Our Lady of Good Counsel School
23 Prospect Avenue - Moorestown, NJ 08057
(856) 235-2778

Dear Parents/Guardians of Prospective Students,

Thank you for your interest in Our Lady of Good Counsel School. Choosing the right school for your child(ren) is one of the most important decisions you will ever make. We are honored that you are considering OLGC School among your options.

Our Catholic identity is integrated into everything we do at OLGC School. We view faith as the foundation and structure of knowledge, wisdom, and values. We are proud to be able to offer a faith-based education that is not offered by our highly qualified public school counterparts.

You will enjoy a partnership at OLGC which includes teachers, staff, and administrators who work together to support all our students. This partnership forms a powerful community united in the belief that Christian values and excellent academics will best prepare your child for the future. We strive to meet each child's individual needs, and we expect our students of all ages to learn the importance of following the example of Jesus by serving others.

I am happy to answer any questions you have about how enrolling at Our Lady of Good Counsel School will make a difference in your child's life. God's blessings to you as you explore options for your child's education.

Cynthia Smith
Principal
cynthiasmith@OLGC.me

Our Lady of Good Counsel School
Tuition Rates 2024 - 2025

	TUITION RATES	
	2023-24	2024-25
PK3 + PK4 Tuition	$ 6,025	$ 6,628
Grades K-8		
One Child in Family	$ 5,819	$ 5,994
Two Children in Family	$ 11,071	$ 11,403
Three or more Children in Family*	$ 16,023	$ 16,504

Family tuition rate is capped at $16, 504.

Our Lady of Good Counsel School
Early Childhood Center

Moorestown, NJ

PK3 & PK4 2024-2025 TUITION AGREEMENT

☐Principal Approval Date_____

MOTHER'S INFORMATION

Name:_____

Home Address: _____

_____

e-mail address: _____

Home Phone Number:_____

Work Phone Number: _____

FATHER'S INFORMATION

Name:_____

Home Address:_____

_____

e-mail address: _____

Home Phone Number: _____

Work Phone Number: _____

Married___ *Divorced___ *Separated___Other_____

*Please include custody paperwork

Child/ren - Name(s):	Grade 2024-2025:	Date of Birth	IEP/504
_____	_____	_____	Y / N
_____	_____	_____	Y / N
_____	_____	_____	Y / N

PK3 + PK4 TUITION

Five (5) Days: Full Day Session 8:20 am - 3:00 pm

_____ Per Child: **$6,628**

Five(5) Days: Half Day Session 8:20 am -12:30 pm

_____ Per Child: **$5,628**

PAYMENT OPTIONS

SINGLE PAYMENT OPTION:

In the event full payment is made on or before September 1, 2024, the tuition listed above shall be reduced by 5%. The discount will be forfeited if the payment is not received by September 1st.

MONTHLY PAYMENT OPTION:

If the Single Payment Option is not chosen, tuition payments must be paid through an automatic monthly electronic bank transfer payment arrangement made with The FACTS Management Company. Enrollment in this payment option is done through FACTS Management https://factsmgt.com/.

There is a $55.00 registration fee charged by FACTS Management Company.

FACTS registration must be completed no later than April 1, 2024.

The first of 10 monthly electronic bank transfer installments (August 2024– May 2025) will be collected starting in August 2024 on either the 5th or 20th day of each month, (your choice). In the event a monthly payment hereunder is not collected due to insufficient funds in the said checking account, FACTS Management Co. will assess a $30.00 fee for each time an unsuccessful draft attempt is made.

Please check one of the following options:

_____ It is my intent to utilize the **Single Payment Option.**
I recognize that if I do not make the single payment in full on or before September 1, 2024 then I shall enroll on-line for the FACTS Management monthly payment plan by this date.

_____ It is my intent to utilize the **Monthly Payment Option**. I will enroll online in the FACTS Management System on or before April 1, 2024.

TUITION ASSISTANCE OPPORTUNITY (Please check if interested)

_____ I would like to make a tax-deductible contribution in addition to my regular tuition payment to assist families that are not able to meet their full tuition obligation but do wish to have their child(ren) experience a Catholic Education. The amount of my donation will be $_____. (Please include a check for this donation or indicate how you would like to make this contribution.)

