • List:	☐ Yes ☐ No		☐ Special Care Plan completed

9. Physician/NP/APRN/PA or Clinic Name, Address, Zip, Phone, Fax

11. *I give my consent for my child's Health Care Provider to discuss the information on this form with my Early Childhood Provider*

____
Early Childhood Provider Name

12. Parent/Guardian Name

10. Physician/NP/ APRN/ PA or Clinic Signature (Signature or stamp) **Date**

13. Parent/Guardian Signature **Date**

*Supplement to the STATE OF HAWAII, DEPARTMENT OF EDUCATION, FORM 14, Rev. 2010, RS 09-1051 (Rev. of RS 06-0698)

Instructions for Completing the Early Childhood Pre-K Health Record Supplement

To Be Completed by the Physician (Please print)

1. Type of Screening: Check all that apply.

- **Head Circumference, Hgb/Hct, Lead, BMI**
- **Developmental Screening:** The screening tools listed are:
  - **PEDS:** Parent's Evaluation of Developmental Status
  - **ASQ:** Ages and Stages Questionnaire
  - **Other:** Print the name of screening tool used.

2. Date Completed
Write the date **mm/dd/year** the screening was performed. i.e., 06/01/2006.

3. Results
Mark (X) to indicate **"Normal"** or **"Abnormal", "No Concern"** or **"Concern", "Normal"** or **"Counsel".** If the box is marked abnormal, concern or counsel, please complete Box 4. Recommendations/Follow up.

4. Recommendations/Follow up
Please complete if abnormal, concern or counsel is selected.

5. Medical Conditions
Mark (X) **"None"** box for each item if the child has no **Allergies/Sensitivities, Medications/Treatments, Special Diet prescribed by physician, Behavioral Issues/Social Emotional Concerns, Medical Conditions/ Related Surgeries. List** type of medical condition, e.g., **Medical Condition/Related Surgeries List:** Asthma

6. Special Care Plan Needed
If child has a medical condition and the Early Childhood Provider should develop a special care plan, mark (X) **Yes,** next to the appropriate category. If child does not need a special care plan, mark (X) **No.**

7. Recommendations
Write your recommendations, e.g., "Medications must be administered by the parent before or after school hours."

8. Early Childhood Provider Use Only
This section is designated for the early childhood provider to complete if physician has marked (X) Yes in Box 6. Sample forms of the Special Care Plans can be requested from Department of Human Service (DHS) office, phone or downloaded from the Department of Human Service website.

9. Physician/NP/APRN/PA or Clinic Name
Type or print legibly physician, nurse practitioner, advanced practiced registered nurse, physician assistant or clinic name, address, zip, phone, and fax.

10. Physician/NP/ APRN/ PA, of Clinic (Signature or Stamp) and Date:
Physician, nurse practitioner, physician assistant must sign his/her name or stamp and write in the date of child's examination.

11. ***"I give my consent for my child's Health Care Provider to discuss the information on this form with my Early Childhood provider."***
The Early Childhood program is encouraged to type, print legibly, or stamp the program name here prior to parent signature.

12. Parent/Guardian Name
Print the name of the Parent or Guardian

13. Parent/Guardian Signature
The Parent or Guardian must sign his/her name and write the date signed.

To be used as part of a cover letter to the preschool, parent or physician.

The purpose of the Hawaii Department of Human Services (DHS) Early Childhood Pre-K Health Record Supplement (EC-Pre-K HRS) is to provide developmentally appropriate information on the child's health, growth and developmental status for (Pre) school entry. The EC-Pre-K HRS is to be used in conjunction with the Hawaii Department of Education (DOE), Student's Health Record Form 14 2010.

The DHS EC Pre-K Health Record can be downloaded from the Hawaii Department of Human Services website, http://humanservices.hawaii.gov/ and search for Form 908. The DOE Student Health Record Form 14 can be downloaded at Department of Education website: http://www.hawaiipublicschools.org/Pages/home.aspx, click on Parents and Students, click on Enrolling in School, click on How to Enroll, look for Related Downloads and click on Student Health Record.

The child's physician is requested to complete the DOE Student Health Record Form 14 and DHS EC Pre-K Health Record Supplement. The following are directions for completing the DHS EC Pre-K Health Record Supplement.

