TIEGERMAN

Preschool/Elementary School: 100 Glen Cove Avenue, Glen Cove, NY 11542 • (516) 609-2000

PREKINDERGARTEN APPLICATION

DATE: _____

CHILD'S NAME: _____ DOB: _____ Sex: [ ] M [ ] F

PARENT/GUARDIAN NAME: _____

ADDRESS: _____ CITY: _____ ZIP: _____

MAILING ADDRESS (IF DIFFERENT): _____ EMAIL: _____

PHONE: (H) _____ (W) _____ (C) _____

Has your child had any previous school experience?: [ ] YES [ ] NO If Yes, what is the name and location of the School/Agency? ____

_____

Household Size:	
# of Adults	_____
# of Children	_____
Total in Household	_____

The Universal Prekindergarten program is a program which provides curriculum and activities, 5 days/week, 5 hours/day, which are appropriate to the age-level and individual needs of eligible children and which promote cognitive, linguistic, physical, cultural, emotional and social development. Activities are learner-centered and designed and provided in a way that promotes the child's total growth and development in all areas including English language development and literacy. Children are encouraged to be self-assured and independent.

Eligible children are those who are four years of age on or before December 1st of the year in which he or she is enrolled, or who will otherwise be first eligible to enter public school kindergarten commencing with the following school year. Selection is based on a lottery system.

Transportation is NOT provided and is the responsibility of the parent/caregiver.

If you are interested in applying for your child, please complete and return to:

Tiegerman Schools
100 Glen Cove Avenue
Glen Cove, NY 11542
Attention: Keira Saavedra
Phone: (516) 609-2000 Ext. 100
Fax: (516) 609-2014
Email: ksaavedra@tiegerman.org

TIEGERMAN

Preschool/Elementary School: 100 Glen Cove Avenue, Glen Cove, NY 11542 • (516) 609-2000

Date: _____

Student's Name: _____ Sex: [ ] M [ ] F
(Last) (First) (Middle)

Hispanic or Latino: □ Yes □ No

Race: (choose all that apply) □ Asian □ Black □ Native American/Native Alaskan □ Pacific Islander □ White

Date of Birth: _____ Place of Birth (city, state): _____ Country (if not U.S.): _____

Custody Papers or Guardian Warnings?: □ Yes □ No

Parents/Guardians with whom child(ren) reside(s): _____

Home Phone #: _____ Unlisted: □ Yes □ No

Primary Contact Person: _____ Relationship to Student: _____

Address: _____ City: _____ State: _____ Zip: _____

Mailing Address, if different: _____

Dominant Home Language: _____

TIEGERMAN

Preschool/Elementary School: 100 Glen Cove Avenue, Glen Cove, NY 11542 • (516) 609-2000

STUDENT HEALTH INVENTORY (PAGE 1)

For New, Prekindergarten Students

Date: _____

Student's Name: _____

Date of Birth: _____ Weight at Birth: ____ lbs. ____ oz.

School: _____ Grade: _____

If this child has no known health problems, SIGN HERE and do not complete the rest of this form.

_____

(Parent/Guardian Signature)

If this child has known health problems, please continue.

If the answer is "YES" to any of the questions below, please provide details, including dates on Page 2 of this form.

At birth, did the baby stay in the hospital longer than the mother? ____ Yes ____ No

Does your child have any of the following health concerns?

Allergy to Bee Sting	____ Yes	____ No
Allergy to Food	____ Yes	____ No
Allergy to Medication	____ Yes	____ No
Allergy to Other (please indicate)	____ Yes	____ No
Asthma or Breathing Problems	____ Yes	____ No
Diabetes	____ Yes	____ No
Difficulty Hearing	____ Yes	____ No
Difficulty Seeing	____ Yes	____ No
Seizures (convulsions)	____ Yes	____ No
Heart Problems	____ Yes	____ No
Other Health Problems (describe on page 2)	____ Yes	____ No

Does your child take daily medication?	____ Yes	____ No
Does your child take emergency medication?	____ Yes	____ No
Has your child ever been hospitalized?	____ Yes	____ No
Has your child had frequent or chronic ear infections?	____ Yes	____ No
Has your child had frequent or chronic Strep throat?	____ Yes	____ No

_____ _____

(Print Name of Parent/Guardian) (Relationship to Student)

_____

(Signature of Parent/Guardian)

TIEGERMAN

Preschool/Elementary School: 100 Glen Cove Avenue, Glen Cove, NY 11542 • (516) 609-2000

STUDENT HEALTH INVENTORY (PAGE 2)

Name of Student: _____

List below any known allergies to insect bites, food, medicines or other substances.
Describe how your child's allergic reactions are handled.

_____

_____

_____

_____

List below any medications your child takes and the reasons for the medication. Include daily and/or emergency medications as well as the frequency and dosage.

_____

_____

_____

_____

Describe any hospitalizations your child has had. Include reasons, outcomes and dates.

_____

_____

_____

_____

Provide any other information about your child's health that is pertinent to his/her well-being in school.

_____

_____

_____

_____

Does your child have any special needs or do you have concerns about your child's development in any area?
If so, please explain.

_____

_____

_____

_____

REQUIRED NYS SCHOOL HEALTH EXAMINATION FORM

TO BE COMPLETED BY PRIVATE HEALTHCARE PROVIDER OR SCHOOL MEDICAL DIRECTOR

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:	Affirmed Name (if applicable):	DOB:
Sex Assigned at Birth: ☐ Female ☐ Male	Gender Identity: ☐ Female ☐ Male ☐ Nonbinary ☐ X	
School:	Grade:	Exam Date:

HEALTH HISTORY

If yes to any diagnoses below, check all that apply and provide additional information.

