

TIEGERMAN

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

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



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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.



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, Child's Address, City/Borough, State, Zip Code, School/Center/Camp Name, District Number, Phone Numbers, Health insurance, Parent/Guardian Last Name, First Name, Email, Cell, Work.

TO BE COMPLETED BY THE HEALTH CARE PRACTITIONER

Birth history, Allergies, Attach MAF if in-school medications needed, Does the child/adolescent have a past or present medical history of the following?, Medications (attach MAF if in-school medication needed).

PHYSICAL EXAM, Date of Exam, General Appearance, Describe abnormalities.

DEVELOPMENTAL (Age 0-6 yrs), Validated Screening Tool Used?, Screening Results, Nutrition, Hearing, Date Done, Results.

Describe Suspected Delay or Concern, SCREENING TESTS, Blood Lead Level (BLL), Lead Risk Assessment, Vision, Acuity, Screened with Glasses?, Strabismus?, Dental.

Child Receives EI/CPSE/CSE services, Hemoglobin or Hematocrit, Visible Tooth Decay, Urgent need for dental referral, Dental Visit within the past 12 months.

CIR Number, Physician Confirmed History of Varicella Infection, Report only positive immunity.

IMMUNIZATIONS - DATES, DTP/DTaP/DT, Td, Polio, Hep B, Hib, PCV, Influenza, HPV, 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, Referral(s), Other.

Health Care Practitioner Signature, Date Form Completed, DOHMH ONLY PRACTITIONER I.D., Health Care Practitioner Name and Degree, Practitioner License No. and State, TYPE OF EXAM, Facility Name, National Provider Identifier (NPI), Date Reviewed, I.D. NUMBER, Address, City, State, Zip, REVIEWER, Telephone, Fax, Email, FORM ID#.

TIEGERMAN EMERGENCY PHONE LIST

Please identify 3 people who would be able to pick up your child during school hours in the event of an EMERGENCY. These individuals would be called if the school is **unable to reach the parent/guardian**. If an Emergency Contact person is called to pick up the child, that person must present identification before the school can release your child into their care.

In the event you must request an unauthorized(not listed) individual to pick up your child, the request must be in writing, and presented to the school before the individual can pick up your child. Photo I.D. must be presented upon arrival at Tiegerman. All information is kept on file in the nurse's office, the business office and in the computer system.

Parents/Guardians are required to update all contact/emergency information yearly, or if there is a change of contact information.

Date _____ Signed _____

Student Name: _____ DOB: _____ CLASS: _____

Address: _____ Home Phone: _____

PARENT/GUARDIAN INFO: Main Contact

Father/Guardian: _____	Address if different from Child: _____ _____ _____
Home Phone: _____	
Work Phone: _____	
Cell Phone: _____	
E-mail address: _____	

PARENT/GUARDIAN INFO: Main Contact

Mother/Guardian: _____	Address if different from Child: _____ _____ _____
Home Phone: _____	
Work Phone: _____	
Cell Phone: _____	
E-mail address: _____	

TO BE CALLED IN EMERGENCY ONLY (please print):

Relationship: Name: Address: Contact Phone #:

1: _____

2: _____

3: _____

Doctor: _____ Phone: _____

TIEGERMAN Health Information Release Form

This form allows the providers designated below to share medical information concerning your child with TIEGERMAN. This information will be used to allow health care collaboration to maintain student safety, provide care, or create/modify programming. Please sign and return this form to your school nurse.

