MIDWEST CHRISTIAN
MONTESSORI ACADEMY

ENROLLMENT DOCUMENTS

Kindergarten | PY 2020 – 2021

Student Information

SCHOOL YEAR _____ **LEVEL**_____ **TEACHER**_____

STUDENT'S NAME: _____ **BIRTHDATE**:_____ **AGE**:_____

Required by Illinois State Board of Education
Ethnic Designation: *Is this student Hispanic/Latino?* _____**Yes** _____**No**

Race: ***(check one or more)*** _____Am. Indian _____Asian _____Black/African Am. _____Pacific Islander _____White

ADDRESS: _____ **CITY:** _____ **ZIP:** _____

PARENT NAMES: _____ **HOME or call <u>FIRST</u>:** _____

PRIMARY EMAIL ADDRESS: _____ **SECONDARY EMAIL:** _____

PLACE OF EMPLOYMENT
FATHER:_____

PLACE OF EMPLOYMENT
MOTHER:_____

WORK PHONE: _____**CELL**:_____ **WORK PHONE:** _____**CELL**:_____

EMERGENCY CONTACT PERSONS *<u>OTHER THAN PARENTS</u>* AUTHORIZED TO PICK UP YOUR CHILD:
(Photo Identification Required)

NAME: _____ **RELATIONSHIP:** _____ **PHONE:** _____

NAME: _____ **RELATIONSHIP:** _____ **PHONE:** _____

NAME: _____ **RELATIONSHIP:** _____ **PHONE:** _____

ANY ILLNESS, ALLERGIES, OR MEDICAL CONDITION WE SHOULD BE AWARE OF: _____

_____

DOCTOR: _____ **ADDRESS:** _____ **PHONE:** _____

*****In case of emergency, I give permission for Midwest Christian Montessori Academy staff to call paramedics or to have my child taken to a hospital or medical center for care. I will assume financial responsibility for charges incurred.**

SIGNATURE OF PARENT: _____ **DATE**:_____

Please update this information whenever it changes. Thank you.

Midwest Christian Montessori Academy admits students of any race, color, and national or ethnic origin to all the rights, privileges, programs, and activities generally accorded or made available to students at our school and does not discriminate on the basis of race, color, and national or ethnic origin in administration of our educational policies, scholarship and loan programs, and athletic and other school-administered programs.

FOR USE IN DCFS LICENSED CHILD CARE FACILITIES
CFS 600
Rev 12/2011

State of Illinois
Certificate of Child Health Examination

Student's Name (Last, First, Middle)	Birth Date (Month/Day/Year)	Sex	Race/Ethnicity	School /Grade Level/ID#
Address (Street, City, Zip Code)	Parent/Guardian	Telephone # Home		Work

IMMUNIZATIONS: To be completed by health care provider. Note the mo/da/yr for *every* dose administered. The day and month is required if you cannot determine if the vaccine was given *after* the minimum interval or age. **If a specific vaccine is medically contraindicated, a separate written statement must be attached explaining the medical reason for the contraindication.**

Vaccine / Dose	1 MO DA YR	2 MO DA YR	3 MO DA YR	4 MO DA YR	5 MO DA YR	6 MO DA YR
DTP or **DTaP**						
Tdap; **Td** or Pediatric **DT (**Check specific type)	☐Tdap☐Td☐DT	☐Tdap☐Td☐DT	☐Tdap☐Td☐DT	☐Tdap☐Td☐DT	☐Tdap☐Td☐DT	☐Tdap☐Td☐DT
Polio (Check specific type)	☐ IPV ☐ OPV	☐ IPV ☐ OPV	☐ IPV ☐ OPV	☐ IPV ☐ OPV	☐ IPV ☐ OPV	☐ IPV ☐ OPV
Hib Haemophilus influenza type b						
Hepatitis B (HB)						
Varicella (Chickenpox)				COMMENTS:		
MMR Combined Measles Mumps. Rubella						
Single Antigen Vaccines	**Measles**	**Rubella**	**Mumps**			
Pneumococcal Conjugate						
Other/Specify Meningococcal, Hepatitis A, HPV, Influenza						

Health care provider (MD, DO, APN, PA, school health professional, health official) verifying above immunization history must sign below. If adding dates to the above immunization history section, put your initials by date(s) and sign here.)

