OUR LADY OF THE MIRACULOUS MEDAL PARISH SCHOOL

Mission Statement

Be it known to ALL who enter
Our Lady of the Miraculous Medal School
that Christ is the reason for the school.

Our purpose as Vincentian educators is to
foster faith, service, and excellence in the
Catholic Christian Education of our youth.

Christ, the unseen but ever present teacher in our classes, harmoniously develops the whole child with emphasis on their spiritual, moral, physical,
and intellectual being.

Together with the school families, the faculty and staff model Gospel values, centered on the Eucharist,
in a community of worship and social concern.

Phone: (323) 728-5435 840 North Garfield Avenue, Montebello, CA Fax: (323) 728-8038
www.olmmschool.com

SCHOOL-WIDE LEARNING EXPECTATIONS

The Students Of Our Lady Of Miraculous Medal School

are:

CATHOLIC-CHRISTIAN LEADERS

I go to mass

I pray everyday

I serve others

DISCIPLINED LEARNERS

I am a lifelong learner

I am a good listener and communicator

I know how to use technology

WELL ROUNDED INDIVIDUALS

I am responsible

I am respectful

I appreciate music, athletics, and the arts

Our Lady of the Miraculous Medal Parish School

840 North Garfield Avenue Montebello, California 90640
323-728-5435

Application For Admission

Grade in August: _____ For: _____ School Year Date: _____

This application with a $200.00 application fee entitles the applicant to take the ENTRANCE/PLACEMENT EXAMINATION for Our Lady of the Miraculous Medal Parish School. It allows the student to be considered as a **possible** candidate for enrollment in the school.

Please Print and Complete the following information:

STUDENTS LEGAL NAME _____
LAST FIRST MIDDLE

ADDRESS _____
STREET APT. # CITY ZIP

BIRTHDATE ____/____/_____ AGE: _____ SEX _____ STUDENT'S _____/_____/_____
Month Day Year Social Security Number

ETHNIC ORIGIN: _____

BAPTISM DATE: _____ CHURCH & CITY _____

HOME TELEPHONE (___) _____ CELL PHONE NUMBER (___) _____

PRESENT SCHOOL _____ PHONE (___) _____

SCHOOL ADDRESS _____
NUMBER AND STREET CITY ZIP

OLMM PARISHIONER: CHURCH ENVELOPE # _____ (REQUIRED FOR IN PARISH TUITION)

(Parents Information)

FATHER'S NAME (Print) _____ Email: _____

MOTHER'S NAME (Print) _____ Email: _____

(Fill in if Applicable)

STEPFATHER'S NAME (Print) _____ Email: _____

STEPMOTHER'S NAME (Print) _____ Email: _____

LEGAL GUARDIAN'S NAME (Print) _____ Relationship _____ Email _____

STUDENT LIVES WITH (PLEASE CHECK):

_____ Father /Mother _____ Father Only _____ Mother Only

_____ Father/Stepmother _____ Mother/Stepfather _____ Legal Guardian(s)

Is there a court order regarding custody of this child? ____ Yes ___No Joint Custody? ____ Yes ____No**
(A COPY OF THE COURT ORDER MUST BE SUBMITTED WITH APPLICATION)

FATHER/GUARDIAN

NAME (Print) _____ _____/_____/_____
Social Security Number

RELATION (Print) _____

OCCUPATION (Print) _____

EMPLOYER (Print) _____
Company Number and Street City

Telephone (____) _____ *EMAIL* _____ (____) _____
Home Work Dept./Extension

PLACE OF BIRTH: _____ MARITAL STATUS _____

RELIGION _____ PARISH _____

MOTHER/GUARDIAN

NAME (Print) _____ _____/_____/_____
Social Security Number

MAIDEN NAME (Print) _____

RELATION (Print) _____

OCCUPATION (Print) _____

EMPLOYER (Print) _____
Company Number and Street City

Telephone (_____) _____ *EMAIL:* _____ (_____) _____
Home Work Dept./Extension

PLACE OF BIRTH: _____ MARITAL STATUS _____

RELIGION _____ PARISH _____

Family attending or have attended Our Lady of the Miraculous Medal Parish School:

Name _____ Class of _____ Relationship _____

Name _____ Class of _____ Relationship _____

STUDENT INFORMATION

Has you child ever been enrolled in Special Education? ____Yes ____No
If yes please explain _____