- Families who enroll their children in Our Lady of Good Counsel School and agree to pay the yearly tuition in one payment by September 1st, will receive a 5% discount off their tuition.
- If you choose to make monthly payments on the 5th or the 20th of each month, , the balance will be due by May 20, 2025.
- Students cannot re-enroll in Our Lady of Good Counsel School if there are outstanding tuition or Aftercare balances, or any other outstanding payment obligation.
- I acknowledge and agree to comply with all of the terms of the Parent/Student Handbook and other rules, regulations, policies, and expectations of Our Lady of Good Counsel School, which are hereby incorporated into this agreement.
- In order to enroll your child(ren) in Our Lady of Good Counsel School for the 2024-2025 academic year, this form must be filed by April 1, 2024. Additionally, if using the Monthly Payment Option, you must have completed your FACTS online enrollment on or before April 1, 2024.

By execution of this Agreement, I hereby understand, agree, and consent to the terms and conditions set forth herein.

Parent/Guardian/Legally Responsible Party **Date**

Our Lady of Good Counsel School

23 W. Prospect Ave.
Moorestown, NJ 08057

Our Lady of Good Counsel Early Childhood Center – ECC

PK3* -- PK3 students must be 3 years old on or before October 1st. All children must be fully independent in the bathroom before enrolling.

PK4* – PK4 students must be 4 years old on or before October 1st. All children must be fully independent in the bathroom before enrolling.

Application materials are collected from all preschool families. Parents will be notified of acceptance and to schedule an early childhood screening appointment for your child.

Our Lady of Good Counsel School Kindergarten

Kindergarten* students must be 5 years old on or before October 1st. There is a limit of 50 students in our kindergarten program. This program consists of two classes.

*PK3, PK4, and Kindergarten students will participate in a screening process to determine readiness for the grade level.

Our Lady of Good Counsel School Elementary Grades

Our grade 1-4 teachers work collaboratively by grade level. There are two classes at each grade level.

Our Lady of Good Counsel School Middle School

Grades 5-8 make up our middle school classes. Students switch classes according to subject. All grade levels participate attend special area classes in Physical Education, Art, Technology, World Language, and Library.

REGISTRATION DOES NOT IMPLY ACCEPTANCE FOR TRANSFER STUDENTS. Preferences is given to current students. Transfer students will be accepted following submission of the following:

1) **Registration Form**
2) **Child's Birth Certificate**
3) **Current and previous academic records including standardized test scores and most recent report card**
4) **$50 nonrefundable registration fee**

Our Lady of Good Counsel School (002) ☐Principal Approval Date_____
23 West Prospect Avenue, Moorestown, NJ
Diocese of Trenton - Registration Form

*Last		*First Name	*Middle Name	
*DOB	*Ethnicity	*Gender	*Incoming Grade/Date	
*Father LN	*Father FN	*Mother LN	*Mother FN	
*Street Address		*City	*State/Zip	
*Home Phone	*Mother Cell	*Father Cell	Mother Email: Father Email:	
*Resident County	Birth City/State	Country of Citizenship	Primary Language & Home Language	
*Transferring from (school)		*City	*State/Zip	
*Baptism (m/d/yr.)	*Parish	*Address	*City	*State/Zip
*First Penance (m/d/yr.)	*Parish	*Address	*City	*State/Zip
*First Eucharist (m/d/yr.)	*Parish	*Address	*City	*State/Zip
*Confirmation (m/d/yr.)	*Parish	*Address	*City	*State/Zip

Application must be completely filled out (both sides) for registration to be processed.
Thank you.

REGISTRATION FEE: $50.00 per student
To be paid at the time of registration.

FAMILY BACKGROUND

	Name	Address	Occupation	Religion	Date of Death	Education
Father						☐ Elem. ☐ Coll. ☐ Sec. ☐ Adv.
Mother (include Maiden name)						☐ Elem. ☐ Coll. ☐ Sec. ☐ Adv.
Guardian						☐ Elem. ☐ Coll. ☐ Sec. ☐ Adv.

Relationship of guardian to student _____

Home situation (Check all that apply):

☐ Two parents ☐ One parent ☐ Parents separated or divorced
☐ Restructured-mother/stepfather ☐ Father remarried ☐ Mother remarried
☐ Restructured-stepmother/father ☐ Other

Child resides with: _____

Class registering for: ____ Pre-k 3 _____Pre-k 4 half-day _____Pre-k 4 full day _____Kindergarten Class request KA __ KB __

Parental rights (in case of separation of divorce)
(attached copy of court order)

SIBLINGS:

Complete Name	Date of Birth	Other Pertinent Information:

Please select one to fully complete application

Academic Intentions at OLGC

❒ **PK3 / 4 only** ❒ **PK3 / 4 & K only** ❒ **PK3 / 4 and K-8** ❒ **Other**_____

APPENDIX H

UNIVERSAL CHILD HEALTH RECORD

Endorsed by: *American Academy of Pediatrics, New Jersey Chapter*
New Jersey Academy of Family Physicians
New Jersey Department of Health

