ST. MICHAEL'S PRESCHOOL/TRANSITIONAL KINDERGARTEN

1315 1st Ave.

South Sioux City, NE 68776

(402)-494-1526

POLICY HANDBOOK FOR PARENTS

Welcome! This is a especial time in your child's life. Your child will be learning a variety of new skills ranging from how play with peers, self-confidence, academic achievement, following directions and muscle motor coordination. St. Michael's Preschool provides environment that develops children's intellectual, physical, emotional, spiritual and social growth. We look forward to working with you as your child experiences the joy of learning.

AGE REQUIREMENT

Children must be 4 years old by July 31st and toilet trained to enter preschool. Classes for 4 years old are held Monday through Friday from 8:00am-3:15pm. After School Program care is offered from 3:00pm to 6:00pm at a cost of $3.00 per hour. Drop ins are $4.00 per hour.

Please be considerate in dropping off and picking up your child on time.

DAILY ACTIVITIES SCHEDULE

Our daily lesions plans include center play, an art/craft project, table time papers, snacks circle time, show and tell, music/finger plays, movement activity, story, and outdoor recess, P.E., Art , music, Computer and library with specials teachers. Students will work on recognition of upper and lower case alphabet, numbers, colors, phone numbers and address. Preschool students will participate in weekly mass.

REGISTARTION FEE AND SCHOOL SUPPLIES

A deposit of $100.00 is requires to reserve a spot for your children in St. Michael's Preschool and is applied to your child's first month of school.

St. Michael's Preschool provides all necessary art and craft supplies, breakfast every morning and afternoon fruit and vegetable snack. Children should bring a backpack or book bag to carry daily papers, art projects and Take-Home weekly folders.

TUITION

4 years old preschool: $3300.00 per year or $330 monthly for 10 months and runs from 8:00am to 3:15pm Monday thru Friday the same as K-8th grade.

****Preschool students may qualify for Children's Scholarship Fund if they have an older sibling enrolled at St. Michael's Catholic School. Tuition that is not paid by the end of the month will be considered delinquent and $30.00 late fee will be added. There is a change of $30.00 for returned checks.

BEFORE AND AFTER SCHOOL CARE

Before School program: 7:30am-8:00am ... FREE

After School Program from 3:00-6:00.... Cost is $3.00 per hour.

Students must be registered quarterly for the After School Program to provide adequate staff and age appropriate activities. You may change your requests quarterly.

SCHOOL CALENDAR

St. Michael's Preschool and before/After School Programs follow the calendar established by St. Michael's School is not in session, St. Michael's Preschool and before/after school programs are not in session.

WEATHER CANCELATIONS

If St. Michael's School cancels classes due to inclement weather or hazardous road conditions, preschool will also be closed. If St. Michael's School dismisses early due to inclement weather, the preschool will dismiss at the same time.

ABSENCES

Please notify the school (402) 494-1526 if your child will be delayed or absent, fees will not be adjusted due to absences.

HEALTH REGULATIONS

To protect your child, teachers, and other students, parents should keep children home if they have the following symptoms:

* Temperature of 100 degrees or higher.

*An upset stomach or diarrhea within the past 24 hours.

*An undiagnosed rash.

*An unexplained lack of appetite, fatigue, listlessness, or irritability.

Ant child an illness associated with fever or any communicable condition such as diarrhea, ringworm, impetigo, head lice, pink eye, and scabies will be removed from preschool until medical treatment is obtained. If a serious injury occurs, a parent or guardian will be contacted.

Any student requiring prescription or over the counter medication must bring a signed statement from parents/guardian specifying dosage and time of dispersal. The school cannot give out medication without parental permission.

Parents must be provide immunization records for a child to attend St. Michael's Preschool. This regulation is mandated by Nebraska Department of Health and the Archdiocese of Omaha.

CLOTHING

Students attending St. Michael's Preschool should wear comfortable clothing. Unlike students in grades K-8th grade, preschool students are not required to wear uniforms. However, please keep in mind that your child is in a Catholic school and should be dresses appropriately. Girls must wear shorts under dresses and skirts. Thank tops and spaghetti straps are not allowed. Clothing may become soiled due to art projects, various activities, or outdoor play. Please provide and oversized shirt with your child's name on the tag to be worn during Art activities. Please mark identification on backpack or book bags.