SPECIAL CARE PLAN FOR A CHILD WITH ALLERGY

CHILD'S NAME: ____________________ Date of Birth: __________

FACILITY NAME: ______________________________

Parent(s) or Guardian(s) Name: ______________________________

Emergency Phone Numbers: Mother ____________ Father: ____________

Primary Health Provider Name: ____________ Emergency Phone: ____________

Specialist's Name (if any): ____________ Emergency Phone: ____________

Description of Allergy: ______________________________

Describe what signs/or symptom look like: ______________________________

Describe known triggers: ______________________________

Describe treatment: ______________________________

Possible side effects: [illegible] no peanut products allowed ____________

Program modification: ______________________________

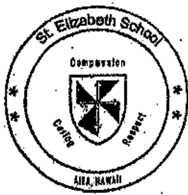
When to call parent/health provider regarding symptoms or failure to respond to treatment:
____

When to consider what condition requires urgent care or reassessment: ____________
____

Physician's Name: ______________________________

Physician's Signature: ____________________ Date: ____________

APE



St. Elizabeth School
99-310 Moanalua Road
Aiea, Hawaii 96701

EMERGENCY CARD 2019-2020

____
Student/Family Name (Last) (First) (Parish)

____
Street Address (City) (Zip Code) (Home Phone)

____
(Email Address) (Father's Cellular Phone) (Mother's Cellular Phone)

____

Fathers Name:____________________ Mother's Name:____________________

Place of Work:____________________ Place Of Work:____________________

Business Phone:____________________ Business Phone:____________________

If parents cannot be reached , please call the following for pickup:

____
Name & Relationship (Sister, Neighbor, Etc) Address (Phone/Cellular Number)

____
Name & Relationship (Sister, Neighbor, Etc) Address (Phone/Cellular Number)

Please list children in this school according to grade, oldest first.

Name	**Grade**	**Name**	**Grade**
1. ____________________	_____	3. ____________________	_____
2. ____________________	_____	4. ____________________	_____

I understand that the school does not assume responsibility for payment of a physician in any case. However, in an emergency, you may choose a physician. My choice of local physicians are as follows:

1. ____
(Name of Local Doctor) (Address) (Phone Number)

2. ____
(Name of Local Doctor) (Address) (Phone Number)

Insurance Coverage: Company____________________ Policy Number:__________

Signature of Parents/Guardians:______________________________

(Over)

Medical Release Consent

I/We hereby give consent to St. Elizabeth School to contact my family physician for medical or surgical care for my child(ren) where such service is required. If the family physician is unavailable, I hereby give my consent to have my child(ren) treated by a physician chosen by the school. Furthermore, in the event of any emergency, I hereby give my consent for medical or surgical care for my child(ren) at any hospital, clinic or other medical facility at the discretion of the school. I authorize St. Elizabeth School to call 911 in an emergency and have my child transported by ambulance to the nearest hospital. I understand that whenever possible, the school will take my child(ren) to the medical facility preferred by the family and listed in my child's records.

Signature of Parent/Guardian:______________________________ **Date:**_______________

Describe your child's current health.

Student's Name____

*Any Allergies?____

*Any medications?____

List, please annotate any prescribed medication taken on a daily basis.

____

____

*Any restrictions?____

Student's Name____

*Any Allergies?____

*Any medications?____

List, please annotate any prescribed medication taken on a daily basis.

____

____

*Any restrictions?____

Student's Name____

*Any Allergies?____

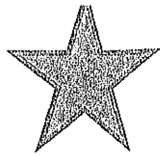
*Any medications?____

List, please annotate any prescribed medication taken on a daily basis.

____

____

*Any restrictions?____



ST. ELIZABETH PRESCHOOL
PERSONAL PROFILE SHEET

Thank you for trusting us with your child this year. Please complete this survey of your child and his/her interest. It will help us to become better acquainted with your child and better able to meet his/her needs.

- Child's Full Name____
- Nickname____________________ Birth Date____________________
- How Many Brother's______________ Sisters______________________
- What kind of things do you like to do as a family? Interest(sports, animals, music, etc.)

____

____

- What is the most important thing we need to know about your child?:

  Favorite things____

  Least Favorite things____

- Tell us about his/her eating and sleeping habits? ________________________

____

- Could you offer some strengths and weaknesses that you see in your child? __________

____

____

- Things you would like to see your child do in his/her class? ________________

____

____

Please feel welcome to visit us. There will be notes posted on our Family Board and I will be sending notes/notices about how your child is doing. Also, send us notes or call when there are something that we need to know as well. This is going to be a great year. You have a precious child and we look forward to being a part of your family this year.