Application Supplemental Forms

The following forms need to be submitted with each application. We cannot process the application until they are received. The forms are:

1. Parent Questionnaire (one per each student applying)

2. Student Questionnaire (Required for 1-8 grade applicants. The form is completed for the grade level the student is applying for.

3. School Entrance Health Form with immunizations attached

4. Request for Records (completed, signed, and returned so we can request records from your child's current school)

5. Application fee paid (link available on the website)

2025-2026 DIOCESAN TUITION ASSISTANCE PROGRAM

Office of Catholic Schools
excellence by design

What is the program?
The Diocesan Tuition Assistance Program provides financial assistance to families in Catholic schools in the Diocese of Arlington through funding from diocesan parishes as well as the *Rooted in Faith~Forward in Hope* Capital Campaign Endowment. It is open to all qualified students whose parents might not otherwise be able to pay the full cost of tuition.

Who is eligible?
- Students attending or accepted by a Diocese of Arlington Catholic School (Preschool students, international students, and students at private Catholic schools associated with the diocese are not eligible)
- Students who are Catholic and members of a parish in the Diocese of Arlington or military base parish
- Families who reside within the boundaries of the Diocese of Arlington and are registered and active members of a diocesan parish or a military base parish
- Families must demonstrate financial need and financial aid applications must be complete with all required tax documents

How do I apply?
Submit a FACTS financial aid application and all supporting tax documentation by the due date. Only one application and processing fee is required per family. Application is available at https://online.factsmgt.com/signin.aspx

Due Dates

March 12, 2025	Elementary/middle school students
2024	Year of tax forms required
January 10, 2025	High school students
2023	Year of tax forms required if submitted by the due date
2024	Year of tax forms required if submitted after the due date

Families applying for financial aid for both high school and elementary/middle school students will need to submit BOTH 2023 and 2024 tax forms.

Awards
Awards are made for one academic year only and are based on each family's demonstrated financial need. Individual schools determine the amount and the distribution of all awards for each academic year. Schools will contact families when award decisions have been made and will credit awards to the tuition accounts of approved families.

Over $4,000,000 awarded in 2024

For more information
https://www.arlingtondiocese.org/catholic-schools/our-schools/tuition-assistance

- Questions regarding FACTS financial aid application, please contact FACTS customer service
  - 1-866-315-9262
  - https://online.factsmgt.com/platform/customer-service
- Questions regarding financial aid process, please contact Bo Zamoyta
  - (703) 841-2551
  - Bo.Zamoyta@arlingtondiocese.org

2025-2026 Programa Diocesano de Asistencia Para La Matrícula

Office of Catholic Schools
excellence by design

¿En qué consiste el programa?

El Programa Diocesano de Asistencia para la Matrícula proporciona ayuda financiera a las familias en las Escuelas Católicas de la Diócesis de Arlington a través de la financiación de las parroquias diocesanas y el Fondo de Donación de la Campaña de Capital *Rooted in Faith~Forward in Hope*. Este programa está abierto a todos los estudiantes calificados cuyos padres no puedan pagar el costo total de la matrícula.

¿Quién es Elegible?

- Estudiantes que asisten o son aceptados por una Escuela Católica de la Diócesis de Arlington (los estudiantes de preescolar, estudiantes internacionales y los estudiantes de Escuelas Católicas privadas asociadas con la Diócesis no son elegibles).

- Estudiantes que sean Católicos y miembros de una parroquia de la Diócesis de Arlington o de una parroquia de una base militar

- Familias que residen dentro de los límites de la Diócesis de Arlington y son miembros registrados y activos de una parroquia diocesana o de una parroquia de base militar

- Las familias deben demostrar necesidad financiera y las solicitudes de ayuda financiera deben estar completas con todos los documentos de impuestos requeridos

¿Cómo solicito la ayuda?