Signature **Title** **Date**

Signature **Title** **Date**

ALTERNATIVE PROOF OF IMMUNITY

1. Clinical diagnosis is acceptable if verified by physician. *(All measles cases diagnosed on or after July 1, 2002, must be confirmed by laboratory evidence.)

***MEASLES (Rubeola)** MO DA YR **MUMPS** MO DA YR **VARICELLA** MO DA YR **Physician's Signature**

2. History of varicella (chickenpox) disease is acceptable if verified by health care provider, school health professional or health official.
Person signing below is verifying that the parent/guardian's description of varicella disease history is indicative of past infection and is accepting such history as documentation of disease.

Date of Disease **Signature** **Title** **Date**

3. Laboratory confirmation (check one) ☐**Measles** ☐**Mumps** ☐**Rubella** ☐**Hepatitis B** ☐**Varicella**
Lab Results **Date** MO DA YR **(Attach copy of lab result)**

VISION AND HEARING SCREENING BY IDPH CERTIFIED SCREENING TECHNICIAN

Date																					**Code:**
Age/ Grade																					**P = Pass**
	R	L	R	L	R	L	R	L	R	L	R	L	R	L	R	L	R	L	R	L	**F = Fail**
Vision																					**U = Unable to test**
Hearing																					**R = Referred**
																					G/C = Glasses/Contacts

Last	First	Middle	Birth Date (Month/Day/ Year)	Sex	School	Grade Level/ ID

HEALTH HISTORY **TO BE COMPLETED AND SIGNED BY PARENT/GUARDIAN AND VERIFIED BY HEALTH CARE PROVIDER**

ALLERGIES (Food, drug, insect, other)			**MEDICATION** (List all prescribed or taken on a regular basis.)			
Diagnosis of asthma? Child wakes during night coughing?	Yes No Yes No		Loss of function of one of paired organs? (eye/ear/kidney/testicle)	Yes No		
Birth defects?	Yes No		Hospitalizations? When? What for?	Yes No		
Developmental delay?	Yes No					
Blood disorders? Hemophilia, Sickle Cell, Other? Explain.	Yes No		Surgery? (List all.) When? What for?	Yes No		
Diabetes?	Yes No		Serious injury or illness?	Yes No		
Head injury/Concussion/Passed out?	Yes No		TB skin test positive (past/present)?	Yes* No	*If yes, refer to local health department.	
Seizures? What are they like?	Yes No		TB disease (past or present)?	Yes* No		
Heart problem/Shortness of breath?	Yes No		Tobacco use (type, frequency)?	Yes No		
Heart murmur/High blood pressure?	Yes No		Alcohol/Drug use?	Yes No		
Dizziness or chest pain with exercise?	Yes No		Family history of sudden death before age 50? (Cause?)	Yes No		
Eye/Vision problems? _____ Glasses ☐ Contacts ☐ Last exam by eye doctor _____ Other concerns? (crossed eye, drooping lids, squinting, difficulty reading)			Dental ☐ Braces ☐ Bridge ☐ Plate Other			
Ear/Hearing problems?	Yes No		Information may be shared with appropriate personnel for health and educational purposes. **Parent/Guardian Signature** **Date**			
Bone/Joint problem/injury/scoliosis?	Yes No					

PHYSICAL EXAMINATION REQUIREMENTS **Entire section below to be completed by MD/DO/APN/PA**

HEAD CIRCUMFERENCE if < 2-3 years old **HEIGHT** **WEIGHT** **BMI** **B/P**

DIABETES SCREENING (NOT REQUIRED FOR DAY CARE) **BMI>85% age/sex** Yes☐ No☐ And any two of the following: **Family History** Yes ☐ No ☐
Ethnic Minority Yes☐ No ☐ **Signs of Insulin Resistance** (hypertension, dyslipidemia, polycystic ovarian syndrome, acanthosis nigricans) Yes☐ No ☐ **At Risk** Yes ☐ No ☐

LEAD RISK QUESTIONNAIRE Required for children age 6 months through 6 years enrolled in licensed or public school operated day care, preschool, nursery school and/or kindergarten.

Questionnaire Administered ? Yes ☐ No ☐ **Blood Test Indicated?** Yes ☐ No ☐ **Blood Test Date** (Blood test required if resides in Chicago.)