Enrollment Application

St. Michael's Catholic School
1315 1st Ave
South Sioux City, NE 68776
4024941526

Website: http://stmichaels.schoolinsites.com/
Lora Crowe, Principal loracrowe@smcsssc.com
Daniela Padilla, Office Manager daniela@smcsssc.com

Intent to Return Pre-Registration Form

2025-26 School Year

This form must be completed at St. Michael's during Registration.

Your family's Intent to Return down payment will be $100 per family for the 2025-26 school year. This payment will be applied to your family's account on your final May payment for the 2025-26 school year. This $100 non-refundable payment must be remitted when this form is completed at St. Michael's School during Pre-Registration.

Please check one:

_____ My child/children will be returning to St. Michael's School for the 2025-26 school year. (Intent to Return Payment of $_____Enclosed)

_____ My child/children will not be returning to St. Michael's School for the 2025-26 school year.

Name of Child:	**Grade Enrolled for 25-26:**
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

Parent's Signature **Date**

TUITION PAYMENT AGREEMENT

Please initial the plan you choose.

One Payment Option:

_____ Payment is due by the first day of school. The one payment plan is encouraged and appreciated.

Two Payment Plan:

_____ First Payment is due August 15th with the second payment due January 15th.
A $30 per month late fee will be applied to accounts that do not have their family monthly payment in by the $15th of January.

Monthly Payment Plan:

_____ 10 payments of $330 per month per child are due by the 15th of the month starting in August and will be continued through May 15th.
***Based on $3300 tuition per year, plus #200 in student fees per student for monthly payment of $330.

It is each and every family's responsibility to make tuition payments on time. Reminder notices will not be issued when payments are due. A $30 per month late fee will be applied to accounts that do not have their family monthly payment in by the 15th of each month. If you should have difficulties making timely payment, please contact the office immediately. If no effort to make payments is made, the delinquent accounts will be brought to the School Board and Finance Committee to determine if the child/ren will be allowed to remain at St. Michael's Catholic School. Delinquent balances will be forwarded to a collection agency.

Parent Signature: _____ Date:_____

St. Michael's Catholic School
Permanent Student Record

Date: _____

Student Name: _____ Grade Applied For:_____
(First) (Middle) (Last)

Place of Birth: _____ Date of Birth: _____ Gender: _____

1st Language: _____ Religion: _____ Parish: _____-_____

Ethnicity: _____ Hispanic/Latino _____ Non-Hispanic/Latino

Race: PLEASE CHECK ALL THAT APPLY _____American Indian/Alaska Native _____ Asian

_____ African American _____White _____ Native Hawaiian/Pacific Islander

Home School District: _____

IEP/Special Assistance Plan/Medical Needs/Other? _____

Parents/Guardians Information:

Name: _____ Relationship: _____Church Affiliation: _____

Address: _____ City: _____State: _____ Zip Code:_____

Occupation: _____ Company Name:_____

Cell Phone: _____ Cell Phone Carrier: _____

Home Phone: _____ Work Phone: _____

Primary E-mail: _____

Name: _____ Relationship: _____Church Affiliation: _____

Address: _____ City: _____State: _____ Zip Code:_____

Occupation: _____ Company Name:_____

Cell Phone: _____ Cell Phone Carrier: _____

Home Phone: _____ Work Phone: _____

Primary E-mail: _____

Home Information:

Parents married [ ] One parent [ ] Parents Separated or Divorced [ ]

Restructured-Stepfather/Stepmother [ ] Father remarried [ ] Mother remarried [ ]

Child resides with: _____

Siblings:

Name	Age	Name	Age
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Parental Rights (in case of separation or divorce): _____ (Provide copy of court order)

Language (other than English) spoken at home: _____

Emergency Contacts:

Name: _____ Relationship to Child: _____

Address: _____ Phone Number: _____

City, State, Zip: _____

Name: _____ Relationship to Child: _____

Address: _____ Phone Number: _____

City, State, Zip: _____

Religious Background:

Registered Parish: _____ Location: _____

	Church Name	City & State	Religion
Baptism:	_____	_____	_____
First Penance:	_____	_____	_____
First Communion:	_____	_____	_____
Confirmation:	_____	_____	_____

Medical Information:

