

## **Saint Anne's Early Childhood Program** **Registration Guide 2024/2025 School Year**

### **NURSERY**

We are currently offering the choice of two nursery school classes for the 2024/2025 school year. A teacher and an aide will be assigned to each class session.

The sessions are:

- 4 Day – Half Day – 8:45 am – 11:15 am (extended day option – 11:15 am – 2 pm)
- 5 Day – Half Day – 8:45 am – 11:15 am (extended day option – 11:15 am – 2 pm)

### **PRE-KINDERGARTEN**

It is anticipated that we will have two Pre-Kindergarten classes in the 2024/2025 school year. A teacher and an aide will be assigned to each of the following classes:

The Sessions are:

- Mon. – Fri. 8:30 – 2:30 p.m.
- Mon. – Fri. 8:30 – 1 p.m.

Parents enrolling students for the Nursery/Pre-K School Program should be aware that the following guidelines will be used during the registration process. Parental choice for a desired session will follow the order listed below in the event a specific session is oversubscribed:

- A. Saint Anne's parishioners who have other children enrolled in Saint Anne's School (K-8).
- B. Saint Anne's parishioners with another child currently enrolled in the early childhood program; Saint Anne's school families (non-parishioners) with other children enrolled in the K-8 program.
- C. Saint Anne's parishioners with no children currently enrolled in any Saint Anne's School program; non-parishioners with a student currently enrolled in a Saint Anne's early childhood program.
- D. Non-parishioners wishing to enroll in the nursery school program.

Families must be current with their tuition payments in order to participate in the above process. The process will work as follows: You may be one of the first individuals to hand in your application, however, individuals who are in a grouping higher than yours (A is the highest group) will get to choose their session first. In the event that a specific program option is oversubscribed, a lottery system using the above criteria will be employed.

Students registering at Saint Anne's for the first time must have the following documentation for registration:

- 1. Birth Certificate – must be 3 yrs. by 12/1/24 (nursery), 4 yrs. old by 12/1/24 (Pre-K).
- 2. Baptismal Certificate.
- 3. Record of immunizations on a physician's letterhead.
- 4. A \$500 non-refundable deposit that will be applied to your school registration form.

Birth Certificate \_\_\_\_\_  
Baptism Certificate \_\_\_\_\_  
Immunizations \_\_\_\_\_

## SAINT ANNE'S SCHOOL NURSERY REGISTRATION FORM

Name \_\_\_\_\_ Male \_\_\_\_\_ Female \_\_\_\_\_

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 \_\_\_\_\_

**CIRCLE ONE:**

4 Day - Half Day (11:15 AM dismissal)

4 Day - Extended Day (2 PM dismissal)

5 Day - Half Day (11:15 AM dismissal)

5 Day - Extended Day (2 PM dismissal)

Mother's Name \_\_\_\_\_ Maiden Name \_\_\_\_\_

Place of Birth \_\_\_\_\_ Religion \_\_\_\_\_

Mother's Occupation \_\_\_\_\_ Company Name \_\_\_\_\_

Business Address \_\_\_\_\_ Phone \_\_\_\_\_

Father's Name \_\_\_\_\_ Religion \_\_\_\_\_

Place of Birth \_\_\_\_\_ Company Name \_\_\_\_\_

Father's Occupation \_\_\_\_\_ Phone \_\_\_\_\_

Business Address \_\_\_\_\_

If other children in St. Anne's School, please list: \_\_\_\_\_

**EMERGENCY CONTACTS, IF PARENTS CANNOT BE REACHED:**

Name: \_\_\_\_\_

Name: \_\_\_\_\_

Relationship: \_\_\_\_\_

Relationship: \_\_\_\_\_

Home No: \_\_\_\_\_

Home No: \_\_\_\_\_

Cell No: \_\_\_\_\_

Cell No: \_\_\_\_\_

\_\_\_\_\_  
Signature of Parent

\_\_\_\_\_  
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 1<sup>st</sup> 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* \_\_\_\_

## 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 an 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 1<sup>st</sup> for the next academic year.

**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 MANNERISME (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: <input type="checkbox"/> M <input type="checkbox"/> F	DOB:
School:	Grade:	Exam Date:

**HEALTH HISTORY**

<b>Allergies</b> <input type="checkbox"/> No <input type="checkbox"/> Yes, indicate type	Type: <input type="checkbox"/> Medication/Treatment Order Attached <input type="checkbox"/> Anaphylaxis Care Plan Attached
<b>Asthma</b> <input type="checkbox"/> No <input type="checkbox"/> Yes, indicate type	<input type="checkbox"/> Intermittent <input type="checkbox"/> Persistent <input type="checkbox"/> Other : <input type="checkbox"/> Medication/Treatment Order Attached <input type="checkbox"/> Asthma Care Plan Attached
<b>Seizures</b> <input type="checkbox"/> No <input type="checkbox"/> Yes, indicate type	Type: <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Date of last seizure: <input type="checkbox"/> <input type="checkbox"/> Medication/Treatment Order Attached <input type="checkbox"/> Seizure Care Plan Attached
<b>Diabetes</b> <input type="checkbox"/> No <input type="checkbox"/> Yes, indicate type	Type: <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> Medication/Treatment Order Attached <input type="checkbox"/> 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):** ☐ <5<sup>th</sup> ☐ 5<sup>th</sup>-49<sup>th</sup> ☐ 50<sup>th</sup>-84<sup>th</sup> ☐ 85<sup>th</sup>-94<sup>th</sup> ☐ 95<sup>th</sup>-98<sup>th</sup> ☐ 99<sup>th</sup> and >