TB SKIN OR BLOOD TEST Recommended only for children in high-risk groups including children immunosuppressed due to HIV infection or other conditions, frequent travel to or born in high prevalence countries or those exposed to adults in high-risk categories. See CDC guidelines. **No test needed ☐** **Test performed ☐**

Skin Test: Date Read / / **Result: Positive ☐ Negative ☐** **mm** _____

Blood Test: Date Reported / / **Result: Positive ☐ Negative ☐** **Value** _____

LAB TESTS (Recommended)	Date	Results		Date	Results
Hemoglobin or Hematocrit			Sickle Cell (when indicated)		
Urinalysis			Developmental Screening Tool		

SYSTEM REVIEW	**Normal**	**Comments/Follow-up/Needs**		**Normal**	**Comments/Follow-up/Needs**
Skin			**Endocrine**		
Ears			**Gastrointestinal**		
Eyes		Amblyopia Yes☐ No☐	**Genito-Urinary**		LMP
Nose			**Neurological**		
Throat			**Musculoskeletal**		
Mouth/Dental			**Spinal Exam**		
Cardiovascular/HTN			**Nutritional status**		
Respiratory		☐ Diagnosis of Asthma	**Mental Health**		
Currently Prescribed Asthma Medication: ☐ Quick-relief medication (e.g. Short Acting Beta Antagonist) ☐ Controller medication (e.g. inhaled corticosteroid)			**Other**		
NEEDS/MODIFICATIONS required in the school setting			**DIETARY** Needs/Restrictions		

SPECIAL INSTRUCTIONS/DEVICES e.g. safety glasses, glass eye, chest protector for arrhythmia, pacemaker, prosthetic device, dental bridge, false teeth, athletic support/cup

MENTAL HEALTH/OTHER Is there anything else the school should know about this student?
If you would like to discuss this student's health with school or school health personnel, check title: ☐ Nurse ☐ Teacher ☐ Counselor ☐ Principal

EMERGENCY ACTION needed while at school due to child's health condition (e.g. ,seizures, asthma, insect sting, food, peanut allergy, bleeding problem, diabetes, heart problem)?
Yes ☐ No ☐ If yes, please describe.

On the basis of the examination on this day, I approve this child's participation in (If No or Modified please attach explanation.)
PHYSICAL EDUCATION Yes ☐ No ☐ Modified ☐ **INTERSCHOLASTIC SPORTS** (for one year) **Yes ☐ No ☐ Limited ☐**

Print Name (MD,DO, APN, PA) **Signature** **Date**

Address **Phone**

(Complete Both Sides)

State of Illinois
Illinois Department of Public Health

PROOF OF SCHOOL DENTAL EXAMINATION FORM

To be completed by the parent (please print):

Student's Name: Last First Middle			Birth Date: (Month/Day/Year) / /
Address: Street City ZIP Code			Telephone:
Name of School:		Grade Level:	Gender: ☐ Male ☐ Female
Parent or Guardian:		Address (of parent/guardian):	

To be completed by dentist:

Oral Health Status (check all that apply)

☐ Yes ☐ No **Dental Sealants Present**

☐ Yes ☐ No **Caries Experience / Restoration History** — A filling (temporary/permanent) OR a tooth that is missing because it was extracted as a result of caries OR missing permanent 1st molars.

☐ Yes ☐ No **Untreated Caries —** At least 1/2 mm of tooth structure loss at the enamel surface. Brown to dark-brown coloration of the walls of the lesion. These criteria apply to pit and fissure cavitated lesions as well as those on smooth tooth surfaces. If retained root, assume that the whole tooth was destroyed by caries. Broken or chipped teeth, plus teeth with temporary fillings, are considered sound unless a cavitated lesion is also present.

☐ Yes ☐ No **Soft Tissue Pathology**

☐ Yes ☐ No **Malocclusion**

Treatment Needs (check all that apply)

☐ **Urgent Treatment** — abscess, nerve exposure, advanced disease state, signs or symptoms that include pain, infection, or swelling

☐ **Restorative Care** — amalgams, composites, crowns, etc.

☐ **Preventive Care** — sealants, fluoride treatment, prophylaxis

☐ **Other** — periodontal, orthodontic

Please note _____

Signature of Dentist _____ Date of Exam _____

Address _____ Telephone _____
Street City ZIP Code

Illinois Department of Public Health, Division of Oral Health
217-785-4899 • TTY (hearing impaired use only) 800-547-0466 • www.idph.state.il.us

IOCI 0600-10 Printed by Authority of the State of Illinois

State of Illinois
Eye Examination Report

Illinois law requires that proof of an eye examination by an optometrist or physician (such as an ophthalmologist) who provides eye examinations be submitted to the school no later than October 15 of the year the child is first enrolled or as required by the school for other children. The examination must be completed within one year prior to the first day of the school year the child enters the Illinois school system for the first time. The parent of any child who is unable to obtain an examination must submit a waiver form to the school.