Name any Health Problems _____

Has Student ever been retained? No ____ Yes/Grade_____

How did you hear about our School? _____

School Recommended or Referred by: _____

OUR LADY OF THE MIRACULOUS MEDAL PARISH SCHOOL

Our Lady of the Miraculous Medal Parish School whose philosophy and mission is based on the call of the United States Catholic Bishops, has general conditions for acceptance including:

- Admissions requirements pertaining to academic and behavior standards as well as teacher's recommendation.
- Accepts students on a space available basis
- Charges tuition for its educational services

THE FOLLOWING IS REQUIRED OF ALL APPLICANTS:

- **A photo (wallet size)**
- **A copy of the students birth certificate and Social Security Card**
- **For Catholics; parents must provide copies of students Baptism and First Communion certificates**
- **A current Health/Immunization record with proof of a TB test results within one year**
- **Application Processing Fee of $200.00 per family. (new families only)**
- **Testing Fee of $50.00 per child. (K-8 students only)**

** **Preschool students only:**

- **State of California Child Care Licensing Forms**
- **Physicians Report**
- **$100.00 Registration**

We have read the application and have completed all of the information and requirements.
We understand and grant approval for Our Lady of the Miraculous Medal Parish School to request information from the student's current school regarding his/her academic achievements, conduct, attendance and potential.

Father's Signature _____ Date_____

Mother's Signature _____ Date _____
(If Applicable)
Guardian's Signature _____ Date_____

STATE OF CALIFORNIA
HEALTH AND HUMAN SERVICES AGENCY

CALIFORNIA DEPARTMENT OF SOCIAL SERVICES
COMMUNITY CARE LICENSING DIVISION

IDENTIFICATION AND EMERGENCY INFORMATION
CHILD CARE CENTERS/FAMILY CHILD CARE HOMES

To Be Completed by Parent or Authorized Representative

CHILD'S NAME LAST	MIDDLE	FIRST	SEX	TELEPHONE ( )
ADDRESS NUMBER	STREET	CITY	STATE ZIP	BIRTHDATE
FATHER'S/GUARDIAN'S/FATHER'S DOMESTIC PARTNER'S NAME LAST	MIDDLE	FIRST		BUSINESS TELEPHONE ( )
HOME ADDRESS NUMBER	STREET	CITY	STATE ZIP	HOME TELEPHONE ( )
MOTHER'S/GUARDIAN'S/MOTHER'S DOMESTIC PARTNER'S NAME LAST	MIDDLE	FIRST		BUSINESS TELEPHONE ( )
HOME ADDRESS NUMBER	STREET	CITY	STATE ZIP	HOME TELEPHONE ( )
PERSON RESPONSIBLE FOR CHILD LAST NAME	MIDDLE	FIRST	HOME TELEPHONE ( )	BUSINESS TELEPHONE ( )

ADDITIONAL PERSONS WHO MAY BE CALLED IN AN EMERGENCY

NAME	ADDRESS	TELEPHONE	RELATIONSHIP

PHYSICIAN OR DENTIST TO BE CALLED IN AN EMERGENCY

PHYSICIAN	ADDRESS	MEDICAL PLAN AND NUMBER	TELEPHONE ( )
DENTIST	ADDRESS	MEDICAL PLAN AND NUMBER	TELEPHONE ( )

IF PHYSICIAN CANNOT BE REACHED, WHAT ACTION SHOULD BE TAKEN?

☐ CALL EMERGENCY HOSPITAL ☐ OTHER EXPLAIN: _____

NAMES OF PERSONS AUTHORIZED TO TAKE CHILD FROM THE FACILITY

(CHILD WILL NOT BE ALLOWED TO LEAVE WITH ANY OTHER PERSON WITHOUT WRITTEN AUTHORIZATION FROM PARENT OR AUTHORIZED REPRESENTATIVE)

NAME	RELATIONSHIP

TIME CHILD WILL BE CALLED FOR

SIGNATURE OF PARENT/GUARDIAN OR AUTHORIZED REPRESENTATIVE | DATE

TO BE COMPLETED BY FACILITY DIRECTOR/ADMINISTRATOR/FAMILY CHILD CARE HOMES LICENSEE

DATE OF ADMISSION	DATE LEFT

CHILD'S PREADMISSION HEALTH HISTORY—PARENT'S REPORT

CHILD'S NAME	SEX	BIRTH DATE
FATHER'S/FATHER'S DOMESTIC PARTNER'S NAME		DOES FATHER/FATHER'S DOMESTIC PARTNER LIVE IN HOME WITH CHILD?
MOTHER'S/MOTHER'S DOMESTIC PARTNER'S NAME		DOES MOTHER/MOTHER'S DOMESTIC PARTNER LIVE IN HOME WITH CHILD?
IS /HAS CHILD BEEN UNDER REGULAR SUPERVISION OF PHYSICIAN?		DATE OF LAST PHYSICAL/MEDICAL EXAMINATION

