ST. CHRISTOPHER'S SCHOOL
ADVANCED ACCREDITED
15 LISBON PLACE
STATEN ISLAND, NEW YORK 10306
TEL: (718) 351-0902 FAX: (718) 351-0975

August 2018

Dear **Pre-K 3/4** Parents and/or Guardians,

We hope you are having an enjoyable summer. It's hard to believe, but the beginning of a new school year will be here before we know it!! We would like to take this opportunity to welcome your family to **Pre-Kindergarten** at St. Christopher's School. This letter is to inform you about our first day of school and orientation. We are looking forward to meeting with you to discuss our exciting early childhood program and school procedures. In addition, if you have not yet submitted an **updated health form**, please have the one enclosed completed by your doctor and sent to school prior to **Monday, August 20, 2018.**

Please note some changes in our school office, Mrs. Rowena Landvogt has decided to move on to another career path, however, we are very happy to have as the new school administrative assistant, Ms. Christina Sobrado. You may know her as she has been part of our school office as the UPK administrative assistant. She has been an asset to our school, and enjoys working with our children. We look forward to working with her in this new capacity this school year! Taking the UPK administrator assistant position, we welcome, Ms. Danielle D'Agosta. We are excited to have her here, and to share her talents as part of our St.Christopher School family!

Orientation will take place for all children in our PK3/4 class on Thursday, September 6th. Please bring your child to the Bedford Ave. entrance at 9:45 a.m. The children will be brought to the classroom for their first session. Parents and guardians will proceed outside the building, around to the lobby entrance on Lisbon Place for orientation in the auditorium. You will meet up with your child at the conclusion of the orientation for your child's dismissal at the Bedford Ave. entrance.

All students will begin to follow their regular schedule on Monday, September 10th.

The following are some points of information you will find useful to have before the beginning of school:

- The only school supply the children need to bring to school is a backpack large enough to fit a full-sized folder. **Please label your child's backpack clearly with his/her full name across the front.** All other supplies are provided in school.

- **Lunch:** *Nucci's* will continue to provide hot (and cold) lunch for our children each day. September's menu will be posted on the school website (www.stchristophersi.com) along with the September calendar for your review. Thereafter, we will provide the menu on the back of the monthly calendar that will be distributed to your child. If your child is purchasing lunch, please provide the necessary money in an envelope with your child's name on it so that their lunch may be purchased. You have the option of providing a bagged lunch for your child. Please make sure that your child's name is on the lunch bag/box. **NO** fast food lunches are permitted (pizza, burgers, etc.). Parents are **not** permitted to deliver their child's/children's lunch on a daily basis.

- Snack is also provided in school. If your child is attending full day, he/she must bring lunch in either a soft lunchbox or paper bag. **Again, please label your child's lunchbox/ lunch bag with his/her full name.**

- Students will need extra clothing. Please put these in a large, zip-lock bag labeled with your child's name. **It is important that everything you send to school be labeled with your child's name** (ex. jackets, backpacks, sweaters, lunch bags, etc.).

- Please keep in mind when shopping for school clothing that Pre-K is fun, messy work! The children are very active and should be in play wear so that they are able to participate fully and comfortably in all of our activities. The children usually "sit like a pretzel" in our circle so if they wear a skirt, the girls are more comfortable with leggings or shorts underneath.

- A favorite part of our day for the children is "Big Moving Time." We use the gym and/or schoolyard almost every day with a variety of materials such as balls, chalk, hoops, etc. **For safety purposes, the only acceptable footwear for the students is sneakers. Any style is permitted – regular laces or velcro, slip-ons, MaryJanes, etc.**

- **If your child is staying from 11:00 – 2:25, or for a full day, please bring a check payable to St. Christopher School for $35.00 to purchase a mat for his/her rest time.**

A word about separation - it takes time for some children to make the adjustment at the beginning of a new school year! This is true even of children who have previously attended school. The best thing you can do to encourage your child is give him/her a confident and happy smile at the door. Children usually stop crying and become engaged in an activity soon after entering the classroom – it's usually much worse for the parent than for the child!

Thank you in advance for your cooperation. We look forward to seeing you in September!!

