Birth Certificate_____
Baptism Certificate_____
Immunizations_____

SAINT ANNE'S SCHOOL
REGISTRATION FORM – K - 8

Name_____ Male ____ Female ____ Grade_____

Address_____

Home Telephone _____ Cell/Mother_____ Cell/Father_____

Date of Birth _____ Email Address _____

Place of Birth_____ Date of Baptism & Church _____

Religion _____ Child Resides with (circle): Both Parents Mother Father Guardian

Parishioner of St. Anne's Yes ____ No ____ If no, name of parish _____

Your School District _____

Mother's Name _____ Maiden Name _____
Place of Birth _____ Religion _____
Mother's Occupation _____ Company Name _____
Business Address _____ Phone _____

Father's Name _____
Place of Birth _____ Religion _____
Father's Occupation _____ Company Name _____
Business Address _____ Phone _____

RELIGIOUS INFO:

Date of Baptism _____ Church _____
Date of First Penance _____ Church _____
Date of First Communion_____ Church _____
Date of Confirmation _____ Church _____

Other Children in Saint Anne's School: Yes ____ No ____

Name(s) _____ Grade ____
_____ Grade ____
_____ Grade ____

EMERGENCY CONTACTS, IF PARENTS CANNOT BE REACHED:

Name: _____ **Name:** _____

Relationship: _____ **Relationship:** _____

Home No: _____ **Home No:** _____

Cell No: _____ **Cell No:** _____

Name and Address of Last School Attended:

_____

_____

_____

PLEASE NOTE: ANY STUDENT WHO WILL BE REQUESTING SPECIAL EDUCATION SERVICES MUST SUBMIT A LETTER OF INTENT WITH THE GARDEN CITY SCHOOL DISTRICT PRIOR TO JUNE 1ST FOR THE NEXT ACADEMIC YEAR.

_____ _____

Signature of Parent or Guardian **Date**

SAINT ANNE'S SCHOOL
2024 – 2025 TUITION INFORMATION FORM

Please submit form along with a $500 deposit by March 15, 2024. If you have already submitted a $500 deposit for the 2024-2025 academic year, no additional deposit is required. However, you MUST complete and return this form indicating your payment choice.

FAMILY NAME:_____

ADDRESS:_____

_____

PHONE #:_____

____Our family will be returning to Saint Anne's School for the 2024/2025 school year.

____No, my child(ren) will not be returning to St. Anne's in September.

PLEASE SELECT ONE PLAN PER THE 2024-2025 TUITION SCHEDULE

PLEASE CHECK YOUR CHOICE:

_____ PLAN A _____PLAN B _____PLAN C _____PLAN D

NURSERY: _____4 DAYS _____5 DAYS

STUDENT'S NAME **2024/2025 GRADE**

1._____

2._____

3._____

4._____

Parent Signature_____

PLEASE NOTE: Any student who will be requesting special education services must submit a letter of intent with the Garden City School District prior to June 1st for the next academic year.

SPECIAL EDUCATION SERVICES

1. Has your child been evaluated by a school district Committee for Special Education?

   Yes ____ No ____

   When _____

2. Did the Committee for Special Education recommend any:

   Testing Accommodations - Yes ____ No ____

   Special Services such as:

   Resource Room Teacher _____
   Speech Teacher _____
   Remedial Reading _____
   Remedial Math _____

3. Do you have and IEP (Individualized Education Plan) from any school district for your child?

   Yes ____ No ____

4. Do you anticipate any special support services your child will need to be a successful student?

   Yes ____ No ____

   If yes, please explain _____

   _____

5. Does your child have a Section 504 Plan for special accommodations?

   Yes ____ No ____

Parent Signature _____ Date _____

PLEASE NOTE: Any student who will be requesting special education services must submit a letter of intent with the Garden City School District prior to June 1st for the next academic year.

SAINT ANNE'S SCHOOL

DATA COLLECTION FORM

DATE_____

STUDENT'S NAME_____ **GRADE**_____

MAILING LABEL _____

(IE, Mr. & Mrs. John Smith)

_____

IN ORDER FOR SAINT ANNE'S TO COMPLY WITH NEW YORK STATE'S STATISTICAL REPORTING REQUIREMENTS, PLEASE COMPLETE THE FOLLOWING INFORMATION FOR YOUR CHILD:

Ethnicity: ***Is your child Hispanic or Latino? ____ Yes ____ No***

Race: ***What is your child's race?***

American Indian or Alaskan Native ____ Asian ____

Native Hawaiian/Other Pacific Islander ____

Black or African American ____

Hispanic or Latino ____ Multiracial ____

White ____

SAINT ANNE'S SCHOOL

25 DARTMOUTH STREET
GARDEN CITY, NY 11530
PHONE: 516-352-1205/FAX: 516-352-5969

DATE: _____

TO: _____ SCHOOL

_____

_____

School Phone _____

FROM: Dr. Thomas Fasano, Principal

RE: Release of Student Records for:

Student Name _____

Student Current Grade _____

I hereby authorize you to release and forward all records regarding my child listed above. Please include all academic, psychological and/or IEP records, and medical records. Kindly forward them to Saint Anne's School, where he/she has been registered to attend school.

