TIEGERMAN

Preschool at Far Rockaway, 264 Beach 19th Street, Far Rockaway, NY 11691 • (718) 868-2961

\

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?_____

Do you feel your child has any special needs? If so, please explain: _____

_____

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 Preschool at Far Rockaway
264 Beach 19th Street
Far Rockaway, NY 11691
Attention: Christine Poblete
Phone: (718) 868-2961 Ext. 1451
Fax: (718) 868-2015

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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: _____

Resident Type: □ Lease □ Own □ Rent □ Trailer Park/Condo Unit □ Unknown

Proof of Residency: □ Mortgage Statement □ Property Tax Bill □ Real Estate Statement □ Utility Bill □ Lease
□ Landlord Verification Form □ Other: _____

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EMERGENCY CONTACT INFORMATION – OTHER THAN PARENT/GUARDIAN

Name of Child: _____
(Last) (First) (Middle)

Name of Emergency Contact: _____

Relationship to Student: _____

Resides in Same Household?: □ Yes □ No

If different household:

Address: _____ City: _____ State: _____ Zip _____

Phone 1: _____ □ Cell □ Home □ Office

Phone 2: _____ □ Cell □ Home □ Office

Name of Emergency Contact: _____

Relationship to Student: _____

Resides in Same Household?: □ Yes □ No

If different household:

Address: _____ City: _____ State: _____ Zip _____

Phone 1: _____ □ Cell □ Home □ Office

Phone 2: _____ □ Cell □ Home □ Office

OTHER CHILDREN RESIDING IN THE HOUSEHOLD

Name of Child: _____ DOB: _____ Enrolled in School?: □ Yes □ No
Name of School (if enrolled): _____

Name of Child: _____ DOB: _____ Enrolled in School?: □ Yes □ No
Name of School (if enrolled): _____

Name of Child: _____ DOB: _____ Enrolled in School?: □ Yes □ No
Name of School (if enrolled): _____

Guardian Warnings?: □ No □ Yes (please explain): _____

Custody Papers?: □ No □ Yes (please explain): _____

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EMERGENCY CONTACT INFORMATION – PARENTS/GUARDIANS WHO LIVE IN THE SAME HOUSEHOLD AS THE CHILD(REN)

Name of Child: _____
(Last) (First) (Middle)

Name of Parent/Guardian: _____

Relationship to Student: _____ Legal Custody?: □ Yes □ No

Phone 1: _____ □ Cell □ Home □ Office

Phone 2: _____ □ Cell □ Home □ Office

Email Address: _____

Employer's Name: _____

Employer's Address: _____
(City) (State) (Zip)

Name of Parent/Guardian: _____

Relationship to Student: _____ Legal Custody?: □ Yes □ No

Phone 1: _____ □ Cell □ Home □ Office

Phone 2: _____ □ Cell □ Home □ Office

Email Address: _____

Employer's Name: _____

Employer's Address: _____
(City) (State) (Zip)

INFORMATION TO BE COMPLETED FOR A PARENT/GUARDIAN WHO DOES NOT LIVE IN THE SAME HOUSEHOLD AS THE CHILD(REN)

Name of Parent/Guardian: _____

Relationship to Student: _____ Legal Custody?: □ Yes □ No

Address: _____

Phone 1: _____ □ Cell □ Home □ Office

Phone 2: _____ □ Cell □ Home □ Office

Email Address: _____

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LANDLORD VERIFICATION FORM

Date: _____

RE: Student's Name: _____ DOB: _____

This is to verify that _____
(Name of Tenant)

is a month to month tenant residing at the following location:

_____

_____

Landlord's Signature: _____

Name and Address: _____

_____

Phone Number: _____

Sworn to before me this _____ day
of _____ 20 _____

State of:

County of:

_____
Notary Public

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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)

If you answered "Yes" to any of the above questions, COMPLETE PAGE 2

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STUDENT HEALTH INVENTORY (PAGE 2)

Complete this page if applicable

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.

_____

_____

_____

_____

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

CHECKLIST FOR REGISTRATION

☐ **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 Health Examination form)

☐ **Custody Papers**

Necessary if the child does not live with both biological parents

☐ **Parent or Guardian Photo Identification**

Driver's license

☐ **District Residency**

One of the following proofs of residency can be provided:

A. Owns Home

1. Most recent utility bill (one only) – electric, phone, water bill

   *Must have name and property/residence address

B. Rents Home

1. Lease agreement - Must have name and property/residence address
2. Parent's name must appear on lease
3. Most recent utility bill (one only) – electric, phone, water bill

   *Must have name and property/residence address

C. Landlord Verification form – *Must be notarized*

1. To be completed by the landlord in instances where there is no lease
2. If you are living with a relative, that person must complete the form and also provide you with a bill (electric, phone, water) showing their name and property/residence address

NOTE: The following will not be accepted as proof of residency: driver's license, checkbook, rent receipt, car insurance cards, bank statement

NYC Health | Department of Health and Mental Hygiene | Department of Education

CHILD & ADOLESCENT HEALTH EXAMINATION FORM

Please Print Clearly

NYC ID (OSIS) ☐☐☐☐☐☐☐☐☐

TO BE COMPLETED BY THE PARENT OR GUARDIAN

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

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
Explain all checked items above.

☐ Seizure disorder
☐ Speech, hearing, or visual impairment
☐ Tuberculosis *(latent infection or disease)*
☐ Hospitalization
☐ Surgery
☐ Other (specify) _____
☐ ***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? ☐ 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 *(at each well child exam, 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 ☐

Report only positive immunity:

IMMUNIZATIONS – DATES

DTP/DTaP/DT	___/___/___	___/___/___	___/___/___	___/___/___	___/___/___	___/___/___	___/___/___	___/___/___	
Td	___/___/___	___/___/___	___/___/___	___/___/___	___/___/___	___/___/___	___/___/___		
Polio	___/___/___	___/___/___	___/___/___	___/___/___	___/___/___	___/17/2023			
Hep B	___/___/___	___/___/___	___/___/___	___/___/___	___/___/___	___/___/___			
Hib	___/___/___	___/___/___	___/___/___	___/___/___	___/___/___	___/___/___			
PCV	___/___/___	___/___/___	___/___/___	___/___/___	___/___/___	___/___/___			
Influenza	___/___/___	___/___/___	___/___/___	___/___/___	___/___/___	___/___/___			
HPV	___/___/___	___/___/___	___/___/___	___/___/___	___/___/___	___/___/___			

Tdap	___/___/___	___/___/___							
MMR	___/___/___	___/___/___							
Varicella	___/___/___	___/___/___							
Mening ACWY	___/___/___	___/___/___							
Hep A	___/___/___	___/___/___							
Rotavirus	___/___/___	___/___/___							
Mening B	___/___/___	___/___/___							
Other _____	___/___/___	_____	___/___/___						

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 ___ / ___ / ___

DOHMH ONLY PRACTITIONER I.D. ☐☐☐☐☐☐☐

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

TYPE OF EXAM: ☐ NAE Current ☐ NAE Prior Year(s)
Comments:

Date Reviewed: ___ / ___ / ___ **I.D. NUMBER** ☐☐☐☐☐☐☐
REVIEWER:

FORM ID# ☐☐☐☐☐☐☐☐☐☐