DEVELOPMENTAL HISTORY (*For infants and preschool-age children only)

WALKED AT*	BEGAN TALKING AT*	TOILET TRAINING STARTED AT*
MONTHS	MONTHS	MONTHS

PAST ILLNESSES — Check illnesses that child has had and specify approximate dates of illnesses:

	DATES		DATES		DATES
☐ Chicken Pox		☐ Diabetes		☐ Poliomyelitis	
☐ Asthma		☐ Epilepsy		☐ Ten-Day Measles (Rubeola)	
☐ Rheumatic Fever		☐ Whooping cough		☐ Three-Day Measles (Rubella)	
☐ Hay Fever		☐ Mumps			

SPECIFY ANY OTHER SERIOUS OR SEVERE ILLNESSES OR ACCIDENTS

DOES CHILD HAVE FREQUENT COLDS? ☐ YES ☐ NO	HOW MANY IN LAST YEAR?	LIST ANY ALLERGIES STAFF SHOULD BE AWARE OF

DAILY ROUTINES (*For infants and preschool-age children only)

WHAT TIME DOES CHILD GET UP?*	WHAT TIME DOES CHILD GO TO BED?*	DOES CHILD SLEEP WELL?*
DOES CHILD SLEEP DURING THE DAY?*	WHEN?*	HOW LONG?*

DIET PATTERN: (What does child usually eat for these meals?)

BREAKFAST

LUNCH

DINNER

WHAT ARE USUAL EATING HOURS?

BREAKFAST _____

LUNCH _____

DINNER

ANY FOOD DISLIKES?	ANY EATING PROBLEMS?

IS CHILD TOILET TRAINED?* ☐ YES ☐ NO	IF YES, AT WHAT STAGE:*	ARE BOWEL MOVEMENTS REGULAR?* ☐ YES ☐ NO	WHAT IS USUAL TIME?*
WORD USED FOR "BOWEL MOVEMENT"*		WORD USED FOR URINATION*	

PARENT'S EVALUATION OF CHILD'S HEALTH

IS CHILD PRESENTLY UNDER A DOCTOR'S CARE? ☐ YES ☐ NO	IF YES, NAME OF DOCTOR:	DOES CHILD TAKE PRESCRIBED MEDICATION(S)? ☐ YES ☐ NO	IF YES, WHAT KIND AND ANY SIDE EFFECTS:
DOES CHILD USE ANY SPECIAL DEVICE(S): ☐ YES ☐ NO	IF YES, WHAT KIND:	DOES CHILD USE ANY SPECIAL DEVICE(S) AT HOME? ☐ YES ☐ NO	IF YES, WHAT KIND:

PARENT'S EVALUATION OF CHILD'S PERSONALITY

HOW DOES CHILD GET ALONG WITH PARENTS, BROTHERS, SISTERS AND OTHER CHILDREN?

HAS THE CHILD HAD GROUP PLAY EXPERIENCES?

DOES THE CHILD HAVE ANY SPECIAL PROBLEMS/FEARS/NEEDS? (EXPLAIN.)

WHAT IS THE PLAN FOR CARE WHEN THE CHILD IS ILL?

REASON FOR REQUESTING DAY CARE PLACEMENT

PARENT'S SIGNATURE	DATE

PERSONAL RIGHTS

Child Care Centers

Personal Rights, See Section 101223 for waiver conditions applicable to Child Care Centers.

(a) Child Care Centers. Each child receiving services from a Child Care Center shall have rights which include, but are not limited to, the following:

(1) To be accorded dignity in his/her personal relationships with staff and other persons.

(2) To be accorded safe, healthful and comfortable accommodations, furnishings and equipment to meet his/her needs.

(3) To be free from corporal or unusual punishment, infliction of pain, humiliation, intimidation, ridicule, coercion, threat, mental abuse, or other actions of a punitive nature, including but not limited to: interference with daily living functions, including eating, sleeping, or toileting; or withholding of shelter, clothing, medication or aids to physical functioning.