Student Name _____
(Last) (First) (Middle Initial)

Birth Date _____ Gender _____ Grade _____
(Month/Day/Year)

Parent or Guardian _____
(Last) (First)

Phone _____
(Area Code)

Address _____
(Number) (Street) (City) (ZIP Code)

County _____

To Be Completed By Examining Doctor

Case History

Date of exam _____

Ocular history: ❑ Normal or Positive for _____

Medical history: ❑ Normal or Positive for _____

Drug allergies: ❑ NKDA or Allergic to _____

Other information _____

Examination

	Distance			**Near**
	Right	Left	Both	Both
Uncorrected visual acuity	20/	20/	20/	20/
Best corrected visual acuity	20/	20/	20/	20/

Was refraction performed with dilation? ❑ Yes ❑ No

	Normal	Abnormal	Not Able to Assess	Comments
External exam (lids, lashes, cornea, etc.)	❑	❑	❑	_____
Internal exam (vitreous, lens, fundus, etc.)	❑	❑	❑	_____
Pupillary reflex (pupils)	❑	❑	❑	_____
Binocular function (stereopsis)	❑	❑	❑	_____
Accommodation and vergence	❑	❑	❑	_____
Color vision	❑	❑	❑	_____
Glaucoma evaluation	❑	❑	❑	_____
Oculomotor assessment	❑	❑	❑	_____
Other _____	❑	❑	❑	_____

NOTE: "Not Able to Assess" refers to the inability of the child to complete the test, not the inability of the doctor to provide the test.

Diagnosis

❑ Normal ❑ Myopia ❑ Hyperopia ❑ Astigmatism ❑ Strabismus ❑ Amblyopia

Other _____

Continued on back

State of Illinois
Eye Examination Report

Recommendations

1. Corrective lenses: ❑ No ❑ Yes, glasses or contacts should be worn for:
   ❑ Constant wear ❑ Near vision ❑ Far vision
   ❑ May be removed for physical education

2. Preferential seating recommended: ❑ No ❑ Yes

   Comments _____

   _____

3. Recommend re-examination: ❑ 3 months ❑ 6 months ❑ 12 months

   ❑ Other _____

4. _____

5. _____

Print name _____ License Number _____

Optometrist or physician (such as an ophthalmologist) who provided the eye examination ❑ MD ❑ OD ❑ DO

Consent of Parent or Guardian

I agree to release the above information on my child or ward to appropriate school or health authorities.

_____
(Parent or Guardian's Signature)

_____
(Date)

Address _____

_____

Phone _____

Signature _____ Date _____

(Source: Amended at 32 Ill. Reg. _____, effective _____)

Printed by Authority of the State of Illinois
6/09

IOCI1271-09

School Medication Authorization Form

_____ _____

STUDENT'S NAME **BIRTHDATE**

I request that a staff member of Midwest Christian Montessori Academy administer medication to my child following the prescribed instructions.

I understand that it is my responsibility to provide the school with necessary medication and supplies, deliver them to a staff member, and retrieve them at the end of the course of medication.

I understand that prescription medications must be delivered in the original labeled container as dispensed, including student's name, medication name, instructions for use, and date. Non-prescription (over-the-counter) medications must be provided in the manufacturer's labeled container.

Please note: Medications must be hand delivered by a parent/guardian to a staff member, and will be stored by the staff. Exception: Asthma inhalers may be retained by the student, with parent's permission.

Name of Medication: _____

Dosage: _____ Time to be given: _____ Number of Days: _____

Condition for which medication has been prescribed _____

Possible side effects: _____

Does medication need to be refrigerated? Yes_____ No_____

Should medication be sent home daily? Yes_____ No_____

SPECIAL INSTRUCTIONS: _____

Parent Signature: _____ Date: _____

DATE	DOSAGE	TIME GIVEN	INITIALS
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Photo Release for Children Under 18 Years of Age

Throughout the year, our teachers and staff may take individual and group pictures of our students in the process of working or participating in school activities. Some of those pictures make excellent representations of our school when included in brochures, newspaper or magazine articles, or on our website. *When publishing pictures for advertisement, names are not included.*

Please check one choice:

YES, ____ I hereby grant to Midwest Christian Montessori Academy and to its representatives, the right to photograph my child and use the photo and or other digital reproduction of him/her or other reproduction of his/her physical likeness for publication processes, whether electronic, print, digital or electronic publishing via the Internet.