Doctor: _____ Doctor's Phone Number: _____

Hospital Preferred: _____ Allergies/medical condition: _____

Medication: _____ Dosage: _____

Dentist: _____ Dentist's Phone Number: _____

Academic Record (Pre-K or Kindergarten applicants include day care experiences):

School Attended: _____ Date Enrolled: _____Date Withdrawn: _____

Reason for leaving: _____

School Attended: _____ Date Enrolled: _____Date Withdrawn: _____

Reason for leaving: _____

School Attended: _____ Date Enrolled: _____Date Withdrawn: _____

Reason for leaving: _____

Has your child ever been suspended, expelled, dismissed, or not allowed to re-enroll in a school?
[ ] No Yes [ ] If yes please provide the name of the school and the reasons on a separate sheet of paper.

Has your student ever been tested or evaluated for any disability [i.e., earning disabilities, ADD/ADHD, emotional disabilities, etc.], English as a Second Language, or medical condition? [ ] No [ ] Yes

If yes, please describe on a separate sheet of paper any disability or medical condition that may affect your child's ability to fully participate in the academic program provided at St. Michaels Catholic School. If you are requesting an adjustment or accommodation to the curriculum, please describe your request.
Information about disabilities is requested for the sole purpose of determining whether the school can provide the applicant with an appropriate education or reasonable accommodation and will not be considered in determining whether he/she is otherwise qualified for admission.

Parent Questionnaire:

How did you learn about St. Michaels Catholic School? _____

What are the first three words that come to mind when you think of your child?

_____

Which activities or hobbies does your child enjoy most?

_____

Describe times when your child is happiest.

_____

How do you feel that your child learns best?

_____

What led you to consider St. Michaels Catholic School for your child?

_____

_____

_____

_____

What are your goals for your child at St. Michaels Catholic School?

_____

_____

_____

_____

PARENT/GUARDIAN FIELD WALKING FILED TRIP CONSENT FORM AND LIABILITY WAIVER

I, _____ (parent name) grant permission for my child/ren, _____ to walk to event activities offered by St. Michael's Catholic School. These events will be under the direction of the St. Michael's faculty/staff/parents.

I agree on behalf of myself, my child, our heirs, successors, and assigns, directors, employees, and agents, and the Arch Diocese of Omaha, its employees and agents, chaperones or representatives associated with the even from any claim arising from or in connection with my child participating/attending the event or in connection with any illness or injury/death or cost of medical treatment in connection therewith. I agree to compensate the parish/school, Arch Diocese of Omaha, its employees and agents, chaperones or representatives associated with the even for reasonable attorney fees and expenses which may occur in any action brought against them, unless such claim arises from the negligence of the parish/school/diocese.

Parent signature: _____ Date: _____

PHOTOGRAPHY CONSENT FORM/RELEASE

I, (print name) _____, parent or official guardian of (child/ren's name) _____, hereby grant permission to St. Michael's Catholic School to take and use photographs and/or digital images of my child for use in news releases and/or educational materials. This may be in the form of printed publications or material, electronic publications, or WEB sites. I agree that my child/ren's name and identity may be revealed in descriptive text or commentary in connection with the image(s). I authorize the use of these images without compensation to me.

Date: _____
Parent Signature: _____
Address: _____
City, State, Zip: _____

******** _____ **Check here ONLY IF YOU DO NOT GIVE CONSENT to the above.**

STUDENT PICK UP PERMISSION SLIP

I grant permission to the following people listed below to pick up my child/ren from St. Michael's Catholic School.

People with permission to pick up after school:

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Child/ren to be picked up:

Name: _____ Name: _____

Name: _____ Name: _____

Name: _____ Name: _____

I give permission to St. Michael's Catholic School to have my child/ren walk home from school.

Parent Signature: _____ Date:_____

Child/ren Names:

Name: _____ Name: _____

Name: _____ Name: _____

Name: _____ Name: _____

SPEECH/LANGUAGE DEVELOPMENT QUESTIONAIRE

Child's Name:_____Child's Date of Birth_____
Parent:_____Address:_____
Phone:_____Date:_____

Your child may be screened at teacher or parent request.

Yes No 1. Do family members *frequently* have difficulty understanding your child's speech?

Yes No 2. Does your child ever become frustrated because of his/her speech or language?

Yes No 3. When your child talks, are his/her sentences *always less* than five words in length?

Yes No 4. Does your child have difficulty understanding directions?