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

**PHYSICAL EXAMINATION/ASSESSMENT**

<b>Height:</b>	<b>Weight:</b>	<b>BP:</b>	<b>Pulse:</b>	<b>Respirations:</b>
<b>Laboratory Testing</b>	<b>Positive</b>	<b>Negative</b>	<b>Date</b>	<b>List Other Pertinent Medical Concerns</b> (e.g. concussion, mental health, one functioning organ)
TB- PRN	<input type="checkbox"/>	<input type="checkbox"/>		
Sickle Cell Screen-PRN	<input type="checkbox"/>	<input type="checkbox"/>		
<b>Lead Level Required Grades Pre- K &amp; K</b>			<b>Date</b>	
<input type="checkbox"/> Test Done <input type="checkbox"/> Lead Elevated $\geq 5$ $\mu\text{g/dL}$				
<b>System Review and Abnormal Findings Listed Below</b>				
<input type="checkbox"/> HEENT	<input type="checkbox"/> Lymph nodes	<input type="checkbox"/> Abdomen	<input type="checkbox"/> Extremities	<input type="checkbox"/> Speech
<input type="checkbox"/> Dental	<input type="checkbox"/> Cardiovascular	<input type="checkbox"/> Back/Spine	<input type="checkbox"/> Skin	<input type="checkbox"/> Social Emotional
<input type="checkbox"/> Neck	<input type="checkbox"/> Lungs	<input type="checkbox"/> Genitourinary	<input type="checkbox"/> Neurological	<input type="checkbox"/> Musculoskeletal
<input type="checkbox"/> Assessment/Abnormalities Noted/Recommendations:			Diagnoses/Problems (list) ICD-10 Code*	
<input type="checkbox"/> Additional Information Attached			*Required only for students with an IEP receiving Medicaid	

Name:		Affirmed Name (if applicable):		DOB:	
<b>SCREENINGS</b>					
Vision & Hearing Screenings Required for PreK or K, 1, 3, 5, 7, & 11					
<b>Vision Screening</b>	With Correction <input type="checkbox"/> Yes <input type="checkbox"/> No	<b>Right</b>	<b>Left</b>	<b>Referral</b>	<b>Not Done</b>
Distance Acuity		20/	20/	<input type="checkbox"/> Yes	<input type="checkbox"/>
Near Vision Acuity		20/	20/	<input type="checkbox"/> Yes	<input type="checkbox"/>
Color Perception Screening	<input type="checkbox"/> Pass <input type="checkbox"/> Fail				<input type="checkbox"/>
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.					<b>Not Done</b>
Pure Tone Screening	<b>Right</b> <input type="checkbox"/> Pass <input type="checkbox"/> Fail	<b>Left</b> <input type="checkbox"/> Pass <input type="checkbox"/> Fail	<b>Referral</b> <input type="checkbox"/> Yes		<input type="checkbox"/>
Notes					
Scoliosis Screening: Boys grade 9, Girls grades 5 & 7		<b>Negative</b>	<b>Positive</b>	<b>Referral</b>	<b>Not Done</b>
		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Yes	<input type="checkbox"/>
<b>FOR PARTICIPATION IN PHYSICAL EDUCATION*/SPORTS*/PLAYGROUND/WORK</b>					
<input type="checkbox"/> <b>*Family cardiac history reviewed</b> – required for Dominick Murray Sudden Cardiac Arrest Prevention Act					
<input type="checkbox"/> <b>Student may participate in all activities without restrictions.</b>					
<b>If Restrictions Apply</b> – Complete the information below					
<input type="checkbox"/> <b>Student is restricted from participation in:</b>					
<input type="checkbox"/> <b>Contact Sports:</b> Basketball, Competitive Cheerleading, Diving, Downhill Skiing, Field Hockey, Football, Gymnastics, Ice Hockey, Lacrosse, Soccer, and Wrestling.					
<input type="checkbox"/> <b>Limited Contact Sports:</b> Baseball, Fencing, Softball, and Volleyball.					
<input type="checkbox"/> <b>Non-Contact Sports:</b> Archery, Badminton, Bowling, Cross-Country, Golf, Riflery, Swimming, Tennis, and Track & Field.					
<input type="checkbox"/> <b>Other Restrictions:</b>					
Developmental Stage for Athletic Placement Process <b>ONLY</b> required for students in Grades 7 & 8 who wish to play at the high school interscholastic sports level <b>OR</b> Grades 9-12 who wish to play at the modified interscholastic sports level.					
Tanner Stage: <input type="checkbox"/> I <input type="checkbox"/> II <input type="checkbox"/> III <input type="checkbox"/> IV <input type="checkbox"/> V					
<input type="checkbox"/> <b>Other Accommodations*:</b> 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.					
<b>MEDICATIONS</b>					
<input type="checkbox"/> Order Form for medication(s) needed at school attached					
<b>COMMUNICABLE DISEASE</b>			<b>IMMUNIZATIONS</b>		
<input type="checkbox"/> Confirmed free of communicable disease during exam			<input type="checkbox"/> Record Attached <input type="checkbox"/> Reported in NYSIIS		
<b>HEALTHCARE PROVIDER</b>					
Healthcare Provider Signature:					
Provider Name: (please print)					
Provider Address:					
Phone:			Fax:		
<b>Please Return This Form to Your Child's School Health Office When Completed.</b>					