☐ **Allergies**	Type: ☐ Medication/Treatment Order Attached ☐ Anaphylaxis Care Plan Attached
☐ **Asthma**	☐ Intermittent ☐ Persistent ☐ Other: ☐ Medication/Treatment Order Attached ☐ Asthma Care Plan Attached
☐ **Seizures**	Type: Date of last seizure: ☐ Medication/Treatment Order Attached ☐ Seizure Care Plan Attached
☐ **Diabetes**	Type: ☐ 1 ☐ 2 ☐ Medication/Treatment Order Attached ☐ 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): ☐ < 5th ☐ 5th- 49th ☐ 50th- 84th ☐ 85th- 94th ☐ 95th- 98th ☐ 99th and >

Hyperlipidemia: ☐ Yes ☐ Not Done **Hypertension:** ☐ Yes ☐ Not Done

PHYSICAL EXAMINATION/ASSESSMENT

Height: **Weight:** **BP:** **Pulse:** **Respirations:**

LaboratoryTesting	Positive	Negative	Date	Lead Level Required for PreK & K	Date
TB- PRN	☐	☐		☐ Test Done ☐ Lead Elevated ≥5 µg/dL	
Sickle Cell Screen-PRN	☐	☐			

☐ **System Review Within Normal Limits**

☐ **Abnormal Findings – List Other Pertinent Medical Concerns Below** (e.g., concussion, mental health, one functioning organ)

☐ HEENT	☐ Lymph nodes	☐ Abdomen	☐ Extremities	☐ Speech
☐ Dental	☐ Cardiovascular	☐ Back/Spine/Neck	☐ Skin	☐ Social Emotional
☐ Mental Health	☐ Lungs	☐ Genitourinary	☐ Neurological	☐ Musculoskeletal

☐ Assessment/Abnormalities Noted/Recommendations:	Diagnoses/Problems (list) ICD-10 Code*
☐ Additional Information Attached	*Required only for students with an IEP receiving Medicaid

Name:	Affirmed Name (if applicable):	DOB:

SCREENINGS

Vision & Hearing Screenings Required for PreK or K, 1, 3, 5, 7, & 11

Vision Screening	**With Correction** ☐Yes ☐ No	**Right**	**Left**	**Referral**	**Not Done**
Distance Acuity		20/	20/	☐ Yes	☐
Near Vision Acuity		20/	20/	☐ Yes	☐
Color Perception Screening	☐ Pass ☐ Fail				☐

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.				**Not Done**
Pure Tone Screening	**Right** ☐ Pass ☐ Fail	**Left** ☐ Pass ☐ Fail	**Referral** ☐ Yes	☐

Notes

Scoliosis Screening: Boys grade 9, Girls grades 5 & 7	**Negative**	**Positive**	**Referral**	**Not Done**
	☐	☐	☐ Yes	☐

FOR PARTICIPATION IN PHYSICAL EDUCATION/SPORTS*/PLAYGROUND/WORK

☐ ***Family cardiac history reviewed –** required for Dominick Murray Sudden Cardiac Arrest Prevention Act

☐ **Student may participate in all activities without restrictions.**

<u>If Restrictions Apply</u> – Complete the information below

☐ **Student is restricted from participation in:**

- ☐ **Contact Sports:** Basketball, Competitive Cheerleading, Diving, Downhill Skiing, Field Hockey, Football, Gymnastics, Ice Hockey, Lacrosse, Soccer, and Wrestling.
- ☐ **Limited Contact Sports:** Baseball, Fencing, Softball, and Volleyball.
- ☐ **Non-Contact Sports:** Archery, Badminton, Bowling, Cross-Country, Golf, Riflery, Swimming, Tennis, and Track & Field.
- ☐ **Other Restrictions:**

Developmental Stage for Athletic Placement Process <u>ONLY</u> required for students in Grades 7 & 8 who wish to play at the high school interscholastic sports level **OR** Grades 9-12 who wish to play at the modified interscholastic sports level.

Tanner Stage: ☐ I ☐ II ☐ III ☐ IV ☐ V

☐ **Other Accommodations*:** 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.

MEDICATIONS

☐ Order Form for medication(s) needed at school attached

COMMUNICABLE DISEASE	**IMMUNIZATIONS**
☐ Confirmed free of communicable disease during exam	☐ Record Attached ☐ Reported in NYSIIS

HEALTHCARE PROVIDER

Healthcare Provider Signature:	
Provider Name: *(please print)*	
Provider Address:	
Phone:	Fax:

Please Return This Form to Your Child's School Health Office When Completed.

TIEGERMAN

Preschool/Elementary School: 100 Glen Cove Avenue, Glen Cove, NY 11542 • (516) 609-2000

CHECKLIST FOR REGISTRATION

Please note that the student will not be allowed to attend school without proof of the below mentioned documents.

- ☐ **Application**
- ☐ **Birth Certificate**
- ☐ **Immunization Record**

  Prepared by a physician or authorized person who administers the immunizing agent and shall specify the vaccines given and the dates of administration
- ☐ **Health Examination Form**

  To be completed by a licensed physician (See attached Tiegerman Health Examination form)
- ☐ **Custody Papers**

  Necessary if the child does not live with both biological parents.
- ☐ **Parent or Guardian Photo Identification**

  Driver's license