5. Does your child have difficulty with any of the following:

Yes No A. Carrying on a conversation with you by telling you what he/she is doing?

Yes No B. Asking questions such as why, when, and how?

Yes No 6. Are you concerned about your child's hearing?

Yes No 7. Do you feel your child stutters?

Yes No 8. Do you have any questions about your child's speech and language development?

HOME LANGUAGE SURVEY

School:_____ Grade:_____ Date:_____

Student Name: _____ Birth Date:_____ Gender: __Male __Female

Parent/Guardian Name:_____

Address:_____

Home telephone;_____ Work telephone:_____

What language did your child fist lean to speak?_____

What language is spoken most often by your child?_____

What language does your child most frequently use at home?_____

_____ _____

Parent or Guardian's Signature Date

ENCUESTA DE IDIOMA DOMESTICO

Escuela:_____ Grado:_____ Fecha:_____

Nombre del estudiante:_____ Fecha de nacimiento:_____ Sexo: __Masculino __Femenino

Nombre del padre o Tutor:_____

Direccion:_____

Numero de telefono del hogar:_____ Numero de telefono del trabajo:_____

Que idioma aprendio su hijo cuando empezo a hablar?:_____

Que idioma utiliza su hijo con mas frecuencia?:_____

Que idioma utiliza su hijo con mas frecuencia en el hogar?:_____

Health Requirements for all students - updated for 2025-2026 school year

All students entering St. Michael's School must meet the health requirements as outlined by Nebraska State Law and the Archdiocese of Omaha. NO student will be admitted to St. Michael's School on the first day of school unless the requirements are met. Parents need to submit the forms to the school by August 1st.

Physical Exams: Nebraska State Law requires all students entering kindergarten, seventh grade or transferring from an out-of-state school to have a physical examination by a physician, physician's assistant, or nurse practitioner with six (6) months prior to entering the school.

Vision Exam: Nebraska State Law states that all students have a visual examination within 6 months prior to entrance into Kindergarten.

Exceptions to the physical examination and/or the visual examination requirement may be made if the parent/guardian submits a written statement refusing physical and/or visual examination.

Immunizations: Nebraska State Law requires students receive the following immunizations:

* 3 doses of DTap, DTP, DT or Td vaccine, one given on or after the 4th birthday.

* 3 doses of Polio vaccine.

* 2 doses of MMR vaccine, given on or after 12 months of age and separated by at least one month.

*3 doses of Hepatitis B vaccine.

* 2 doses of varicella (chicken pox) or written documentation (including year) of varicella disease.

* Students entering 7th grade also require 1 dose of Tdap (contain Pertussis booster).

An exception to the immunization requirement is made only if a medical reason is documented by a physician, physician assistant, or nurse practitioner, or for valid religious objections as specified in Archdiocese of Omaha policy.

Health screening: As required by Nebraska State Law, each year students in grades PK-4 and 7 are screened in the areas of vision, dental, hearing, height and weight at the school. If parent/guardian wishes to refuse school health screening, parents/guardian must submit written statement(s) from a qualified examiner that the child has received the minimum required screenings within the past six months or the child will be screened at school.

Each student is encouraged to have a physical performed yearly by their family physician.

FOOD ALLERGY ACTION PLAN

IMPORTANT: Please complete attached forms if your child have any form of Allergies & return to school office as soon as possible.

ALLERGY TO:_____

Student Name:_____ D.O.B.:_____ Teacher:_____

Asthmatic: Yes*___ No___ *High risk for severe reaction

SIGNS OF AN ALLERGIC REACTION

-MOUTH Itching & swelling of the lips, tongue or mouth.

-THROAT Itching and / or sense of tightness in the throat, hoarseness, and hacking cough.

-SKIN Hives, itchy rash, and / or swelling about the face or extremities.

-GUT Nausea, abdominal cramps, vomiting and / or diarrhea.

-LUNG* shortness of breath, repetitive coughing and / or wheezing.

-HEART* "thready" pulse, "passing-out"

The severity of symptoms can quickly chance. *All above symptoms can potentially progress to a life-threatening situation.

ACTION FOR MINOR REACTION

1. If only symptom(s) are:_____

give_____

Then call:

2. Mother_____ Father_____ or emergency contacts.

3. Dr. _____ at_____.

If condition does not improve within 10 minutes, follow steps for Major Reaction below.