SECTION I - TO BE COMPLETED BY PARENT(S)

Child's Name *(Last)*	*(First)*	Gender ☐ Male ☐ Female	Date of Birth / /
Does Child Have Health Insurance? ☐Yes ☐No	If Yes, Name of Child's Health Insurance Carrier		
Parent/Guardian Name	Home Telephone Number ( ) -	Work Telephone/Cell Phone Number ( ) -	
Parent/Guardian Name	Home Telephone Number ( ) -	Work Telephone/Cell Phone Number ( ) -	

I give my consent for my child's Health Care Provider and Child Care Provider/School Nurse to discuss the information on this form.

Signature/Date	This form may be released to WIC. ☐Yes ☐No

SECTION II - TO BE COMPLETED BY HEALTH CARE PROVIDER

Date of Physical Examination:	Results of physical examination normal? ☐Yes ☐No

Abnormalities Noted:		
	Weight *(must be taken within 30 days for WIC)*	
	Height *(must be taken within 30 days for WIC)*	
	Head Circumference *(if <2 Years)*	
	Blood Pressure *(if ≥3 Years)*	

IMMUNIZATIONS	☐ Immunization Record Attached ☐ Date Next Immunization Due: _____

MEDICAL CONDITIONS

Chronic Medical Conditions/Related Surgeries • List medical conditions/ongoing surgical concerns:	☐ None ☐ Special Care Plan Attached	Comments
Medications/Treatments • List medications/treatments:	☐ None ☐ Special Care Plan Attached	Comments
Limitations to Physical Activity • List limitations/special considerations:	☐ None ☐ Special Care Plan Attached	Comments
Special Equipment Needs • List items necessary for daily activities	☐ None ☐ Special Care Plan Attached	Comments
Allergies/Sensitivities • List allergies:	☐ None ☐ Special Care Plan Attached	Comments
Special Diet/Vitamin & Mineral Supplements • List dietary specifications:	☐ None ☐ Special Care Plan Attached	Comments
Behavioral Issues/Mental Health Diagnosis • List behavioral/mental health issues/concerns:	☐ None ☐ Special Care Plan Attached	Comments
Emergency Plans • List emergency plan that might be needed and the sign/symptoms to watch for:	☐ None ☐ Special Care Plan Attached	Comments

PREVENTIVE HEALTH SCREENINGS

Type Screening	Date Performed	Record Value	Type Screening	Date Performed	Note if Abnormal
Hgb/Hct			Hearing		
Lead: ☐ Capillary ☐ Venous			Vision		
TB (mm of Induration)			Dental		
Other:			Developmental		
Other:			Scoliosis		

☐ ***I have examined the above student and reviewed his/her health history. It is my opinion that he/she is medically cleared to participate fully in all child care/school activities, including physical education and competitive contact sports, unless noted above.***

Name of Health Care Provider (Print)	Health Care Provider Stamp:
Signature/Date	

Instructions for Completing the Universal Child Health Record (CH-14)

Section 1 - Parent

Please have the parent/guardian complete the top section and sign the consent for the child care provider/school nurse to discuss any information on this form with the health care provider.

The WIC box needs to be checked only if this form is being sent to the WIC office. WIC is a supplemental nutrition program for Women, Infants and Children that provides nutritious foods, nutrition counseling, health care referrals and breast feeding support to income eligible families. For more information about WIC in your area call 1-800-328-3838.

Section 2 - Health Care Provider

1. Please enter the date of the physical exam that is being used to complete the form. Note significant abnormalities especially if the child needs treatment for that abnormality (e.g. creams for eczema; asthma medications for wheezing etc.)
   - **Weight** - Please note pounds vs. kilograms. If the form is being used for WIC, the weight must have been taken within the last 30 days.
   - **Height** - Please note inches vs. centimeters. If the form is being used for WIC, the height must have been taken within the last 30 days.
   - **Head Circumference** - Only enter if the child is less than 2 years.
   - **Blood Pressure** - Only enter if the child is 3 years or older.

2. **Immunization** - A copy of an immunization record may be copied and attached. If you need a blank form on which to enter the immunization dates, you can request a supply of Personal Immunization Record (IMM-9) cards from the New Jersey Department of Health, Vaccine Preventable Diseases Program at 609-826-4860. The Immunization record must be attached for the form to be valid.
   - "Date next immunization is due" is optional but helps child care providers to assure that children in their care are up-to-date with immunizations.

