



KINGS BAY Y (MAIN SITE)
AFTER SCHOOL ACADEMY 2025-2026

3495 NOSTRAND AVENUE
TEL: 718-648-7703 FAX: 718-648-0758

Date: ____ / ____ / ____

School Name: _____

Dear Teacher,

I have enrolled my child _____, class _____ in the Kings Bay Y After School Academy for the 2025-2026 school year.

He/She will be picked up by an After School Counselor on the following days (Circle all days that apply):

Monday

Tuesday

Wednesday

Thursday

Friday

The start date for my child is: ____ / ____ / ____.

Please allow my child to be dismissed to the Kings Bay Y After School Academy staff at the time of dismissal.

If you have any questions about the program, please contact Kings Bay Y After School Academy office at (718) 648-7703 ext. 0.

Thank you,

Parent/Guardian Name: _____ Contact Number: _____

Parent/Guardian Signature: _____ Date: _____

CHILD & ADOLESCENT HEALTH EXAMINATION FORM NYC DEPARTMENT OF HEALTH & MENTAL HYGIENE — DEPARTMENT OF EDUCATION					Please Print Clearly		NYC ID (OSIS)																													
TO BE COMPLETED BY THE PARENT OR GUARDIAN																																				
Child's Last Name					First Name				Middle Name				Sex <input type="checkbox"/> Female <input type="checkbox"/> Male		Date of Birth (Month/Day/Year) ____/____/____																					
Child's Address							Hispanic/Latino? <input type="checkbox"/> Yes <input type="checkbox"/> No		Race (Check ALL that apply) <input type="checkbox"/> American Indian <input type="checkbox"/> Asian <input type="checkbox"/> Black <input type="checkbox"/> White <input type="checkbox"/> Native Hawaiian/Pacific Islander <input type="checkbox"/> Other _____																											
City/Borough				State		Zip Code		School/Center/Camp Name				District Number ____		Phone Numbers Home _____ Cell _____ Work _____																						
Health insurance <input type="checkbox"/> Yes (including Medicaid)? <input type="checkbox"/> No		<input type="checkbox"/> Parent/Guardian <input type="checkbox"/> Foster Parent		Last Name				First Name				Email																								
TO BE COMPLETED BY THE HEALTH CARE PRACTITIONER																																				
Birth history (age 0-6 yrs) <input type="checkbox"/> Uncomplicated <input type="checkbox"/> Premature: _____ weeks gestation <input type="checkbox"/> Complicated by _____					Does the child/adolescent have a past or present medical history of the following? <input type="checkbox"/> Asthma (check severity and attach MAF): If persistent, check all current medication(s): Asthma Control Status <input type="checkbox"/> Anaphylaxis <input type="checkbox"/> Behavioral/mental health disorder <input type="checkbox"/> Congenital or acquired heart disorder <input type="checkbox"/> Developmental/learning problem <input type="checkbox"/> Diabetes (attach MAF) <input type="checkbox"/> Orthopedic injury/disability Explain all checked items above. <input type="checkbox"/> Intermittent <input type="checkbox"/> Quick Relief Medication <input type="checkbox"/> Well-controlled <input type="checkbox"/> Seizure disorder <input type="checkbox"/> Speech, hearing, or visual impairment <input type="checkbox"/> Tuberculosis (latent infection or disease) <input type="checkbox"/> Hospitalization <input type="checkbox"/> Surgery <input type="checkbox"/> Other (specify) _____ Addendum attached. <input type="checkbox"/> Mild Persistent <input type="checkbox"/> Inhaled Corticosteroid <input type="checkbox"/> Poorly Controlled or Not Controlled <input type="checkbox"/> Moderate Persistent <input type="checkbox"/> Oral Steroid <input type="checkbox"/> Other Controller <input type="checkbox"/> None Medications (attach MAF if in-school medication needed) <input type="checkbox"/> None <input type="checkbox"/> Yes (list below) _____ _____ _____																															
Allergies <input type="checkbox"/> None <input type="checkbox"/> Epi pen prescribed <input type="checkbox"/> Drugs (list) _____ <input type="checkbox"/> Foods (list) _____ <input type="checkbox"/> Other (list) _____																																				
Attach MAF if in-school medications needed																																				
PHYSICAL EXAM Date of Exam: ____/____/____					General Appearance: <input type="checkbox"/> Physical Exam WNL <table><tr><td>Ni Abnl</td><td>Ni Abnl</td><td>Ni Abnl</td><td>Ni Abnl</td><td>Ni Abnl</td></tr><tr><td><input type="checkbox"/> Psychosocial Development</td><td><input type="checkbox"/> HEENT</td><td><input type="checkbox"/> Lymph nodes</td><td><input type="checkbox"/> Abdomen</td><td><input type="checkbox"/> Skin</td></tr><tr><td><input type="checkbox"/> Language</td><td><input type="checkbox"/> Dental</td><td><input type="checkbox"/> Lungs</td><td><input type="checkbox"/> Genitourinary</td><td><input type="checkbox"/> Neurological</td></tr><tr><td><input type="checkbox"/> Behavioral</td><td><input type="checkbox"/> Neck</td><td><input type="checkbox"/> Cardiovascular</td><td><input type="checkbox"/> Extremities</td><td><input type="checkbox"/> Back/spine</td></tr></table>												Ni Abnl	Ni Abnl	Ni Abnl	Ni Abnl	Ni Abnl	<input type="checkbox"/> Psychosocial Development	<input type="checkbox"/> HEENT	<input type="checkbox"/> Lymph nodes	<input type="checkbox"/> Abdomen	<input type="checkbox"/> Skin	<input type="checkbox"/> Language	<input type="checkbox"/> Dental	<input type="checkbox"/> Lungs	<input type="checkbox"/> Genitourinary	<input type="checkbox"/> Neurological	<input type="checkbox"/> Behavioral	<input type="checkbox"/> Neck	<input type="checkbox"/> Cardiovascular	<input type="checkbox"/> Extremities	<input type="checkbox"/> Back/spine
