ST. LUKE SCHOOL
Where faith & knowledge meet

DOCUMENTATION NEEDED AT TIME OF REGISTRATION

- Birth Certificate (original or notarized copy)
- Immunization Record from birth to present age
- Baptismal Certificate (original) if child is a baptized Catholic
- Registration fee of $250 (non-refundable)
- For students entering grade 2 through 8: (1) Recent report card and test scores from the school they are transferring from and (2) Letter from previous Catholic School or Religious Education Program stating the dates of: First Communion, Reconciliation and/or Confirmation.
- Current Individualized Education Plan (IEP) if applicable.
- Age Requirements: 3 year olds for Nursery must be 3 years old by December 31, 2021, Pre-Kindergarten must be 4 years old by December 31, 2021, Kindergarten must be 5 years old by December 31, 2021, and Grade 1 must be 6 years old by December 31, 2021.

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Tuition Information

All families must enroll in FACTS Tuition Management for the collection of tuition. FACTS is the company that manages Saint Luke's tuition billing and payment activities. Once you have registered, FACTS will send you an e-mail inviting you to open your account using a link provided in the email. Once you have followed the link, you will choose a payment option – either monthly debits, on-line payment, pay by mail, or pay over the phone. Cash will not be accepted for tuition payments. FACTS will automatically bill and provide monthly statements, secure on-line access to your account and a phone number to contact a representative if needed. There is no cost to you as the Diocese will pay for the service directly. Partial tuition assistance is available through Futures in Education. To apply, go to Futures in Education at www.futuresineducation.org. The deadline to apply is July 24th.

Tuition fees and information can be found on our website at slswhitesone.org. Click on "Admissions,", then "Tuition."

ST. LUKE SCHOOL

16-01 150 PLACE
WHITESTONE, NEW YORK 11357
718-746-3833

2021/2022

TUITION RATES		
GRADE	**CATHOLIC**	**NON-CATHOLIC**
NURSERY 3 FULL DAY	$5350	$5350
NURSERY 5 HALF DAY (AM)	$5350	$5350
NURSERY 5 FULL DAY – GRADE 8 ONE CHILD	$5650	$6500
NURSERY 5 FULL DAY – Grade 8 TWO CHILDREN	$10,000	$11,550
NURSERY 5 FULL DAY – Grade 8 THREE CHILDREN OR MORE	$14,050	$16,200

SCHOOL FEES – (non refundable fees)		
Registration Fee – N - 8 (New Students)	$250.00 Per Child	Due with Application
Re-Registration Fee N – 7 (Current Students)	$250.00 Per Child	Due January 1

Tuition must be paid through our Tuition management company, "FACTS".
We offer several payment plan options.
Pay in full with a 5% discount, semiannually, quarterly, or monthly.
Invites will be sent out to each family to sign up for a payment plan. (late June or early July)
Tuition payments begin in August.
A $25.00 late fee will be charged to your account if payment is late.
No child will be admitted to class in September unless August payment has been made.

Registration Form
ST LUKE SCHOOL - WHITESTONE, NEW YORK

Grade Level you are applying for: _____

Student Information

First Name _____ Middle Initial: _____ Last Name _____

Family Last Name _____

Circle one Male Female Birth date: _____ Age _____
mm/dd/yyyy

Mailing Address _____ Apt. # _____

City _____ State _____ Zip _____

Home Phone # _____

Family Main E-mail Address _____@_____

What is the city, state, country where this student was born?_____ _____
City State

What is the primary language that is spoken in your home? _____

Ethnicity _____ PUBLIC SCHOOL DISTRICT CODE _____

How many children in your family? _____ How many attend St. Luke School?_____

PREVIOUS SCHOOL INFORMATION

Name of School _____ Location _____

Does this student have an Individualized Education Plan (IEP) on file? Yes No

Religious Affiliation

Catholic? _____ Non-Catholic? _____
Religion if Non-Catholic? _____

What is the name of the church where this student currently worships? _____

Baptism information:

_____ _____
Date Name of Church

If the student has received any of the following sacraments of the Catholic Church, please enter the dates and names of the church:

Penance _____ _____
mm/dd/yyyy Name of Church

Communion: _____ _____
mm/dd/yyyy Name of Church

Confirmation: _____ _____
mm/dd/yyyy Name of Church

What was the date of this student's first polio vaccine shot? _____

Family Member 1 (This is the primary care taker of the student and resides with the student)

Title: _____ (Mr., Mrs., Dr., Ms., etc.)

What is this person's relationship to the student: (mother, father, grand mother, aunt, etc)
_____

First Name _____ Middle Initial ___

Last Name _____ Maiden Name _____

Work Phone (____) ____ - _____ Phone Extension _____

Occupation _____ Employer _____

Religion _____ (Catholic or Non-Catholic)

Home Phone (____) ____ - _____ Cell Phone (____) ____ - _____

Home Email _____ Work Email _____

Family Member 2 (the person listed here should reside at the same address as Family Member 1 and the student)

Title: _____ (Mr., Mrs., Dr., Ms., etc.)

What is this person's relationship to the student: (mother, step father, grand mother, aunt, etc)
_____

First Name _____ Middle Initial ___

Last Name _____ Maiden Name _____

Work Phone (____) ____ - _____ Phone Extension _____

Occupation _____ Employer _____

Religion _____ (Catholic or Non-Catholic)

Home Phone (____) ____ - _____ Cell Phone (____) ____ - _____

Home Email _____ Work Email _____

DOCUMENTATION NEEDED – for verification purposes only, we are required to inspect the following original documents

ORIGINAL Birth Certificate
ORIGINAL Baptismal Certificate
ORIGINAL First Communion Certificate
Photo or duplicate copy of the latest Report Card
Standardized Test Results (grades 3 – 8)
Health Records (form given at registration to be filled out completely by your Physician)

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 ☐ Foster Parent | Last Name | First Name | Email

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

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

Describe abnormalities:

DEVELOPMENTAL *(age 0-5 yrs)*

Validated Screening Tool Used? ☐ Yes ☐ No — Date Screened ___/___/___

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	___/___/___	☐ Nl ☐ Abnl ☐ Referred
OAE	___/___/___	☐ Nl ☐ Abnl ☐ Referred
≥ 4 yrs: pure tone audiometry	___/___/___	☐ Nl ☐ Abnl ☐ Referred

Vision

	Date Done	Results
<3 years: Vision appears:	___/___/___	☐ Nl ☐ 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	___/___/___	___/___/___	___/___/___	___/___/___	___/___/___	___/___/___	Tdap	___/___/___	___/___/___
Td	___/___/___	___/___/___	___/___/___	___/___/___	___/___/___	___/___/___	MMR	___/___/___	___/___/___
Polio	___/___/___	___/___/___	___/___/___	___/___/___	___/___/___	___/___/___	Varicella	___/___/___	___/___/___
Hep B	___/___/___	___/___/___	___/___/___	___/___/___	___/___/___	___/___/___	Mening ACWY	___/___/___	___/___/___
Hib	___/___/___	___/___/___	___/___/___	___/___/___	___/___/___	___/___/___	Hep A	___/___/___	___/___/___
PCV	___/___/___	___/___/___	___/___/___	___/___/___	___/___/___	___/___/___	Rotavirus	___/___/___	___/___/___
Influenza	___/___/___	___/___/___	___/___/___	___/___/___	___/___/___	___/___/___	Mening B	___/___/___	___/___/___
HPV	___/___/___	___/___/___	___/___/___	___/___/___	___/___/___	___/___/___	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: ☐ NAE Current ☐ NAE Prior Year(s):

Comments:

Date Reviewed: ___/___/___ I.D. NUMBER

REVIEWER:

FORM ID#