



TIEGERMAN

TEACHING THE EXTRAORDINARY

EXPERTS IN LANGUAGE AND COMMUNICATION DEVELOPMENT

Father's Name: _____

Address (if different from page 1): _____

Email Address: _____ Cell #: _____

Occupation and Title: _____ Employer: _____

Employer Address: _____ Telephone: _____

College(s) attended _____ Degree/Date: _____

Secondary School: _____ Degree/Date: _____

Mother's Name: _____

Address (if Different from Page 1): _____

Email Address: _____ Cell#: _____

Occupation and Title: _____ Employer: _____

Employer Address: _____ Phone #: _____

College(s) attended _____ Degree/ Date: _____

Secondary School: _____ Degree/Date: _____

Please check all that apply:

_____ Father or Mother deceased _____ Parents separated _____ Parents divorced

_____ Single parent _____ Child is adopted _____ Other

If parents are separated or divorced:

a) Who is the child's legal guardian? _____

b) To whom should we send correspondence? _____

Child lives with (check all that apply): _____ Father _____ Mother _____ Stepfather _____ Stepmother

Other- relationship _____



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Names of Sisters and Brothers:

Age:

Present school/occupation

_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

If there are additional members in the household other than parents and siblings, what is their relationship to the applicant? _____

Primary Language of the child: _____

Primary Language spoken in the home: _____

Applicant's district: _____

District contact person & contact information:

Name of applicant's current school:

Previous school(s): _____

What grade will your child be entering in September? _____

Has your child been retained? _____ If yes, in what grade and why? _____

Has your child ever been suspended from school? _____

If yes, when and why? _____

Describe your child's school experience:



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Please check all that apply:

Has your child been under the care or received any of the following professional services/evaluations?

Audiologist	_____	Psychologist	_____
Speech/Language Pathologist	_____	Occupational Therapist	_____
Otolaryngologist (ENT)	_____	Physical Therapist	_____
Neurologist	_____	Psychiatrist	_____
Neuropsychologist	_____	Ophthalmologist	_____

Other: _____

Why was your child seen? _____

Health:

Please check yes or no to the following health conditions:

	YES	NO		YES	NO
1. Anemia	_____	_____	10. Endocrine/hormonal	_____	_____
2. Allergies	_____	_____	11. Hyperactivity	_____	_____
3. Asthma	_____	_____	12. Sleeping Problems	_____	_____
4. Fainting	_____	_____	13. Vision Problems	_____	_____
5. Epilepsy	_____	_____	14. Wears Glasses	_____	_____
6. Convulsions	_____	_____	15. Hearing Problems	_____	_____
7. Migraine Headaches	_____	_____	16. Uses Hearing Device	_____	_____
8. Heart Problems	_____	_____	17. Physical Problems	_____	_____
9. Kidney Problems	_____	_____	18. Uses Orthopedic Device	_____	_____

Other: _____



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Current Medications:

Medication:

Dosage:

How long has your child used medication(s)? _____

Does your child have any limitations or health problem of which the school should be aware of:

What do you believe are your child's greatest strengths? _____

What do you believe are your child's greatest challenges? _____

Please comment briefly on your reasons for wanting to attend Tiegerman:

Please initial: This allows Tiegerman to send future emails concerning our school. _____