(4) To be informed, and to have his/her authorized representative, if any, informed by the licensee of the provisions of law regarding complaints including, but not limited to, the address and telephone number of the complaint receiving unit of the licensing agency and of information regarding confidentiality.

(5) To be free to attend religious services or activities of his/her choice and to have visits from the spiritual advisor of his/her choice. Attendance at religious services, either in or outside the facility, shall be on a completely voluntary basis. In Child Care Centers, decisions concerning attendance at religious services or visits from spiritual advisors shall be made by the parent(s), or guardian(s) of the child.

(6) Not to be locked in any room, building, or facility premises by day or night.

(7) Not to be placed in any restraining device, except a supportive restraint approved in advance by the licensing agency.

THE REPRESENTATIVE/PARENT/GUARDIAN HAS THE RIGHT TO BE INFORMED OF THE APPROPRIATE LICENSING AGENCY TO CONTACT REGARDING COMPLAINTS, WHICH IS:

Department of Social Services

NAME

Community Care Licensing

ADDRESS

1000 Corporate Center Drive, Suite 200B

CITY	ZIP CODE	AREA CODE/TELEPHONE NUMBER
Monterey Park	91754	(323) 981-3350

DETACH HERE

TO: PARENT/GUARDIAN/CHILD OR AUTHORIZED REPRESENTATIVE: **PLACE IN CHILD'S FILE**

Upon satisfactory and full disclosure of the personal rights as explained, complete the following acknowledgment:

ACKNOWLEDGMENT: I/We have been personally advised of, and have received a copy of the personal rights contained in the California Code of Regulations, Title 22, at the time of admission to:

(PRINT THE NAME OF THE FACILITY)	(PRINT THE ADDRESS OF THE FACILITY)

(PRINT THE NAME OF THE CHILD)

(SIGNATURE OF THE REPRESENTATIVE/PARENT/GUARDIAN)

(TITLE OF THE REPRESENTATIVE/PARENT/GUARDIAN)	(DATE)

CONSENT FOR EMERGENCY MEDICAL TREATMENT-
Child Care Centers Or Family Child Care Homes

AS THE PARENT OR AUTHORIZED REPRESENTATIVE, I HEREBY GIVE CONSENT TO

_____ TO OBTAIN ALL EMERGENCY MEDICAL OR DENTAL CARE
FACILITY NAME

PRESCRIBED BY A DULY LICENSED PHYSICIAN (M.D.) OSTEOPATH (D.O.) OR DENTIST (D.D.S.) FOR

_____ . THIS CARE MAY BE GIVEN UNDER
NAME

WHATEVER CONDITIONS ARE NECESSARY TO PRESERVE THE LIFE, LIMB OR WELL BEING OF THE CHILD NAMED ABOVE.

CHILD HAS THE FOLLOWING MEDICATION ALLERGIES:

_____ _____
DATE PARENT OR AUTHORIZED REPRESENTATIVE SIGNATURE

HOME ADDRESS

HOME PHONE	WORK PHONE
( )	( )

CHILD CARE CENTER
NOTIFICATION OF PARENTS' RIGHTS

PARENTS' RIGHTS

As a Parent/Authorized Representative, you have the right to:

1. Enter and inspect the child care center without advance notice whenever children are in care.

2. File a complaint against the licensee with the licensing office and review the licensee's public file kept by the licensing office.

3. Review, at the child care center, reports of licensing visits and substantiated complaints against the licensee made during the last three years.

4. Complain to the licensing office and inspect the child care center without discrimination or retaliation against you or your child.

5. Request in writing that a parent not be allowed to visit your child or take your child from the child care center, provided you have shown a certified copy of a court order.

6. Receive from the licensee the name, address and telephone number of the local licensing office.

   Licensing Office Name: _____

   Licensing Office Address: _____

   Licensing Office Telephone #: _____

7. Be informed by the licensee, upon request, of the name and type of association to the child care center for any adult who has been granted a criminal record exemption, and that the name of the person may also be obtained by contacting the local licensing office.

8. Receive, from the licensee, the Caregiver Background Check Process form.

NOTE: CALIFORNIA STATE LAW PROVIDES THAT THE LICENSEE MAY DENY ACCESS TO THE CHILD CARE CENTER TO A PARENT/AUTHORIZED REPRESENTATIVE IF THE BEHAVIOR OF THE PARENT/AUTHORIZED REPRESENTATIVE POSES A RISK TO CHILDREN IN CARE.

