



# 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 1<sup>st</sup> 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: Miriam Christodoulou  
Phone: (516) 609-2000 Ext. 200  
Fax: (516) 609-2014  
Email: [mchristodoulou@tiegerman.org](mailto:mchristodoulou@tiegerman.org)



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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

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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: \_\_\_\_\_



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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)



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## 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.

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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.

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

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

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

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# 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: <input type="checkbox"/> Female <input type="checkbox"/> Male	Gender Identity: <input type="checkbox"/> Female <input type="checkbox"/> Male <input type="checkbox"/> Nonbinary <input type="checkbox"/> X	
School:	Grade:	Exam Date:

## HEALTH HISTORY

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

<input type="checkbox"/> <b>Allergies</b>	Type: <input type="checkbox"/> Medication/Treatment Order Attached <input type="checkbox"/> Anaphylaxis Care Plan Attached
<input type="checkbox"/> <b>Asthma</b>	<input type="checkbox"/> Intermittent <input type="checkbox"/> Persistent <input type="checkbox"/> Other: <input type="checkbox"/> Medication/Treatment Order Attached <input type="checkbox"/> Asthma Care Plan Attached
<input type="checkbox"/> <b>Seizures</b>	Type: <span style="float: right;">Date of last seizure:</span> <input type="checkbox"/> Medication/Treatment Order Attached <input type="checkbox"/> Seizure Care Plan Attached
<input type="checkbox"/> <b>Diabetes</b>	Type: <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> Medication/Treatment Order Attached <input type="checkbox"/> 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/m<sup>2</sup>

**Percentile (Weight Status Category):**     < 5<sup>th</sup>     5<sup>th</sup>- 49<sup>th</sup>     50<sup>th</sup>- 84<sup>th</sup>     85<sup>th</sup>- 94<sup>th</sup>     95<sup>th</sup>- 98<sup>th</sup>     99<sup>th</sup> and >

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

## PHYSICAL EXAMINATION/ASSESSMENT

Height:	Weight:	BP:	Pulse:	Respirations:
<b>Laboratory Testing</b>	<b>Positive</b>	<b>Negative</b>	<b>Date</b>	<b>Lead Level Required for PreK &amp; K</b>
TB- PRN	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/> Test Done <input type="checkbox"/> Lead Elevated $\geq 5$ $\mu\text{g/dL}$
Sickle Cell Screen-PRN	<input type="checkbox"/>	<input type="checkbox"/>		

**System Review Within Normal Limits**

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

<input type="checkbox"/> HEENT	<input type="checkbox"/> Lymph nodes	<input type="checkbox"/> Abdomen	<input type="checkbox"/> Extremities	<input type="checkbox"/> Speech
<input type="checkbox"/> Dental	<input type="checkbox"/> Cardiovascular	<input type="checkbox"/> Back/Spine/Neck	<input type="checkbox"/> Skin	<input type="checkbox"/> Social Emotional
<input type="checkbox"/> Mental Health	<input type="checkbox"/> Lungs	<input type="checkbox"/> Genitourinary	<input type="checkbox"/> Neurological	<input type="checkbox"/> Musculoskeletal

<input type="checkbox"/> Assessment/Abnormalities Noted/Recommendations:	Diagnoses/Problems (list) <span style="float: right;">ICD-10 Code*</span>
<input type="checkbox"/> Additional Information Attached	*Required only for students with an IEP receiving Medicaid

Name:	Affirmed Name (if applicable):	DOB:
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**SCREENINGS**

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

Vision Screening	With Correction <input type="checkbox"/> Yes <input type="checkbox"/> No	Right	Left	Referral	Not Done
Distance Acuity		20/	20/	<input type="checkbox"/> Yes	<input type="checkbox"/>
Near Vision Acuity		20/	20/	<input type="checkbox"/> Yes	<input type="checkbox"/>
Color Perception Screening	<input type="checkbox"/> Pass <input type="checkbox"/> Fail				<input type="checkbox"/>

Notes

<b>Hearing Screening:</b> 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.	<b>Not Done</b>
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Pure Tone Screening	Right <input type="checkbox"/> Pass <input type="checkbox"/> Fail	Left <input type="checkbox"/> Pass <input type="checkbox"/> Fail	Referral <input type="checkbox"/> Yes	<input type="checkbox"/>
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Notes

Scoliosis Screening: Boys grade 9, Girls grades 5 & 7	<b>Negative</b>	<b>Positive</b>	<b>Referral</b>	<b>Not Done</b>
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Yes	<input type="checkbox"/>

**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.**

**If Restrictions Apply** – 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 ONLY 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
<input type="checkbox"/> Confirmed free of communicable disease during exam	<input type="checkbox"/> Record Attached <input type="checkbox"/> Reported in NYSIS

**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.**

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## 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