AUTHORIZATION FOR USE OR DISCLOSURE OF PROTECTED HEALTH INFORMATION

I, _____ authorize my child's healthcare provider(s) **listed below**
(Parent/Guardian Name)

to share medical information of my child, _____, with the district's Physician, School Nurse, Occupational Therapist (OT), Physical Therapist (PT), Speech Therapist (ST), School Counselor, Psychologist, or the following individuals:

List Health Care Providers (Physician, Dentist, Mental Health Care Provider)

Name _____	Phone _____	FAX _____
Name _____	Phone _____	FAX _____
Name _____	Phone _____	FAX _____
Name _____	Phone _____	FAX _____

The healthcare provider may disclose the following protected health information: (check all that apply)

- Immunizations
- Health Appraisals
- Past/Current Medical Condition and Impact on Attendance, Care at school or School Programming
- All of the above
- Other _____

The Protected Health Information may be used, disclosed or received for the following purpose(s): (check all that apply)

- To develop care or therapy plans for routine and emergent school management
- To assess the impact of the medical condition(s) on school programming and/or attendance in order to design appropriate educational programs
- To share school observations/concerns surrounding behavior
- To assess a medical basis for modification of transportation and/or home tutoring
- Medication delivery or therapy prescriptions
- All of the above
- Other _____

Please note:

This authorization shall expire on my child's last date of enrollment at _____ **TIEGERMAN** _____.

- I acknowledge that I have the right to revoke this authorization at any time by sending written notification to the Privacy Officer at my healthcare provider's office and to the District Administration Building.
- I understand that the revocation of this authorization is not effective if the Healthcare Provider or District has used the authorization for disclosure of the Protected Health Information before receiving my written revocation notice.
- I understand that any Protected Health Information disclosed as a result of this Authorization to anyone not covered by the state and federal privacy laws and regulations may be subject to re-disclosure and may no longer be protected by federal or state law.
- I understand that my child's treatment is not dependent on my agreement to release or withhold information.

Signature of Patient (Over 18), Parent, or Guardian Date _____ Relationship _____

YOU MAY REFUSE TO SIGN THIS AUTHORIZATION



TIEGERMAN

TEACHING THE EXTRAORDINARY

EXPERTS IN LANGUAGE AND COMMUNICATION DEVELOPMENT

To Be Completed By Parent/Guardian

Student Name: _____

I request the school nurse give the medication listed on this plan; or after the nurse determines my child can take their own medications; trained staff may assist my child to take their own medications. I will provide the medication in the original pharmacy or over the counter container. This plan will be shared with school staff caring for my child.

X _____
Parent/Guardian Name

X _____
Parent/Guardian Signature

X _____
Date

To Be Completed By Health Care Provider-Valid for 1 Year

Diagnosis _____

Medication _____

Dose _____ Route _____ Time(s) _____

Note: Medication will be given as close to the prescribed time as possible, but may be given up to one hour before or after the prescribed time. Please advise if there is a time-specific concern regarding administration.

As per New York State Law, all medication, including **Over-the-Counter medication, needs parental and physician authorization to be administered at school.** The following standard Over-the-Counter Medications will be available in the Health Office. Only medications that are checked yes and determined to be necessary will be administered at the discretion of a registered nurse. Administration of these medications will be as per label instructions unless otherwise indicated by your physician.

Acetaminophen	_____ yes	_____ no	Ibuprofen	_____ yes	_____ no
Benadryl/Zyrtec	_____ yes	_____ no	Cortisone cream	_____ yes	_____ no
Antibiotic cream	_____ yes	_____ no	Vaseline	_____ yes	_____ no

X _____
Name/Title of Prescriber (Please Print)

X _____
Prescriber's Signature

X _____
Date

X _____
Prescriber's Email

X _____
Prescriber's Phone

X _____
Date



TIEGERMAN

TEACHING THE EXTRAORDINARY

EXPERTS IN LANGUAGE AND COMMUNICATION DEVELOPMENT

MEDICAL PROCEDURE FORM*

If it is decided that a child who is attending TIEGERMAN is in need of emergency treatment at a hospital, the following procedure will be followed:

- Parent(s)/Guardian(s) will be notified immediately. If the parent(s)/guardian(s) cannot be reached, an emergency contact will be notified. In the event parent(s)/guardian(s) and emergency contacts cannot be reached, your child, where necessary, will be transported to the nearest medical facility. A parent liaison and/or administrator will accompany the student.
- If your child attends the **Glen Cove Preschool/Elementary School**, Glen Cove Police/EMS will be called. The 1st Precinct has stated that the ambulance will take the child to the nearest hospital, which is Northwell Hospital at Glen Cove.
- If your child attends the **Glen Cove Middle School**, **Glen Cove Police/EMS** will be called. The 1st Precinct has stated that the ambulance will take the child to the nearest hospital, which is Northwell Hospital at Glen Cove.
- If your child attends the **Richmond Hill School**, 911 will be called. The ambulance will take the child to the nearest hospital, which for this location is Jamaica Medical Center.
- If your child attends the **Woodside School**, 911 will be called. The ambulance will take the child to the nearest hospital, which for this location is Elmhurst Hospital.
- If your child attends the **Far Rockaway School**, 911 will be called. The ambulance will take the child to the nearest hospital, which for this location is St. John's Episcopal Hospital.
- If your child attends the **Tiegerman Preschool at St. Catherine's in Franklin Square**, 911 will be called. The ambulance will take the child to the nearest hospital, which for this location is Long Island Jewish Valley Stream.

Child's name

Signature of Parent or Guardian

Date

*This release will remain in place for the duration of your child's enrollment at TIEGERMAN.
2026-2027



PHOTO/VIDEO/MEDIA RELEASE

From time to time, Tiegerman (FKA School for Language and Communication Development) takes pictures or records videos of students and their families participating in Tiegerman programs, using its facilities, or attending one of its special events. Additionally, Tiegerman may permit members of the media (the "Media") to take such pictures or record such videos in order to promote Tiegerman's mission and for other journalistic purposes. The individual named below signing this release for the purposes of allowing Tiegerman and the media to use one or more such photographs, video recordings, and/or sound recordings (collectively, "Recordings") of such person for any purpose consistent with Tiegerman's mission, which includes, but is not limited to, Tiegerman or the media publishing such recordings in newspapers, on web sites, on social media channels and any print or electronic publications, on television, or on the radio. By signing this Release, such person acknowledges that he or she has freely consented to be photographed, filmed, or otherwise recorded and has signed this Release of his or her own free will. If the person named below is under age 18, a parent or guardian of such person must sign on such person's behalf.

1. I agree that I am willing to have me/my child photographed, filmed, or otherwise recorded by Tiegerman, its contractors, and the Media, either individually or as part of a group recording, which may include my/my child's image, likeness, and/or voice. I further agree that my/my child's first name may be used to identify me/my child as a subject of any Recordings featuring my/my child's image, likeness, and/or voice.
2. I understand that Tiegerman will own all rights in the Recordings of me/my child that Tiegerman or a contractor takes or records ("Tiegerman Recordings"), and that Tiegerman will have the exclusive right to use, or allow others to use, such Tiegerman Recordings in any medium for any purpose consistent with Tiegerman's charitable mission as determined by Tiegerman.
3. I understand that the Media will own all rights in the Recordings of me/my child that the Media takes or records ("Media Recordings"), and that the Media will have the exclusive right to use, or allow others to use, such Media Recordings in any medium for any lawful purpose.
4. I understand that I am waiving any and all rights that may preclude Tiegerman's or the Media's use of the Recordings as described above.
5. I acknowledge that neither Tiegerman nor the Media has any obligation to use any Recordings of me or to use such Recordings for any particular purpose.
6. I understand that I will receive no monetary payment or other compensation in exchange for the rights to use Recordings of me/my child.

Child's Name (printed)	Parent / Guardian Signature
Name of Parent / Guardian (printed)	Date

*This agreement will remain in effect for the duration of this student's enrollment at Tiegerman.



TIEGERMAN

TEACHING THE EXTRAORDINARY

EXPERTS IN LANGUAGE AND COMMUNICATION DEVELOPMENT

ALLERGY & MEDICATION FORM*

Name: _____ Sex: _____ Date of Birth: _____

My child, _____ Grade: _____

(Complete name)

has the following allergies (medication, food, etc.), diet restriction, etc.:

My child does NOT have any allergies _____ (check here and sign below).