For the Department of Justice "Registered Sex Offender"database, go to www.meganslaw.ca.gov

LIC 995 (9/08) (Detach Here - Give Upper Portion to Parents)

ACKNOWLEDGEMENT OF NOTIFICATION OF PARENTS' RIGHTS
(Parent/Authorized Representative Signature Required)

I, the parent/authorized representative of _____, have received a copy of the "CHILD CARE CENTER NOTIFICATION OF PARENTS' RIGHTS" and the CAREGIVER BACKGROUND CHECK PROCESS form from the licensee.

_____
Name of Child Care Center

_____ _____
Signature (Parent/Authorized Representative) Date

NOTE: This Acknowledgement must be kept in child's file and a copy of the Notification given to parent/authorized representative.

For the Department of Justice "Registered Sex Offender"database go to www.meganslaw.ca.gov

IMPORTANT INFORMATION FOR PARENTS

CAREGIVER BACKGROUND CHECK PROCESS CALIFORNIA DEPARTMENT OF SOCIAL SERVICES

The California Department of Social Services works to protect the safety of children in child care by licensing child care centers and family child care homes. Our highest priority is to be sure that children are in safe and healthy child care settings. California law requires a background check for any adult who owns, lives in, or works in a licensed child care home or center. Each of these adults must submit fingerprints so that a background check can be done to see if they have any history of crime. If we find that a person has been convicted of a crime other than a minor traffic violation or a marijuana-related offense covered by the marijuana reform legislation codified at Health and Safety Code sections 11361.5 and 11361.7, he/she cannot work or live in the licensed child care home or center unless approved by the Department. This approval is called an exemption.

A person convicted of a crime such as murder, rape, torture, kidnapping, crimes of sexual violence or molestation against children **cannot by law be given an exemption that would allow them to own, live in or work in** a licensed child care home or center. If the crime was a felony or a serious misdemeanor, the person must leave the facility while the request is being reviewed. If the crime is less serious, he/she may be allowed to remain in the licensed child care home or center while the exemption request is being reviewed.

How the Exemption Request is Reviewed

We request information from police departments, the FBI and the courts about the person's record. We consider the type of crime, how many crimes there were, how long ago the crime happened and whether the person has been honest in what they told us.

The person who needs the exemption must provide information about:

- The crime
- What they have done to change their life and obey the law
- Whether they are working, going to school, or receiving training
- Whether they have successfully completed a counseling or rehabilitation program

The person also gives us reference letters from people who aren't related to them who know about their history and their life now.

We look at all these things very carefully in making our decision on exemptions. By law this information cannot be shared with the public.

How to Obtain More Information

As a parent or authorized representative of a child in licensed child care, you have the right to ask the licensed child care home or center whether anyone working or living there has an exemption. If you request this information, and there is a person with an exemption, the child care home or center must tell you the person's name and how he or she is involved with the home or center and give you the name, address, and telephone number of the local licensing office. You may also get the person's name by contacting the local licensing office. You may find the address and phone number on our website. The website address is **http://ccld.ca.gov/contact.htm**.

Appendix PHS-2 Parent's Medicine Consent Form

I, _____
(Name of parent)

give permission to _____
(Name of caregiver)

to give my child _____
(Name of child)

the following medicine _____
(Name of medicine)

for _____
(Problem or illness)

on _____
(Date or dates)

at _____
(Time or times)

in the amount of _____
(Amount or amounts)

by _____
(Body location and method of use)

Side effects of the medicine to watch for _____

_____
(Possible side effects)

This medicine has been prescribed by _____
(Name of doctor)

The telephone number of the doctor is _____

By _____ _____
(Signature of parent or legal guardian) (Date)

STATE OF CALIFORNIA
HEALTH AND HUMAN SERVICES AGENCY

CALIFORNIA DEPARTMENT OF SOCIAL SERVICES
COMMUNITY CARE LICENSING

PHYSICIAN'S REPORT—CHILD CARE CENTERS
(CHILD'S PRE-ADMISSION HEALTH EVALUATION)

PART A – PARENT'S CONSENT (TO BE COMPLETED BY PARENT)

_____, born _____ is being studied for readiness to enter
(NAME OF CHILD) (BIRTH DATE)

_____. This Child Care Center/School provides a program which extends from ____ : ____
(NAME OF CHILD CARE CENTER/SCHOOL)

a.m./p.m. to _____ a.m./p.m., _____ days a week.