Parent Signature _____ Date _____

HEALTH FORM

SAINT ANNE'S SCHOOL--GARDEN CITY, NY

STUDENT'S NAME	BIRTHDATE	PLACE OF BIRTH

ADDRESS	PHONE NUMBER	SEX	GRADE

SCHOOLS PREVIOUSLY ATTENDED

DOCTOR (NAME AND TELEPHONE)

ADULTS IN HOUSEHOLD (NAMES)	AGE	OCCUPATION	WORK PHONE	HEALTH PROBLEMS
MOTHER				
FATHER				
GUARDIAN				

CHILDREN IN HOUSEHOLD (NAMES)	AGE	SCHOOL	HEALTH PROBLEMS

STUDENT HEALTH HISTORY

HAS YOUR CHILD HAD ANY OF THE FOLLOWING? PLEASE CHECK AND EXPLAIN BELOW.

	YEAR		YEAR		YEAR
ALLERGIES (SPECIFY)		FIFTHS DISEASE		WHOOPING COUGH (PERTUSSIS)	
ASTHMA		HEART DISEASE		TUBERCULOSIS	
EAR CONDITIONS		IMMUNOSUPPRESSION		CONTACT WITH TB	
FREQUENT COLDS & SORE THROATS		KIDNEY DISORDER		BIRTH COMPLICATIONS	
CONVULSIONS		LYME DISEASE		PREMATURITY	
ANEMIA		PNEUMONIA		CONGENITAL DEFECTS	
CHICKEN POX		RHEUMATIC FEVER		HOSPITALIZATIONS (SPECIFY)	
DIABETES		SEIZURE DISORDER		SERIOUS INJURY (SPECIFY)	

EXPLANATION

MEDICATIONS

HAS YOUR CHILD HAD ANY OF THE PROBLEMS IN THE AREAS LISTED BELOW? PLEASE CHECK AND EXPLAIN.

VISION		SPEECH		OTHER (SPECIFY)	
HEARING		ORTHOPEDIC			
LEARNING DISABILITY		EMOTIONAL DISTURBANCES			

ARE ANY OF THE ABOVE PRESENT IN YOUR FAMILY? IF SO, PLEASE EXPLAIN.

HAS YOUR CHILD RECEIVED PROFESSIONAL SERVICES FOR THE ABOVE?

PARENT'S CONCERNS ABOUT CHILD. PLEASE CHECK.

RESTLESS, OVERACTIVE		NERVOUS MANNERISMS (TICS, ROCKS, ETC)		WITHDRAWN	
IMMATURE		SUCKS THUMB, BITES NAILS		IMPULSIVE	
TEMPER TANTRUMS		AGGRESSIVE		CRIES EASILY	
DAYDREAMS		DESTRUCTIVE		POOR SELF IMAGE	

PLEASE ADD ANY ADDITIONAL PERTINENT INFORMATION/CIRCUMSTANCES, THAT MAY HAVE AFFECTED YOUR CHILD.

SIGNED (PARENT OR GUARDIAN) DATE

REQUIRED NYS SCHOOL HEALTH EXAMINATION FORM

TO BE COMPLETED BY PRIVATE HEALTH CARE PROVIDER OR SCHOOL MEDICAL DIRECTOR

IF AN AREA IS NOT ASSESSED INDICATE NOT DONE

Note: NYSED requires a physical exam for new entrants and students in Grades Pre-K or K, 1, 3, 5, 7, 9 & 11; annually for interscholastic sports; and working papers as needed; or as required by the Committee on Special Education (CSE) or Committee on Pre-School Special education (CPSE).

STUDENT INFORMATION

Name	Sex: ☐ M ☐ F	DOB:
School:	Grade:	Exam Date:

HEALTH HISTORY

Allergies ☐ No ☐ Yes, indicate type	Type: ☐ Medication/Treatment Order Attached	☐ Anaphylaxis Care Plan Attached
Asthma ☐ No ☐ Yes, indicate type	☐ Intermittent ☐ Persistent ☐ Other : ☐ Medication/Treatment Order Attached	☐ Asthma Care Plan Attached
Seizures ☐ No ☐ Yes, indicate type	Type: ☐ Medication/Treatment Order Attached	Date of last seizure: ☐ Seizure Care Plan Attached
Diabetes ☐ No ☐ Yes, indicate type	Type: ☐ 1 ☐ 2 ☐ Medication/Treatment Order Attached	☐ Diabetes Medical Mgmt. Plan Attached