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Height _____ cm (____ %ile) Weight _____ kg (____ %ile) BMI _____ kg/m ² (____ %ile) Head Circumference (age ≤2 yrs) _____ cm (____ %ile) Blood Pressure (age ≥3 yrs) _____ / _____					Describe abnormalities: _____ _____ _____																															
DEVELOPMENTAL (age 0-6 yrs) Validated Screening Tool Used? _____ Date Screened ____/____/____ <input type="checkbox"/> Yes <input type="checkbox"/> No Screening Results: <input type="checkbox"/> WNL <input type="checkbox"/> Delay or Concern Suspected/Confirmed (specify area(s) below): <input type="checkbox"/> Cognitive/Problem Solving <input type="checkbox"/> Adaptive/Self-Help <input type="checkbox"/> Communication/Language <input type="checkbox"/> Gross Motor/Fine Motor <input type="checkbox"/> Social-Emotional or Personal-Social <input type="checkbox"/> Other Area of Concern: _____					Nutrition < 1 year <input type="checkbox"/> Breastfed <input type="checkbox"/> Formula <input type="checkbox"/> Both ≥ 1 year <input type="checkbox"/> Well-balanced <input type="checkbox"/> Needs guidance <input type="checkbox"/> Counseled <input type="checkbox"/> Referred Dietary Restrictions <input type="checkbox"/> None <input type="checkbox"/> Yes (list below) _____ _____					Hearing Date Done Results < 4 years: gross hearing ____/____/____ <input type="checkbox"/> NI <input type="checkbox"/> Abnl <input type="checkbox"/> Referred OAE ____/____/____ <input type="checkbox"/> NI <input type="checkbox"/> Abnl <input type="checkbox"/> Referred ≥ 4 yrs: pure tone audiometry ____/____/____ <input type="checkbox"/> NI <input type="checkbox"/> Abnl <input type="checkbox"/> Referred																										
Describe Suspected Delay or Concern: _____					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					Vision Date Done Results <3 years: Vision appears: ____/____/____ <input type="checkbox"/> NI <input type="checkbox"/> Abnl Acuity (required for new entrants and children age 3-7 years) ____/____/____ Right ____/____/____ Left ____/____/____ <input type="checkbox"/> Unable to test Screened with Glasses? <input type="checkbox"/> Yes <input type="checkbox"/> No Strabismus? <input type="checkbox"/> Yes <input type="checkbox"/> No																										
					Lead Risk Assessment (annually, age 6 mo-6 yrs) ____/____/____ <input type="checkbox"/> At risk (do BLL) <input type="checkbox"/> Not at risk					Dental Visible Tooth Decay <input type="checkbox"/> Yes <input type="checkbox"/> No Urgent need for dental referral (pain, swelling, infection) <input type="checkbox"/> Yes <input type="checkbox"/> No Dental Visit within the past 12 months <input type="checkbox"/> Yes <input type="checkbox"/> No																										
Child Receives EI/CPSE/CSE services <input type="checkbox"/> Yes <input type="checkbox"/> No					Child Care Only																															
CIR Number _____					Physician Confirmed History of Varicella Infection <input type="checkbox"/>					Report only positive immunity: <table><tr><td>IgG Titers</td><td>Date</td></tr><tr><td>Hepatitis B</td><td>____/____/____</td></tr><tr><td>Measles</td><td>____/____/____</td></tr><tr><td>Mumps</td><td>____/____/____</td></tr><tr><td>Rubella</td><td>____/____/____</td></tr><tr><td>Varicella</td><td>____/____/____</td></tr><tr><td>Polio 1</td><td>____/____/____</td></tr><tr><td>Polio 2</td><td>____/____/____</td></tr><tr><td>Polio 3</td><td>____/____/____</td></tr></table>							IgG Titers	Date	Hepatitis B	____/____/____	Measles	____/____/____	Mumps	____/____/____	Rubella	____/____/____	Varicella	____/____/____	Polio 1	____/____/____	Polio 2	____/____/____	Polio 3	____/____/____		
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DTP/DTaP/DT _____ Tdap _____																																				
Td _____ MMR _____																																				
Polio _____ Varicella _____																																				
Hep B _____ Mening ACWY _____																																				
Hib _____ Hep A _____																																				
PCV _____ Rotavirus _____																																				
Influenza _____ Mening B _____																																				
HPV _____ Other _____																																				
ASSESSMENT <input type="checkbox"/> Well Child (Z00.129) <input type="checkbox"/> Diagnoses/Problems (list) _____ ICD-10 Code _____					RECOMMENDATIONS <input type="checkbox"/> Full physical activity <input type="checkbox"/> Restrictions (specify) _____ Follow-up Needed <input type="checkbox"/> No <input type="checkbox"/> Yes, for _____ Appt. date: ____/____/____ Referral(s): <input type="checkbox"/> None <input type="checkbox"/> Early Intervention <input type="checkbox"/> IEP <input type="checkbox"/> Dental <input type="checkbox"/> Vision <input type="checkbox"/> 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					TYPE OF EXAM: <input type="checkbox"/> NAE Current <input type="checkbox"/> NAE Prior Year(s) Comments: _____																										
Facility Name					National Provider Identifier (NPI)					Date Reviewed: ____/____/____ I.D. NUMBER _____																										
Address					City State Zip					REVIEWER: _____																										
Telephone					Fax					Email					FORM ID# _____																					

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