NO, ____ I do not wish to have my child's photograph used in any publication process, whether electronic, print, digital or electronic publishing via the Internet.

Please note: This release does not pertain to a school yearbook, if published.

Student's Name: _____

Signature of Parent or Guardian: _____

Print Name of Parent or Guardian: _____

Address: _____

_____

Date: _____

Directory Information

Please fill out the form below for our 2020 – 2021Student Directory. It will be made available to every family. ***We use e-mail as our primary method of notification for messages from school.*** Our directory may be used for your purposes to arrange car pools and play dates, etc. If you do not wish for your child to be included in the directory, please indicate this below.

Thank you.

Student Information

Student Name: _____

Teacher: _____

Parent Names: _____

Address: _____
(street) (city) (zipcode)

Home phone:_____

Parent Information

Mom work/cell phone (optional):_____

Dad work/cell phone (optional):_____

PRIMARY e-mail address_____

ALTERNATE e-mail address_____

(A signature is only required if opting out of the directory)

_____ No, I do not wish for my child to be included in the Student Directory.

Parent Signature: _____

Student Handbook Receipt

The current handbook on our website is available to our families to keep them informed of our school's guidelines, procedures, and policies. Please read the handbook and sign below to indicate your acceptance.

I/We have received, have read, and agree to abide by the guidelines of the 2020 – 2021 Midwest Christian Montessori Academy Handbook.

_____ _____

Parent/Guardian Signature **Date**

_____

Student Name(s)

MCMA Parent - Teacher Organization

Please see below for those items due to the PTO

Student's/Family Name: _____

___$25____**PTO dues** - *per Family*

_____ **Activities fee**

Preschool/Kindergarten. . . *$55*
Elementary *$80*

_____ **T-shirt order** *(please return with order form)*

_____ **Total Amount Due** *(all items may be combined in one check)*

Make checks payable to **MCMA PTO**. Thank you.

_____ **Total Amount Paid** __ **cash** __ **check #**_____

Please remember to frequently check e-mail messages and the calendar on our school website. www.mcmacademy.org

2020-2021 Spirit Wear Sale

A

*  

B

*  

Style: Regular ☐ | V-neck ☐ (* for adults in purple only)

MIDWEST CHRISTIAN MONTESSORI ACADEMY

MIDWEST CHRISTIAN MONTESSORI ACADEMY

Spirit Items		
Car Window Decal	$4.50	☐
Baseball Cap (Logo Design B)	$10.00	☐
• Adults: Green, Purple or White	Color:	☐
• Children: White Only		☐

Youth		Adult	
Small	6-8	Small	34-36
Medium	10-12	Medium	38-40
Large	14-16	Large	42-44
		X Large	46-48

Youth T-Shirts: Short Sleeve $8.50 Color: _____ Design: ___ S ☐ M ☐ L ☐

Youth T-Shirts: Long Sleeve $11.50 Color: _____ Design: ___ S ☐ M ☐ L ☐

Youth Hooded Sweatshirt $19.50 Color: _____ Design: ___ S ☐ M ☐ L ☐

Adult T-Shirts: Short Sleeve $9.50 XL $11.50 Color: _____ Design: ___ S ☐ M ☐ L ☐ 2X ☐3X ☐

Adult T-Shirts: Long Sleeve $12.50 XL $14.50 Color: _____ Design: ___ S ☐ M ☐ L ☐ 2X ☐3X ☐

Adult Hooded Sweatshirt $21.00 XL $23.00 Color: _____ Design: ___ S ☐ M ☐ L ☐ 2X ☐3X ☐

Student Name _____

Teacher _____ Grade _____

Total Amt. Enclosed _____ Cash ☐ Check ☐ *Make payable to MCMA PTO*

Orders Due by August 21st

School T-Shirts or Sweatshirts are required to be worn on off-campus field trips.