Envíe una solicitud de ayuda financiera FACTS y toda la documentación de impuestos de respaldo antes de la fecha límite. Sólo se requiere una solicitud y una tarifa de procesamiento por familia. La solicitud está disponible en https://online.factsmgt.com/signin.aspx

Fechas de vencimiento

Marzo 12, 2025	Escuelas Primarias y Medias
2024	Año de formularios de impuestos requeridos
Enero 10, 2025	Escuelas Secundarias
2023	Año de formularios de impuestos requeridos si se presentan antes de la fecha límite
2024	Año de los formularios de impuestos requeridos si se presentan después de la fecha límite

Las familias que soliciten ayuda financiera tanto para estudiantes de Escuela Secundaria como para los estudiantes de las Escuelas Primaria y Media deben enviar AMBOS formularios de impuestos 2023 y 2024.

St. Thomas Aquinas Regional School
AQUINAS
13750 Mary's Way
Woodbridge, VA 22191
Phone: 703.491.4447
www.aquinastars.org

2025-2026 Family Faith Form (one per family/not per student)

(Previously Parish Confirmation Form)

All families need to complete the top portion of this form and check **the appropriate boxes.** If you are a Catholic family at one of our three parishes you can email your form to (Our Lady of Angels: olas.t.a.r.s@olacc.org; St. Elizabeth Ann Seton: c.ohearn@setonlakeridge.org; Sacred Heart: office@shcva.org) or drop it off at the Parish Office. If you are a non-Catholic family, please return your form directly to the school office. **Returning families must have their form submitted to their Parish by March 1 or incur a late fee**. Please print all the information.

Date: _____

Parent Name(s): _____

Parent street address: _____

City: _____ State: _____ Zip: _____

Parent Email: _____ Parent Phone: _____

List all student(s) names/grades: _____

_____

ARE YOU …

Catholic

_____ Yes, we are Catholic

New applicants: I've provided a copy of my child(ren)'s baptismal certificate as part of my application. ☐

Non Catholic. We want to be sensitive to families of other faiths. Please share with us your faith background or religion. Our family is:

_____

_____

Submit this form to the school office

Are you a parishioner of __ Our Lady of Angels, __ Saint Elizabeth Ann Seton, or __Sacred Heart?

Yes. Submit this form to your parish.

No. Please list your Catholic parish

_____

Submit this form to your parish or if no parish return this completed form to the school office

To be completed by the Parish Office

____ Parishioner _____ Subsidized or _____ not Subsidized

____ Non-Parishioner

_____ _____

Pastor Signature **Date**

St. Thomas Aquinas Regional School
AQUINAS

13750 Mary's Way
Woodbridge, VA 22191
Phone: 703.491.4447
Fax: 703.492.8828
www.aquinastars.org

Release of Student Records

Date: _____

Name and Address of School currently attending:

_____ Phone # _____
_____ Fax# _____
_____

The following student(s) have applied for admission to St. Thomas Aquinas Regional School for the 2025-2026 school year:

_____ _____
Childs name Date of Birth Grade

_____ _____
Childs name Date of Birth Grade

Please forward the following information to my attention at the above address or by email as soon as possible so that their application and educational placement may be considered. Final records will be requested when/if the student is accepted.

Academic Transcripts
Standardized Test Scores
Current Year Grades to Date
Attendance Information
Discipline Record
Psychological/Educational Evaluations
School Entrance Health Form/Immunizations
Sociological Information
IEP/504 Plan
Child Study Referrals
Speech and Language Evaluations
Custody Information
Screening and Eligibility Minutes

Note: In accordance with FERPA (Family Educational Rights and Privacy Act), records transferred between schools do not require parent signature for release.

Thank you in advance for your assistance.

Sincerely,
Ms. Karen Cardinale
Admissions/Registrar
kcardinale@aquinastars.org

I give my consent for my child's records to be released to St. Thomas Aquinas Regional School.

_____ _____
Parent Signature Date

Parent Questionnaire for Grades PK-8

Student Last Name:	**Student First Name:**	**What grade is your student currently in?**

Aquinas requires a Student Recommendation Form to be completed by your student's current teacher for students in grades 1-8. The recommendation form will be sent from Aquinas to the teacher's email account. Please provide the following information:	
Name of academic/homeroom teacher	Subject(s) taught
Email address of teacher (please print)	Name of school your child is currently attending:

Are there any custody arrangements of which we should be aware?

Who does your child live with?