Please indicate any medication that is prescribed to your child.

Daily med taken
at school:

Daily med taken
at home:

PRN med:

Please provide a 3-day supply of medication in case of a widespread emergency.

Thank you.

_____ X _____
Date Parent or Guardian Signature

*** Please note, this form must be submitted annually. 2026-2027**



**NEW YORK STATE EDUCATION DEPARTMENT
Emergent Multilingual Learners Language Profile for
Prekindergarten Studentsⁱ**

*Dear Parent or Guardian,
Thank you for completing the Emergent Multilingual Learners Language Profile. This survey will assist your new school with valuable information about your child's experience with languages. Information gathered will assist Prekindergarten educators in delivering academically and linguistically relevant instruction that strengthens the language and literacy of all students.*

THIS SECTION TO BE COMPLETED BY ENROLLMENT OR SCHOOL PERSONNEL ONLY AND MAINTAINED ON FILE
Date Profile Completed:
Student Name:
Gender:
Date of Birth:
District or Community Based Organization Name:
Student ID (if applicable):
Name of Person Administering Profile:
Title:

Parent or Person in Parental Relation Information

Name of parent or person in parental relation:

Relationship (to student) of person providing information for this profile: mother father other _____

In what language(s) would you like to receive information from the school? English other home language:

Language in the Home

1. In what language(s) do you (parents or guardians) speak to your child at home?

2. What is/are the primary language(s) of each parent/guardian in your home? (List all that apply.)

3. Is there a caretaker in the home? yes no

If yes, what language(s) does the caretaker speak most frequently?

4. What language(s) does your child understand?

5. In what language(s) does your child speak with other people?

6. Does your child have siblings? yes no

If yes, in what language(s) do the children speak with each other most of the time?

7a. At what age did your child begin to speak in short sentences?

In what language?

7b. At what age did your child begin to speak in full sentences?

In what language?

8. In what language does your child pretend play?

9. How has your child learned English so far (television shows, siblings, childcare, etc.)?

Language Outside the Home/Family

10. Has your child attended any nursery, Head Start or childcare program? yes no

If yes, in what language was the program conducted?

In what language does your child interact with other people in the nursery or childcare setting?

11. How would you describe your child's language use with friends?

Language Goals

12. What are your language goals for your child? For example, do you want child to become proficient in more than one language?

13. Have you exposed your child to more than one language to ensure that he or she is bilingual or multilingual? yes no

14. Does your child need to speak a language other than English in order to communicate with your relatives or extended family?

yes no

If yes, in what language(s)?

Emergent Literacy

15. Does your child have books at home or does he or she read books from the library?

In what language(s) are these books read to him or her?

16a. Can your child name any letters or sounds in English? yes no

16b. Can your child recognize letters or symbols in another language? yes no

<p>If yes, in what language(s)?</p>
<p>17a. Does your child pretend to read? <input type="checkbox"/> yes <input type="checkbox"/> no <input type="checkbox"/> unsure</p> <p>If yes, in what language(s)?</p> <p>17b. Does your child pretend to write? <input type="checkbox"/> yes <input type="checkbox"/> no <input type="checkbox"/> unsure</p> <p>If yes, in what language(s)?</p>
<p>18. Does your child tell the stories from his/her favorite books or videos? <input type="checkbox"/> yes <input type="checkbox"/> no</p> <p>If yes, in what language(s)?</p>
<p>19. Does your child's childcare or nursery program describe goals for his or her learning? <input type="checkbox"/> yes <input type="checkbox"/> no</p> <p>If so, what goals do they describe?</p>
<p>20. Please describe anything special you did to prepare your child to begin Prekindergarten.</p>

ⁱ For more information contact: the New York State Education Department Office of Early Learning at (518) 474-5807 or email OEL@nysed.gov or the New York State Education Department Office of Bilingual Education and World Languages at (518) 474-8775 or (718) 722-2445 or email OBEWL@nysed.gov.