MIDWEST CHRISTIAN MONTESSORI ACADEMY
314 East Briarcliff Road, Bolingbrook IL 60440 630.7838644 www.mcmacademy.org

Volunteer Form

Our school needs you! We are so very grateful to our families who help the school enrich the children's experiences. Our school family needs everyone to pitch in on these small tasks, so please check a box if you can give an hour or two to help with these fun events. Thank you!

Volunteer's Name_____

Phone Number(s) #1_____ **#2**_____

Email Address _____

Best way to reach me:*(phone, text, email?)*_____

Do you have a talent / expertise to share?

_____

_____

_____

I can be available:

☐ days / hours: _____

☐ call me

☐ **Fundraiser committee**

- ☐ event planning
- ☐ community relations

☐ **School Picnic (circle one or more)**

- ☐ set up
- ☐ games
- ☐ clean up

☐ **School Picture Day**

☐ **Christmas Program**

- ☐ set up
- ☐ clean up

☐ **Classroom helper** (listening to readers, monitoring lunchroom/recess)

☐ **Chaperone for Field Trips**

☐ **Spirit Wear/T-shirt Helper –** tallying, sorting and distributing to classrooms

2020 – 2021 School Calendar

Student Attendance and School Closings

Monday, Aug. 17	New student Orientation: 9-10:30am New Preschool Students Parent Orientation 9-10:30am *(for any parents new to the school)*
Tuesday, Aug. 18	First day of school – *ALL STUDENTS – HALF DAY 8:45-12:00* *No After-School Care*
Wednesday, Aug. 19	Regular Attendance – *ALL STUDENTS*
Monday, Sept. 7	Labor Day – *No School / No Childcare*
Friday, Oct. 9	Parent-Teacher Conferences – *No school/No Childcare*
Monday, Oct. 12	Columbus Day – *No School / No Childcare*
Wednesday, Nov. 11	Veterans Day – *No School / No Childcare*
Wed.-Fri, Nov. 25-27	Thanksgiving Break – *No School / No Childcare*
Friday, Dec. 18	HALF DAY *8:45-12:00* *No After-School Care*
Dec. 21 – Jan. 1	Christmas Break – *No School/ No Childcare*

2020 – 2021 School Calendar

Student Attendance and School Closings

Monday, Jan. 4	School Resumes
Monday, Jan. 18	Martin Luther King Day – *No School / No Childcare*
Monday, Feb. 15	Presidents' Day – *No School / No Childcare*
Monday, March 1	Casimir Pulaski Day – *No School / No Childcare*
Friday, April 2	Good Friday – *No School / No Childcare*
April 5-9	Easter Break – *No School / No Childcare*
Monday, April 12	School Resumes
Friday, May 14	Institute Day – *No School / No Childcare*
Wednesday, May 26	Last Day of School – *HALF DAY 8:45-12:00* *No After - School Childcare*

Please refer to the school's website regularly and watch your MCMA News e-mails for additional information and updates

Kindergarten Students Bring:

- ***A complete change of clothing*** (in case of accidents or spills): shirt, pants, underwear, socks, perhaps a sweater. These go into their storage box that will be provided by the school. Parents are responsible for keeping these up-to-date with the season, and also for returning clothes to school promptly after each use.

- ***Rubber-soled slippers or indoor shoes*** (labeled with child's name) to be worn in the classroom when boots or muddy shoes are worn to school. These are kept in the storage box or on a shoe tray. *No slipper socks or big, fuzzy slippers, please.*

- ***A backpack*** is necessary every day to carry home notes and papers belonging to your child. ***Due to space concerns, we request backpacks <u>without</u> luggage-type wheels or hard handles.*** Please be sure to check your child's backpack daily.

- ***Personal Daily Snacks*** are brought by the students. Please send a small nutritious snack in a bag/container marked with your child's name. We provide bottled water in the classrooms, and we would prefer no liquid or messy refreshments be included with your child's snack. Candy is not considered a snack, and will be sent home.

- ***A lunchbox/sack lunch*** each day containing a ready-to-eat nutritious meal. *No candy or carbonated beverages, please; these items will be sent home.*

- ***An extra small snack*** for the afternoon, *if desired.*

- ***2 full-sized boxes of tissues***. These will be shared in the classroom throughout the year.

- ***One roll of paper towels***

- ***One container of Clorox Wipes*** *(or other brand of sanitizing wipes)*

Personal school supplies are included in annual fees