Sincerely,

Catherine Falabella

Catherine Falabella, Principal

CHILD & ADOLESCENT HEALTH EXAMINATION FORM

NYC DEPARTMENT OF HEALTH & MENTAL HYGIENE — DEPARTMENT OF EDUCATION

Please Print Clearly

NYC ID (OSIS)

TO BE COMPLETED BY THE PARENT OR GUARDIAN

Child's Last Name | First Name | Middle Name | Sex ☐ Female ☐ Male | Date of Birth (Month/Day/Year) ___/___/____

Child's Address | Hispanic/Latino? ☐ Yes ☐ No | Race (Check ALL that apply) ☐ American Indian ☐ Asian ☐ Black ☐ White ☐ Native Hawaiian/Pacific Islander ☐ Other

City/Borough | State | Zip Code | School/Center/Camp Name | District ___ Number ____

Phone Numbers: Home | Cell | Work

Health insurance (including Medicaid)? ☐ Yes ☐ No

☐ Parent/Guardian Last Name First Name Email

☐ Foster Parent

TO BE COMPLETED BY THE HEALTH CARE PRACTITIONER

Birth history *(age 0-6 yrs)*

☐ Uncomplicated ☐ Premature: _____ weeks gestation

☐ Complicated by _____

Allergies ☐ None ☐ Epi pen prescribed

☐ Drugs *(list)* _____

☐ Foods *(list)* _____

☐ Other *(list)* _____

Attach MAF if in-school medications needed

Does the child/adolescent have a past or present medical history of the following?

☐ Asthma *(check severity and attach MAF)*: ☐ Intermittent ☐ Mild Persistent ☐ Moderate Persistent ☐ Severe Persistent

If persistent, check all current medication(s): ☐ Quick Relief Medication ☐ Inhaled Corticosteroid ☐ Oral Steroid ☐ Other Controller ☐ None

Asthma Control Status ☐ Well-controlled ☐ Poorly Controlled or Not Controlled

☐ Anaphylaxis
☐ Behavioral/mental health disorder
☐ Congenital or acquired heart disorder
☐ Developmental/learning problem
☐ Diabetes *(attach MAF)*
☐ Orthopedic injury/disability
☐ Seizure disorder
☐ Speech, hearing, or visual impairment
☐ Tuberculosis *(latent infection or disease)*
☐ Hospitalization
☐ Surgery
☐ Other (specify) _____
Explain all checked items above.
☐ *Addendum attached.*

Medications *(attach MAF if in-school medication needed)*

☐ None ☐ Yes *(list below)*

_____

_____

_____

_____

PHYSICAL EXAM Date of Exam: ___/___/___

Height _____ cm (____ %ile)

Weight _____ kg (____ %ile)

BMI _____ kg/m² (____ %ile)

Head Circumference *(age ≤2 yrs)* _____ cm (____ %ile)

Blood Pressure *(age ≥3 yrs)* _____/_____

General Appearance:

☐ Physical Exam WNL

	NI	Abnl
Psychosocial Development	☐	☐
Language	☐	☐
Behavioral	☐	☐
HEENT	☐	☐
Dental	☐	☐
Neck	☐	☐
Lymph nodes	☐	☐
Lungs	☐	☐
Cardiovascular	☐	☐
Abdomen	☐	☐
Genitourinary	☐	☐
Extremities	☐	☐
Skin	☐	☐
Neurological	☐	☐
Back/spine	☐	☐

Describe abnormalities:

DEVELOPMENTAL *(age 0-6 yrs)*

Validated Screening Tool Used? Date Screened ___/___/___

☐ Yes ☐ No

Screening Results: ☐ WNL

☐ Delay or Concern Suspected/Confirmed (specify area(s) below):

☐ Cognitive/Problem Solving ☐ Adaptive/Self-Help
☐ Communication/Language ☐ Gross Motor/Fine Motor
☐ Social-Emotional or Personal-Social ☐ Other Area of Concern:

Describe Suspected Delay or Concern:

Child Receives EI/CPSE/CSE services ☐ Yes ☐ No

Nutrition

< 1 year ☐ Breastfed ☐ Formula ☐ Both

≥ 1 year ☐ Well-balanced ☐ Needs guidance ☐ Counseled ☐ Referred

Dietary Restrictions ☐ None ☐ Yes *(list below)*

SCREENING TESTS

	Date Done	Results
Blood Lead Level (BLL) *(required at age 1 yr and 2 yrs and for those at risk)*	___/___/___	_____ µg/dL
	___/___/___	_____ µg/dL
Lead Risk Assessment *(annually, age 6 mo-6 yrs)*	___/___/___	☐ At risk *(do BLL)* ☐ Not at risk

Child Care Only

Hemoglobin or Hematocrit	___/___/___	_____ g/dL _____ %

Hearing

	Date Done	Results
< 4 years: gross hearing	___/___/___	☐ NI ☐ Abnl ☐ Referred
OAE	___/___/___	☐ NI ☐ Abnl ☐ Referred
≥ 4 yrs: pure tone audiometry	___/___/___	☐ NI ☐ Abnl ☐ Referred

Vision

	Date Done	Results
<3 years: Vision appears:	___/___/___	☐ NI ☐ Abnl
Acuity (required for new entrants and children age 3-7 years)	___/___/___	Right ___/___ Left ___/___ ☐ Unable to test
Screened with Glasses?		☐ Yes ☐ No
Strabismus?		☐ Yes ☐ No

Dental

Visible Tooth Decay ☐ Yes ☐ No

Urgent need for dental referral *(pain, swelling, infection)* ☐ Yes ☐ No

Dental Visit within the past 12 months ☐ Yes ☐ No

CIR Number

Physician Confirmed History of Varicella Infection ☐

IMMUNIZATIONS – DATES

DTP/DTaP/DT	___/___/___	___/___/___	___/___/___	___/___/___
Td	___/___/___	___/___/___	___/___/___	___/___/___
Polio	___/___/___	___/___/___	___/___/___	___/___/___
Hep B	___/___/___	___/___/___	___/___/___	___/___/___
Hib	___/___/___	___/___/___	___/___/___	___/___/___
PCV	___/___/___	___/___/___	___/___/___	___/___/___
Influenza	___/___/___	___/___/___	___/___/___	___/___/___
HPV	___/___/___	___/___/___	___/___/___	___/___/___
Tdap	___/___/___	___/___/___		
MMR	___/___/___	___/___/___	___/___/___	___/___/___
Varicella	___/___/___	___/___/___	___/___/___	___/___/___
Mening ACWY	___/___/___	___/___/___	___/___/___	___/___/___
Hep A	___/___/___	___/___/___	___/___/___	___/___/___
Rotavirus	___/___/___	___/___/___	___/___/___	___/___/___
Mening B	___/___/___	___/___/___	___/___/___	___/___/___
Other _____	___/___/___	___/___/___	___/___/___	___/___/___

Report only positive immunity:

	IgG Titers	Date
Hepatitis B		___/___/___
Measles		___/___/___
Mumps		___/___/___
Rubella		___/___/___
Varicella		___/___/___
Polio 1		___/___/___
Polio 2		___/___/___
Polio 3		___/___/___

ASSESSMENT ☐ Well Child (Z00.129) ☐ Diagnoses/Problems *(list)* ICD-10 Code

_____ _____

_____ _____

_____ _____

RECOMMENDATIONS ☐ Full physical activity

☐ Restrictions *(specify)* _____

Follow-up Needed ☐ No ☐ Yes, for _____ Appt. date: ___/___/___

Referral(s): ☐ None ☐ Early Intervention ☐ IEP ☐ Dental ☐ Vision

☐ Other _____

Health Care Practitioner Signature | Date Form Completed ___/___/___

Health Care Practitioner Name and Degree *(print)* | Practitioner License No. and State

Facility Name | National Provider Identifier (NPI)

Address | City | State | Zip

Telephone | Fax | Email

DOHMH ONLY PRACTITIONER I.D.

TYPE OF EXAM: ☐ NAF Current ☐ NAF Prior Year(s)

Comments

Date Reviewed I.D. NUMBER

REVIEWER

FORM ID#