3. **Medical Conditions** - Please list any ongoing medical conditions that might impact the child's health and well being in the child care or school setting.

   a. Note any significant medical conditions or major surgical history. **If the child has a complex medical condition, a special care plan should be completed and attached for any of the medical issue blocks that follow.** A generic care plan (CH-15) can be downloaded at www.nj.gov/health/forms/ch-15.dot or pdf. Hard copies of the CH-15 can be requested from the Division of Family Health Services at 609-292-5666.

   b. **Medications** - List any ongoing medications. Include any medications given at home if they might impact the child's health while in child care (seizure, cardiac or asthma medications, etc.). Short-term medications such as antibiotics do not need to be listed on this form. Long-term antibiotics such as antibiotics for urinary tract infections or sickle cell prophylaxis should be included.

      PRN Medications are medications given only as needed and should have guidelines as to specific factors that should trigger medication administration. *Please be specific about what over-the-counter (OTC) medications you recommend, and include information for the parent and child care provider as to dosage, route, frequency, and possible side effects. Many child care providers may require separate permissions slips for prescription and OTC medications.*

   c. **Limitations to physical activity** - Please be as specific as possible and include dates of limitation as appropriate. Any limitation to field trips should be noted. Note any special considerations such as avoiding sun exposure or exposure to allergens. Potential severe reaction to insect stings should be noted. Special considerations such as back-only sleeping for infants should be noted.

   d. **Special Equipment** – Enter if the child wears glasses, orthodontic devices, orthotics, or other special equipment. Children with complex equipment needs should have a care plan.

   e. **Allergies/Sensitivities** - Children with life-threatening allergies should have a special care plan. Severe allergic reactions to animals or foods (wheezing etc.) should be noted. Pediatric asthma action plans can be obtained from The Pediatric Asthma Coalition of New Jersey at www.pacnj.org or by phone at 908-687-9340.

   f. **Special Diets** - Any special diet and/or supplements that are medically indicated should be included. Exclusive breastfeeding should be noted.

   g. **Behavioral/Mental Health issues** – Please note any significant behavioral problems or mental health diagnoses such as autism, breath holding, or ADHD.

   h. **Emergency Plans** - May require a special care plan if interventions are complex. Be specific about signs and symptoms to watch for. Use simple language and avoid the use of complex medical terms.

4. **Screening** - This section is required for school, WIC, Head Start, child care settings, and some other programs. This section can provide valuable data for public heath personnel to track children's health. Please enter the date that the test was performed. Note if the test was abnormal or place an "N" if it was normal.
   - For lead screening state if the blood sample was capillary or venous and the value of the test performed.
   - For PPD enter millimeters of induration, and the date listed should be the date read. If a chest x-ray was done, record results.
   - Scoliosis screenings are done biennially in the public schools beginning at age 10.

   This form may be used for clearance for sports or physical education. As such, please check the box above the signature line and make any appropriate notations in the Limitation to Physical Activities block.

5. Please sign and date the form with the date the form was completed (note the date of the exam, if different)
   - Print the health care provider's name.
   - Stamp with health care site's name, address and phone number.

Our Lady of Good Counsel Religious Education Ministry
122 West Main Street Moorestown NJ 08057
856-235-7136 reprogram@olgcnj.org

SACRAMENTAL INFORMATION SHEET

Child's Name: _____ Grade: _____

Mother (Include Maiden): _____ Religion: _____

Father: _____ Religion: _____

Address: _____

Phone: _____

Email: _____

If duplicate mailings are requested, please list contact information for each parent.

Sacraments Received:

Baptism: Church: _____
(Please attach copy of Baptismal Certificate, if not baptized at OLGC)

First Eucharist: Church: _____
(Please attach copy of First Eucharist Certificate, if not received at OLGC)

Confirmation: Church: _____
(Please attach copy of Confirmation Certificate, if not received at OLGC)

Desire to Receive Sacraments:

_____ I wish my child to prepare for and receive **Baptism**

_____ I wish my child to prepare for and receive **First Eucharist**
(Children prepare for and celebrate Eucharist in Grade 2)
Child must be baptized before receiving Eucharist

_____ I wish my child to prepare for and receive **Confirmation**
(Children prepare in grades 7 and 8. Confirmation is celebrated in grade 8)
Child must be baptized and have received Eucharist before being confirmed

_____ _____
Parent Signature *Date*

Please return this completed form, and certificates requested in a sealed envelope to: Mrs. Cynthia Robinson, Parish Catechetical Leader, through the school office. Thank you!