___Both parents full time ____Both parents part time ___ Mother _____Father ____ Grandparent

___Guardian ___ Other, please specify _____

How did you hear about Aquinas (postcard, friend recommended, bulletin ad, announcement at Mass)? Why are you interested in having your child attend Aquinas? Please explain.

Are you Catholic? What Catholic parish are you registered at? If not, what religion is your family? Does your family attend Mass/religious services? List some examples of how your family lives your faith?

Describe and explain any disciplinary problems that your child has experienced at any previous school? Have they every been suspended, received a detention, or demerit? Has your child been withdrawn, dismissed or been asked to leave any school for any reason? If yes to any of the above, please explain.

Has your child participated in a gifted or talented program? If yes, please include years attended.

Has your child ever been administered a psycho-educational test or battery? Does your child have a learning disability or an IEP/504 Plan? Has your child ever been diagnosed as ADD or ADD/ADHD? Is your child on medication?

What are your child's feelings about school? Does he/she have any fears or worries?

Who disciplines your child? What method is used? How does your child respond?

How do siblings and other children interact socially with your child?

Has your child received treatment in the last three years for any serious medical condition? If so, describe the condition for which treatment was received and the nature of the treatment provided. Have you been out of the country? If so, when? How long?

Is there anything you would like us to know about your child as we consider your application?

Student Questionnaire for Grades 1-3

Student First and Last name:

Parents, please check the appropriate box. If possible, the child should complete the questionnaire on his/her own.

- ☐ **Completed with help from parent**
- ☐ **Transcribed by parent from verbal responses from child (For Kindergarten only)**
- ☐ **Completed independently without help from parent**

1. What is your favorite subject in school? What do you like about it? If you can, please answer in complete sentences.

Student Questionnaire for Grades 1-3

2. Do you know how to pray? Do you have a favorite prayer? If you can, please answer in complete sentences.

3. What is one way students should be kind to their friends? What is your favorite game to play with your friends? If you can, please answer in complete sentences.

4th-8th Grade Student Questionnaire

Please print in your own handwriting, completing the front and back. Attach a separate sheet if needed. Return completed form to Admissions office via email at admissions@aquinastars.org or drop off at school office.

Student Name:_____(please print)

What School are you currently attending? _____

Please answer all questions in complete sentences.

What do you think about homework? How much do you usually have? Have you ever worked with tutor ?
Have you ever been tested for any special academic programs (honors, gifted, accelerated courses)?
What academic subjects do you enjoy the most? The least? How do you define “academic success”? How can you achieve it?
Tell us about your current school. What do you like/dislike? What is your classroom like? What would you change and why?

4th – 8th Grade Student Questionnaire Pg. 2

All answers should be written in complete sentences.

What Math Class are you in? (Math, Pre-Algebra, Algebra). What Math textbook do you use? Do you write often? Have you studied a foreign language? If so, which one?
What are your primary interests outside of school? (hobbies, special interests, musical instruments, talents, sports)
Have you even gotten into trouble at school? Received a detention, demerit, or suspension?
Are you Catholic? If so, where do you attend Mass? If not, what religion are you and where do you attend church services? Do you like going to church? How do you practice your faith?
Tell us the name of a book you read recently. Using complete sentences write 3-5 sentences about the characters and what you liked or disliked. If you have not read a book recently, tell us about a trip you took, why you went there, and what did you see?
Scenario: In your class there is a student who is considered a "nerd" and some of your classmates call him/her names. The problem is getting worse. How would you handle it if you were the student? A classmate? Why do you think these things happen?

COMMONWEALTH OF VIRGINIA
SCHOOL ENTRANCE HEALTH FORM
Health Information Form/Comprehensive Physical Examination Report/Certification of Immunization

Part I – HEALTH INFORMATION FORM

State law (Ref. Code of Virginia § 22.1-270) requires that your child is immunized and receives a comprehensive physical examination before entering public kindergarten or elementary school. **The parent or guardian completes this page (Part I) of the form.** The Medical Provider completes Part II and Part III of the form. This form must be completed no earlier than one year before your child's entry into school.