Please provide a report on above-named child using the form below. I hereby authorize release of medical information contained in this report to the above-named Child Care Center.

_____ _____
(SIGNATURE OF PARENT, GUARDIAN, OR CHILD'S AUTHORIZED REPRESENTATIVE) (TODAY'S DATE)

PART B – PHYSICIAN'S REPORT (TO BE COMPLETED BY PHYSICIAN)

Problems of which you should be aware:

Hearing: Allergies: medicine:

Vision: Insect stings:

Developmental: Food:

Language/Speech: Asthma:

Dental:

Other (Include behavioral concerns):

Comments/Explanations:

MEDICATION PRESCRIBED/SPECIAL ROUTINES/RESTRICTIONS FOR THIS CHILD:

IMMUNIZATION HISTORY: (Fill out or enclose California Immunization Record, PM-298.)

VACCINE	DATE EACH DOSE WAS GIVEN				
	1st	2nd	3rd	4th	5th
POLIO (OPV OR IPV)	/ /	/ /	/ /	/ /	/ /
DTP/DTaP/ DT/Td (DIPHTHERIA, TETANUS AND [ACELLULAR] PERTUSSIS OR TETANUS AND DIPHTHERIA ONLY)	/ /	/ /	/ /	/ /	/ /
MMR (MEASLES, MUMPS, AND RUBELLA)	/ /	/ /			
HIB MENINGITIS (REQUIRED FOR CHILD CARE ONLY) (HAEMOPHILUS B)	/ /	/ /	/ /	/ /	
HEPATITIS B	/ /	/ /	/ /		
VARICELLA (CHICKENPOX)	/ /	/ /			

SCREENING OF TB RISK FACTORS (listing on reverse side)

☐ Risk factors not present; TB skin test not required.

☐ Risk factors present; Mantoux TB skin test performed (unless previous positive skin test documented).
___ Communicable TB disease not present.

I have ☐ have not ☐ reviewed the above information with the parent/guardian.

Physician: _____ Date of Physical Exam: _____
Address: _____ Date This Form Completed: _____
Telephone: _____ Signature _____

☐ Physician ☐ Physician's Assistant ☐ Nurse Practioner

O.L.M.M. PARENT PARTICIPATION INFORMATION

(DATES MENTIONED BELOW ARE BASED ON 2018-2019 SCHOOL YEAR)

PARENT HOURS:

Each family will be required to work a minimum of 16 Carnival Hours** (mandatory) toward the Spring Carnival and 14 Miscellaneous Hours* (mandatory) throughout the school year, working a total of 30 HOURS. Our next annual Carnival is scheduled for: **FRIDAY, SATURDAY & SUNDAY, MARCH 15th, 16th & 17th, 2019**

FUNDRAISING (Family Pledge):

Each family is required to contribute a **minimum of $400 profit** through our various fundraisers. The following is a list of the fundraisers that will qualify for credit toward your $400 fundraising contribution. This list is subject to change. Please note, the Spring Carnival raffle tickets are mandatory. Each family will be required to purchase 5 books of tickets, totaling $50 (paid during, registration), leaving you a balance of **$350**. Percentage of profit earned on these fundraisers is indicated in parenthesis.

- Jog-A-Thon Fall Fundraiser (100%)
- Spring Carnival Raffle Tickets - Mandatory (*5 Books - $50 - Paid Prior To Tickets Being received)*
- Gift Wrap and/or Cookie Dough Fall Fundraisers (40% - 50% Of Sales)
- World's Finest Candy Winter/Spring Fundraiser (50% Of Sales)
- Gift Match Donations - Year-Round (100% for both the parent's & employer's donation)
- Other Fundraisers May Be Added (TBA)

Example for paying your $400:

$50 for 5 books of Raffle Tickets sold (paid at registration)
$40 for Gift Wrap Fall Fundraiser
$150 for $300 in Cookie Dough sales
$100 for Jog-a-thon
$60 for World Finest Chocolates

Total: $400.00

PLEASE NOTE: All Fundraising and Volunteer Hours must be met by **May 31st 2019**. Any open balances will be billed directly to your Family TADS' account after May 31st (*Every unmet Carnival Hour = $40 and every unmet Miscellaneous Hour = $10)*