ENROLLMENT DOCUMENTS

Kindergarten | PY 2021 – 2022

Early Bird Registration for 2021 – 2022

MCMA is offering you an opportunity for early mail-in registration. In this email you will find a checklist and forms required for each class level to register your child/ren for the 2021-22 school year. Please fill out the forms in their entirety and mail (or scan and email) them back to school with your payment for school fees. Statements will be sent in a separate email.

These forms must be received in our office on or before July 16th to avoid coming in person to register. Walk-in registration dates for those who did not mail in their forms will be July 27th, 28th and 29th by appointment, between 9:00am -12:00pm

If mailing, send completed forms to:

Midwest Christian Montessori Academy
314 E. Briarcliff Rd.
Bolingbrook, IL 60440

ANNUAL SCHOOL FEES DUE:
(Includes enrollment, materials & supplies)

Preschool: $110 **Kindergarten: $135** **Elementary: $160**

PTO fee . . . **$25** *per Family*
Activity fee *per student:*
$55 . . .*Preschool/Kindergarten*
$80 . . . *Elementary*
T-shirt order *(please complete order form)*

SCHOOL PHYSICAL EXAMS FOR FALL ENROLLMENT: Please note the state requirements for enrollment. Students in the following levels will need:

New Preschool	Kindergarten	2nd Grade	6th Grade	*New* Elementary Students
Physical	Physical	Dental	Physical	Physical *(within 12 months)*
	Dental		Dental	Dental & Eye Exam
	Eye Exam			*(copy of previous exams)*

Please Note: Students may not attend school until the appropriate physical health forms (with up-to-date immunizations) are on file in our office.

NEW STUDENTS *in any level* must present a copy of their birth certificate upon registration.

Please e-mail the office with any questions regarding registration and fees.
Summary office hours are 9am -12pm, by appointment

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 FIRST:** ________________________

PRIMARY EMAIL ADDRESS: _______________________ **SECONDARY EMAIL:** _______________________________

PLACE OF EMPLOYMENT
FATHER:____

PLACE OF EMPLOYMENT
MOTHER:____

WORK PHONE: ___________________**CELL:**_________________ **WORK PHONE:** ________________**CELL:**____________

EMERGENCY CONTACT PERSONS *OTHER THAN PARENTS* 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.

State of Illinois
Certificate of Child Health Examination

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

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

																			Code:
Date																			**P = Pass**
Age/ Grade																			**F = Fail**
	R	L	R	L	R	L	R	L	R	L	R	L	R	L	R	L	R	L	**U = Unable to test**
Vision																			**R = Referred**
Hearing																			**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 ______________________________
Optometrist or physician (such as an ophthalmologist) who provided the eye examination ❑ MD ❑ OD ❑ DO

License Number ______________________________

Address ______________________________
____

Phone ______________________________

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)

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 2021 – 2022Student 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 2021 – 2022 Midwest Christian Montessori Academy Handbook.

____   _______________
Parent/Guardian Signature   **Date**

____
Student Name(s)

MCMA Parent - Teacher Organization | Annual Fees

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 will be added to student account)*

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

Spirit Wear Order Form

Youth sizes Small (6-8), Med (10-12), Large (14-16)
Adult sizes Small through 3XL (add $2 for XL +)

Youth Short sleeve: $8.50
Design: A or B *(circle one)* Size: _____ Color: Purple or Green (circle one) Quantity: _____

Youth long sleeve: $11.50
Design: A or B *(circle one)* Size: _____ Color: Purple or Green *(circle one)* Quantity: _____

Youth Hooded Sweatshirt: $19.50
Design: A or B *(circle one)* Size: _____ Color: Purple or Green *(circle one)* Quantity: _____

Adult short sleeve: $9.50
Design: A or B *(circle one)* Size: _____ Color: Purple or Green *(circle one)* Quantity: _____

Adult long sleeve: $12.50
Design: A or B *(circle one)* Size: _____ Color: Purple or Green *(circle one)* Quantity: _____

Adult Hooded sweatshirt: $21.00
Design: A or B *(circle one)* Size: _____ Color: Purple or Green *(circle one)* Quantity: _____

Total: ________ *(student accounts will be billed)*

Student Name: ___________________________________

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?)*_________________

□ **Fundraiser committee**
- event planning
- community relations

□ **Christmas Program**
- set up
- clean up

□ **Chaperone for Field Trips**

Do you have a special talent/expertise to share?

____

____

____

I can be available:
□ days / hours: ___________________
□ schedule varies, please contact me

MCMA requires a copy of volunteers' driver's licenses for any involvement directly with students / classrooms

2021 – 2022 School Calendar
Student Attendance and School Closings

Wednesday, August 18	Regular Attendance – *ALL STUDENTS*
Monday, September 6	Labor Day – *No School / No Childcare*
Monday, October 11	Columbus Day – *No School / No Childcare*
Thursday, November 11	Veterans Day – *No School / No Childcare*
Friday, November 12	Parent-Teacher Conferences – *No school/No Childcare*
Wed – Fri, November 24 – 26	Thanksgiving Break – *No School / No Childcare*
December 22 – January 4	Christmas Break – *No School/ No Childcare*

2021 – 2022 School Calendar
Student Attendance and School Closings

Wednesday, January 5	School Resumes
Monday, January 17	Martin Luther King Day – *No School / No Childcare*
Monday, February 21	Presidents' Day – *No School / No Childcare*
Monday, March 7	Casimir Pulaski Day – *No School / No Childcare*
March 28 – April 1 *	Spring Break *(* tentative)* – *No School / No Childcare*
Friday, April 15	Good Friday – *No School / No Childcare*
Friday, May 13	Institute Day – *No School / No Childcare*
Thursday, 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