Name of School: _____ Current Grade: _____

Student's Name: _____
Last First Middle

Student's Date of Birth: _____/____/_____ Sex: _____ State or Country of Birth:_____Main Language Spoken: _____

Student's Address_____ City_____ State_____ Zip Code_____

Name of Parent or Legal Guardian 1:_____Phone:_____-_____-_____Work or Cell: _____ - _____-_____

Name of Parent or Legal Guardian 2:_____Phone:_____-_____-_____Work or Cell: _____-_____-_____

Emergency Contact:_____Phone:_____-_____-_____Work or Cell: _____-_____-_____

Hospital Preference: _____

Child's Health Insurance: None☐ FAMIS Plus (Medicaid) ☐ FAMIS☐ Private/Commercial/ Employer Sponsored☐_____

Box 1. Pre-Existing Conditions

Condition	Yes	Comments	Condition	Yes	Comments
Allergies (food, insects, drugs, latex)			Diabetes: Type 1		
Please list **Life Threatening Allergies**:			Diabetes: Type 2		
			Insulin pump		
Allergies (seasonal)			Head injury, concussion		
Asthma or breathing conditions			Hearing conditions or deafness		
Attention-Deficit/Hyperactivity Disorder			Heart conditions		
Behavioral/Psych/ Social conditions			Lead poisoning		
Developmental conditions			Muscle conditions		
Bladder conditions			Seizures		
Bleeding conditions			Sickle Cell Disease (not trait)		
Bowel conditions			Speech conditions		
Cerebral Palsy			Spinal injury		
Cystic fibrosis			Surgery		
Dental Health conditions			Vision conditions		

Describe any other important health-related information about your child (☐ Feeding tube , ☐ Trach , ☐Oxygen support, ☐ Hearing aids, ☐ Dental appliance, ☐ Wheelchair, Hospitalizations, etc.):

Box 2. Medications

List all prescription, emergency, over-the-counter, and herbal medications your child takes regularly (Home/ School):

Medication Name	Dosage	Time Administered (Home/School)	Notes
1.			
2.			
3.			
4.			

Additional Medications (Name, Dose, Time Administered, Notes)

Check here if you want to discuss confidential information with the school nurse or other school authority. Yes No Please provide the following information:

	Name	Phone	Date of Last Appointment
Pediatrician/primary care provider			
Specialist			
Dentist			
Case Worker (if applicable)			

I_____ authorize my child's health care provider and designated provider of health care in the school setting to discuss my child's health concerns and/or exchange information pertaining to this form. This authorization will be in place until or unless you withdraw it. You may withdraw your authorization at any time by contacting your child's school. When information is released from your child's record, documentation of the disclosure is maintained in your child's health or scholastic record.

Signature of Parent or Legal Guardian:_____Date:_____/_____/_____

Signature of Interpreter: _____Date_____/_____/_____

COMMONWEALTH OF VIRGINIA
SCHOOL ENTRANCE HEALTH FORM
Part II - Certification of Immunization

Check if the student's Immunization Records are attached using a separate form signed by HCP ☐

Section I

See Section II for conditional enrollment and exemptions.

A copy of the immunization record signed or stamped by a physician or designee, registered nurse, or health department official indicating the dates of administration including month, day, and year of the required vaccines shall be acceptable in lieu of recording these dates on this form as long as the record is attached to this form. Form must be signed and dated by the Medical Provider or Health Department Official in the appropriate box. Please contact your local health department for assistance with foreign vaccine records.