ACTION MAJOR REACTION

1. If ingestion is suspected and / or symptom (s) are:_____

give_____ IMMEDIATELY!

Then call

2.Resucue Squad (ask for advanced life support)

3.Mother_____ Father_____ or emergency contacts.

4.Dr. _____ at _____

DO NOT HESITATE TO CALL RESCUE SQUAD!

Parent's signature_____ Date_____

Doctor's Signature_____ Date_____

ATTACHMENT A: Emergency Care Plan

To be used for a child with known asthma/anaphylaxis

NAME_____ GRADE_____ AGE_____

SCHOOL_____ TEACHER_____

Parent/Guardian Name_____ Phone (H)_____

Address_____ Phone (W)_____

Parent/Guardian Name_____ Phone (H)_____

Address_____ Phone (W)_____

Emergency Contact #1_____ Phone_____

Emergency Contact #2_____ Phone_____

Physician student sees for asthma/anaphylaxis_____ Phone_____

NATURE OF ASTHMA/ANAPHYLAXIS- Describe, including triggers, signs and symptoms of allergic response and known allergens.

_____

_____

MANAGEMENT PLAN - Describe environmental controls and list medication prescribed. If asthma, identify zones for peak flow.

_____

_____

TREATMENT PLAN - Describe the steps to be taken for treatment.

_____

_____

_____

****

RELEASE OF INFORMATION

I give the school nurse permission to contact Dr. _____ regarding this plan for my child_____.

Parent/Guardian Signature_____ Date_____

NEBRASKA
Good Life. Great Mission.
DEPT. OF HEALTH AND HUMAN SERVICES

Division of Public Health - Licensure Unit - Children's Services Licensing Program

Children's Record

PARENTS: PLEASE FILL IN ALL BLANKS

Child(ren)'s Name:_____ Birthdate(s):_____

Enrollment Date:_____ Updates:_____ Date Care Ceased: _____

Parent or Guardian's Home Address and Employment Address:

FATHER (or Guardian):

Name: _____ Employer:_____

Address:_____ Address:_____

City: _____ Phone: _____ City: _____ Phone:_____

MOTHER (or Guardian):

Name: _____ Employer:_____

Address:_____ Address:_____

City: _____ Phone: _____ City: _____ Phone:_____

Person(s) to Whom the Child(ren) may be Released by the Caregiver: (If no one, please write "none")

Name: _____ Name: _____

Address:_____ Address:_____

City: _____ Phone: _____ City: _____ Phone:_____

Name: _____ Name: _____

Address:_____ Address:_____

City: _____ Phone: _____ City: _____ Phone:_____

Person(s) Who Will Take Responsibility for the Child(ren) in an Emergency When the Parent (or Guardian) Cannot be Reached: (ONE NAME MUST BE GIVEN)

Name: _____ Name: _____

Address:_____ Address:_____

City: _____ Phone: _____ City: _____ Phone:_____

Name: _____ Name: _____

Address:_____ Address:_____

City: _____ Phone: _____ City: _____ Phone:_____

Consent to Contact Physician in Emergency:

Consent to Contact Physician in Emergency:

In the event I cannot be reached to make arrangements, I hereby give my consent to _____
Caregiver

to contact Doctor _____ _____
Name of Physician Phone

_____ and, if necessary, take my child(ren) to the
Address City

following doctor(s), clinics, or hospital _____

_____ _____
Signature of Parent/Guardian Date

MEDICATION COMPETENCY STATEMENT

I,_____have determined
Parent /Guardian Name

that_____is/are competent to give or apply medication to my child(ren).
Provider/Director/Staff Name(s)

_____ _____
Signature of Parent/Guardian Date

CHILD'S MEDICAL INFORMATION

Current health status or any health problems caregiver should know: _____
_____
_____
_____

Medication, if any: _____
_____
_____
_____

List any allergies and/or intolerance to food, insect bites, or stings, or other factors that result in a medical reaction. Please give clear instructions in the event of an exposure of the factor: _____
_____

Special Concerns: (Glasses, Hearing Aid, Crutches)_____
_____

Any activities child(ren) should NOT engage in: _____
_____

Company providing health and/or accident insurance coverage: (Optional) _____

I certify that the above information is correct to the best of my knowledge.

_____ _____
Signature of Parent/Guardian Date