Risk Factors for Diabetes or Pre-Diabetes: *Consider screening for T2DM if BMI% > 85% and has 2 or more risk factors: Family Hx T2DM, Ethnicity, Sx Insulin Resistance, Gestational Hx of Mother, and/or pre-diabetes.*

BMI_____kg/m2

Percentile (Weight Status Category): ☐ <5th ☐ 5th-49th ☐ 50th-84th ☐ 85th-94th ☐ 95th-98th ☐ 99th and>

Hyperlipidemia: ☐ No ☐ Yes ☐ Not Done **Hypertension:** ☐ No ☐ Yes ☐ Not Done

PHYSICAL EXAMINATION/ASSESSMENT

Height: **Weight:** **BP:** **Pulse:** **Respirations:**

Laboratory Testing	Positive	Negative	Date
TB- PRN	☐	☐	
Sickle Cell Screen-PRN	☐	☐	
Lead Level Required Grades Pre- K & K			**Date**
☐ Test Done ☐ Lead Elevated ≥5 µg/dL			

List Other Pertinent Medical Concerns (e.g. concussion, mental health, one functioning organ)

☐ **System Review and Abnormal Findings Listed Below**

☐ HEENT	☐ Lymph nodes	☐ Abdomen	☐ Extremities	☐ Speech
☐ Dental	☐ Cardiovascular	☐ Back/Spine	☐ Skin	☐ Social Emotional
☐ Neck	☐ Lungs	☐ Genitourinary	☐ Neurological	☐ Musculoskeletal

☐ Assessment/Abnormalities Noted/Recommendations:

☐ Additional Information Attached

Diagnoses/Problems (list) ICD-10 Code*

*Required only for students with an IEP receiving Medicaid

Name:	Affirmed Name (if applicable):	DOB:

SCREENINGS

Vision & Hearing Screenings Required for PreK or K, 1, 3, 5, 7, & 11

Vision Screening	**With Correction** ☐Yes ☐ No	**Right**	**Left**	**Referral**	**Not Done**
Distance Acuity		20/	20/	☐ Yes	☐
Near Vision Acuity		20/	20/	☐ Yes	☐
Color Perception Screening	☐ Pass ☐ Fail				☐

Notes

Hearing Screening: Passing indicates student can hear 20dB at all frequencies: 500, 1000, 2000, 3000, 4000 Hz; for grades 7 & 11 also test at 6000 & 8000 Hz.				**Not Done**
Pure Tone Screening	**Right** ☐ Pass ☐ Fail	**Left** ☐ Pass ☐ Fail	**Referral** ☐ Yes	☐

Notes

Scoliosis Screening: Boys grade 9, Girls grades 5 & 7	**Negative**	**Positive**	**Referral**	**Not Done**
	☐	☐	☐ Yes	☐

FOR PARTICIPATION IN PHYSICAL EDUCATION*/SPORTS*/PLAYGROUND/WORK

☐ ***Family cardiac history reviewed** – required for Dominick Murray Sudden Cardiac Arrest Prevention Act

☐ **Student may participate in all activities without restrictions.**

If Restrictions Apply – Complete the information below

☐ **Student is restricted from participation in:**

- ☐ **Contact Sports:** Basketball, Competitive Cheerleading, Diving, Downhill Skiing, Field Hockey, Football, Gymnastics, Ice Hockey, Lacrosse, Soccer, and Wrestling.
- ☐ **Limited Contact Sports:** Baseball, Fencing, Softball, and Volleyball.
- ☐ **Non-Contact Sports:** Archery, Badminton, Bowling, Cross-Country, Golf, Riflery, Swimming, Tennis, and Track & Field.
- ☐ **Other Restrictions:**

Developmental Stage for Athletic Placement Process ONLY required for students in Grades 7 & 8 who wish to play at the high school interscholastic sports level **OR** Grades 9-12 who wish to play at the modified interscholastic sports level.

Tanner Stage: ☐ I ☐ II ☐ III ☐ IV ☐ V

☐ **Other Accommodations*:** Provide Details (e.g., brace, insulin pump, prosthetic, sports goggles, etc.):

*Check with the athletic governing body if prior approval/form completion is required for use of the device at athletic competitions.

MEDICATIONS

☐ Order Form for medication(s) needed at school attached

COMMUNICABLE DISEASE	**IMMUNIZATIONS**
☐ Confirmed free of communicable disease during exam	☐ Record Attached ☐ Reported in NYSIIS

HEALTHCARE PROVIDER

Healthcare Provider Signature:	
Provider Name: *(please print)*	
Provider Address:	
Phone:	Fax:

Please Return This Form to Your Child's School Health Office When Completed.