Student Name: **Date of Birth :** / / **Sex:**

Race (Optional): **Ethnicity:** ☐ **Hispanic** ☐ **Non-Hispanic**

IMMUNIZATION	RECORD COMPLETE DATES (month, day, year) OF VACCINE DOSES GIVEN				
Diphtheria, Tetanus, Pertussis Vaccine (DTP, DTaP)	1	2	3	4	5
Diphtheria, Tetanus (DT) or Tdap or Td Vaccine (given after 7 years of age)	1	2	3	4	5
Tdap Vaccine booster	1				
Poliomyelitis Vaccine (IPV, OPV)	1	2	3	4	5
Haemophilus influenzae Type b Vaccine (Hib conjugate) only for children <60 months of age	1	2	3	4	
Rotavirus Vaccine (RV) only for children < 8 months of age	1	2	3		
Pneumococcal Vaccine (PCV conjugate) only for children <60 months of age	1	2	3	4	
Varicella Vaccine	1	2	Date of Varicella Disease OR Serological Confirmation of Varicella Immunity:		
Measles, Mumps, Rubella Vaccine (MMR vaccine)	1	2			
Measles Vaccine (Rubeola)	1	2	Serological Confirmation of Measles Immunity:		
Rubella Vaccine	1	2	Serological Confirmation of Rubella Immunity:		
Mumps Vaccine	1	2	Serological Confirmation of Mumps Immunity:		
Hepatitis **B** Vaccine (HBV) ☐ Merck adult formulation used	1	2	3	4	
Hepatitis **A** Vaccine	1	2			
Meningococcal **ACWY** Vaccine	1	2			
Meningococcal **B** Vaccine	1	2	3		
Human Papillomavirus Vaccine (HPV)	1	2	3		
Influenza (Yearly)	1	2	3	4	5
Other	1	2	3	4	5
Other	1	2	3	4	5

Certification of Immunization

I certify that this child is **ADEQUATELY OR AGE APPROPRIATELY IMMUNIZED** in accordance with the MINIMUM requirements for attending school, child care or preschool prescribed by the State Board of Health's *Regulations for the Immunization of School Children* (Reference Section III).

Signature of Medical Provider or Health Department Official:_____**Date (*Mo., Day, Yr.*):** ___/___/____

Section II
Conditional Enrollment and Exemptions

Complete the medical exemption or conditional enrollment section as appropriate to include signature and date. This section must be attached to Part I Health Information (to be filled out and signed by parent).

Student's Name: _____ Date of Birth: |____|____|_____|
Parent or Legal Guardian Name: _____
Parent or Legal Guardian Name: _____
Phone Number: _____

MEDICAL EXEMPTION: As specified in the *Code of Virginia* § 22.1-271.2, C (ii), I certify that administration of the vaccine(s) designated below would be detrimental to this student's health. The vaccine(s) is (are) specifically contraindicated because (please specify):

_____

_____

_____

DTP/DTaP/Tdap :[____]; DT/Td:[____]; OPV/IPV:[____]; Hib:[____]; PCV:[_____]; RV:[____]; Measles :[_____];

Mumps:[____]; Rubella :[____]; VAR:[_____]; Men ACWY:[____]; Men B:[____]; Hep A:[_____]; HBV:[____]

This contraindication is permanent: [ ], or temporary [ ] and expected to preclude immunizations until: Date (*Mo., Day, Yr.*): |_____|_____|_____.

Signature of Medical Provider or Health Department Official:_____Date (*Mo., Day, Yr.*):___/___/___

RELIGIOUS EXEMPTION: The *Code of Virginia* allows a child an exemption from receiving immunizations required for school attendance if the student or the student's parent/guardian submits an affidavit to the school's admitting official stating that the administration of immunizing agents conflicts with the student's religious tenets or practices. Any student entering school must submit this affidavit on a CERTIFICATE OF RELIGIOUS EXEMPTION (Form CRE-1), which may be obtained at any local health department, school division superintendent's office or local department of social services. Ref. *Code of Virginia* § 22.1-271.2, C (i).

CONDITIONAL ENROLLMENT: As specified in the *Code of Virginia* § 22.1-271.2, B, I certify that this child has received at least one dose of each of the vaccines required by the State Board of Health for attending school and that this child has a plan for the completion of his/her requirements within the next 90 calendar days. Next immunization due on_____.

Signature of Medical Provider or Health Department Official:_____Date (*Mo., Day, Yr.*):|___|___|___|

Section III Requirements

For Minimum Immunization Requirements for Entry into School and Day Care, consult the Division of Immunization web site at http://www.vdh.virginia.gov/epidemiology/immunization

Children shall be immunized in accordance with the Immunization Schedule developed and published by the Centers for Disease Control (CDC), Advisory Committee on Immunization Practices (ACIP), the American Academy of Pediatrics (AAP), and the American Academy of Family Physicians (AAFP), otherwise known as ACIP recommendations (Ref. *Code of Virginia* § 32.1-46(a)).
(Requirements are subject to change.)

Part III -- COMPREHENSIVE PHYSICAL EXAMINATION REPORT

A qualified licensed physician, nurse practitioner, or physician assistant must complete Part III. The exam must be done no longer than one year before entry into kindergarten or elementary school (Ref. Code of Virginia § 22.1-270). Instructions for completing this form can be found at www.vahealth.org/schoolhealth.

Student's Name: _____ Date of Birth:_____/_____/_____ Sex: M F

Health Assessment

Date of Assessment: ____/____/____ **Must be dated after 8/23/2024**

Weight:_____lbs. Height:_____ft._____in.

Body Mass Index (BMI):_____BP_____

❑ Age / gender appropriate history completed

❑ Anticipatory guidance provided

Physical Examination

1 = Within normal 2 = Abnormal finding 3 = Referred for evaluation or treatment

	1	2	3		1	2	3		1	2	3	
HEENT				Neurological				Skin				
Lungs				Abdomen				Genital				
Heart				Extremities				Urinary				

Tuberculosis Screening

Check the box that applies:

☐ No risk for TB infection identified	☐ No symptoms compatible with active TB disease	☐ Risk for TB infection or symptoms identified

Test for TB Infection: TST IGRA Date: TST Reading mm TST/IGRA Result: ☐ Negative ☐ Positive

CXR required if positive test for TB infection or TB symptoms. CXR Date:_____ ☐ Normal ☐ Abnormal

EPSDT Screens Required for Head Start – include specific results and date:

Blood Lead:_____ Hct/Hgb _____

Developmental Screen

Assessed for:	*Assessment Method:*	*Within normal*	*Concern identified:*	*Referred for Evaluation*
Emotional/Social				
Problem Solving				
Language/Communication				
Fine Motor Skills				
Gross Motor Skills				

Hearing Screen

❑ Screened at 20dB: Indicate Pass (P) or Refer (R) in each box.

❑ Screened by OAE (Otoacoustic Emissions): ☐ Pass ☐ Referred

	1000	2000	4000
R			
L			

☐ Referred to Audiologist/ENT ☐ **Unable to test – needs rescreen**

☐ Permanent Hearing Loss Previously identified: ☐ Left ☐ Right

☐ Hearing aid or another assistive device

Vision Screen

☐ With Corrective Lenses (Check if yes)

Stereopsis ☐ Pass ☐ Fail				☐ Not tested
Distance	Both	R	L	Test used:
	20/	20/	20/	

☐ Pass ☐ Referred to eye doctor ☐ **Unable to test-needs rescreen**

Dental Screen

☐ Problems Identified: Referred for Treatment

☐ No Problem: Referred for prevention

☐ No Referral: Already receiving dental care

☐ **Unable to perform**

Recommendations to (Pre) School, Child Care, or Early Intervention Personnel

Summary of Findings (check one):

☐ Well child; no conditions identified of concern to school program activities

Conditions identified that are important to schooling or physical activity (complete sections below and/or explain here):

_____

____**Allergy:** ☐ food:_____ ☐ insect:_____ ☐ medicine:_____ ☐ other:_____

Type of allergic reaction: ☐ *anaphylaxis* ☐ *local reaction* *Response required:* ☐ *none* ☐ *epinephrine auto-injector* ☐ other::_____

____I**ndividualized Health Care Plan needed** (e.g., asthma, diabetes, seizure disorder, severe allergy, etc)

____**Restricted Activity Specify:** :_____

____**Developmental Evaluation** ☐ Has IEP ☐ Further evaluation needed for: _____

____**Medication.** Child takes medicine for specific health condition(s). ☐ Medication must be given and/or available at school.

____**Special Diet Specify:** _____

____**Special Needs Specify:**_____

Other Comments:_____

Health Care Professional's Certification (Write legibly or stamp) ☐ **By checking this box, I certify with an electronic signature that all of the information entered above is accurate (enter name and date on signature and date lines below).**

Name:_____ **Signature:**_____

Practice/Clinic Name: _____ **Address:**_____

Phone:_____-_____-_____ **Fax:** _____-_____-_____ **Email:**_____