

KINGS BAY Y KOCHAVIM AFTER SCHOOL ACADEMY 2025-2026

LA	ST NAME:	STUDENT INF	RETIMATION_		GENDER: _				
DA	TE OF BIRTH:		_ AGE:	_GRADE: _	SCHOOL:				
HC	OME ADDRESS:		CITY: _		_ STATE: ZI	P CODE:			
HC	OW DID YOU HEAR A	ABOUT US?							
			PARENT INF	ORMATIO	N				
LA	ST NAME:	FIRS	ST NAME:		RELATIONSHIP):			
PL	ACE OF EMPLOYMI	ENT:		occi	JPATION:				
HC	OME PHONE:	C	ELL PHONE:		WORK PHO	NE:			
ΕN	MAIL ADDRESS:								
LA	ST NAME:	FIRS	ST NAME:		RELATIONSHIP):			
PL	ACE OF EMPLOYM	ENT:		occi	JPATION:				
HC	OME PHONE:	C	ELL PHONE:		WORK PHOI	NE:			
ΕN	IAIL ADDRESS:								
	PROGRAM HOURS: DISMISSAL UNTIL 6:00 PM, MONDAY TO FRIDAY								
	5 DAYS	4 Days	3 Da		2 Days	1 Day			
	\$685 PER MONTH	\$655 PER MON	TH \$600 PER	MONTH	\$575 PER MONTH	\$485 PER MONTH			
E	EXTENDED HOURS (UI	NTIL 7 PM): \$65/	1 DAY \$75/2 DA	YS \$90/3	DAYS \$100/4 DAYS	\$110/5 DAYS HRA/ACD			
					JBMIT YOUR APPLICATIO	N WITHOUT A DEPOSIT.			
	*Program rates a	re \$55.00 per cla	ss for those util	zing Self [Direction Funding.				
		т	ELL US ABOU ¹	r your c	HILD				
DO	ES YOUR CHILD HAVE				E (ST, SEIT, OT, PT, ABA	A, ETC.)? YES NO IF			
ΥE	S, PLEASE EXPLAIN:								
* PI	lease submit a copy of their	most recent Individualiz	red Education Program	ı (IEP) to deter	mine if our program fits your	child. Upon receiving			
			_		person interview with you a				
	_	•							
LIS'	I ANY ALLERGIES YOUR	CHILD HAS:				•			
ı ıs	T ANY DIETARY RESTRIC	TIONS YOUR CHILD H	AS:						

3495 NOSTRAND AVENUE, BROOKLYN, NY 11229

TEL. 718-648-7703 FAX. 718-648-0758 TERMS OF ENROLLMENT

STAFF SIGNATURE AND TITLE:	DATE:
SIGNATURE:	DATE:
NAME OF CHILD:	PARENT/GUARDIAN NAME:
I have read and acknowledge the above	e statement and agree to accept all the above terms.
	e subject to change prior to and during the school year.
	resulting from the pictures taken on, before, or after the date of this communication. I
•	ays for the purpose of promoting interest in the Kings Bay Y programming. I release the
hereby give permission to the Kings Bay YM	-YWHA, Inc. to take photographs of me and/or my child to be shown in videos,
in the activities (including all forms of transpo	ortation) or the rendering of emergency medical procedures or treatment, if any. I
known or unknown, directly or indirectly, for participation	any losses, damages or injuries arising out of, during, or in connection with the child's
	sibling, the child, or any other person, firm or corporation may have or claim to have
	nd representatives thereof, as well as activity supervisors, from and against any claim
I release and waive, and further agree to in	ndemnify, hold harmless, or reimburse the Kings Bay Y After School Program and the
procedure or operation, to give treatment, an	nd to administer anesthetic to my child, as deemed necessary.
	ght (and whomever they may designate as their assistants) to perform any emergency
	tion that the family will be notified as soon as possible. I hereby authorize the doctor or
	e any decision and take any action to arrange for such procedures or treatments at the
	iiu. I treatment or procedures during the activities, I hereby consent to and authorize the
any liability arising out of any injury to my chi	
	and aquatics, provided by Kings Bay YM-YWHA, Inc. I fully understand and recognize Kings Bay YM-YWHA, Inc. and any of its sponsors, benefactors, and employees from
	arent\guardian(s) of the child and hereby consent to the child's participation in all
remainder will then be applied toward current in	
	fault, will apply for the payment first to the oldest unpaid invoice with the Kings Bay Y. Any
4. There are no refunds or transfers for days misse	
3. Kings Bay YM-YWHA, Inc. is not responsible for	
·	can only attend with valid, completed Medical and Emergency Authorization forms.
2. A standard Department of Health Medical Form	MUST be submitted before the program start. Medical Forms MUST be dated within one
11. Children will be charged a \$1.00 per minute rat	te for late pick-ups past the 6:00 pm dismissal time (7:00 pm for registered late stay).
with less than 24 hours' notice) is \$90.00 daily. Plea	ase note that you must notify our office of any pick-up changes by 11:00 am.
	75.00 per day for those registered for 1-4 days per month 10. Daily Drop-In Rate
 Payment is due by the first of the month. Any pay payments will result in your child not being pick 	ments received on or after the first of the month will incur a \$100.00 late fee. Late
. Mini Camp dates are separate from the After Sch	
6. Any applicable early bird registration discounts wi	
i. Previous pricing and discounts will not apply to ar	ny pauses or cancellations in enrollment
	the month.
 An increase in days will result in an increase of the first of all autopay billing will be completed on the first of 	e non-refundable June deposit, with the balance due immediately
	t be transferred to other months or outside programs
·	d June is due upon registration. June payment will be a non-refundable deposit to secure
	will remain unchanged regardless of the number of school days listed.
i. Tuition accounts for the full school year (Septen	nder to June) and <u>does not</u> include any school closings or hait-days listed by the

Kings Bay YM-YWHA does not discriminate any person on the basis of race, color, religion, sex, gender identity or expression, sexual orientation, national origin, age, disability, marital status, family status or any other characteristic protected by Federal and State laws. Kings Bay YM-YWHA will make reasonable accommodations in compliance with the Americans with Disabilities Act of 1990. To file a complaint of discrimination, write Office for Civil Rights, U.S. DHHS 26 Federal Plaza - Suite 3313 New York, NY 10278 (212) 264-3313; (212) 264-2355 (TDD); (212) 264-3039 FAX In accordance with Federal law and U.S. Department of Agriculture policy, this institution is prohibited from discriminating on the basis of race, color, national origin, sex, age or disability. To file a complaint of discrimination, write USDA, Director, Office of Civil Rights, 1400 Independence Avenue, S.W., Washington, D.C. 20250-9410, or call (866) 632-9992 (voice) or (800) 877-8339 (TDD). USDA is an equal opportunity provider and employer.



KINGS BAY Y

AFTER SCHOOL ACADEMY 2025-2026

3495 NOSTRAND AVENUE

TEL: 718-648-7703 FAX: 718-648-0758

Dear Parents and Guardians,

We are asking our families to please all adults authorized to pick up your child from the program.

Please note those individuals not listed on the authorized pick-up list attempting to sign out a child will not be permitted to do so until proper channels are followed. NO Exception will be made for the safety of our students.

Proper identification (Federal or State Issued) is required for all student pick-ups and will be checked thoroughly.

Thank you,

Authorized Adult #1: Authorized Adult #4:

Kings Bay Y After School Administration

Full Name: Contact Number: Relationship:	Relationship:
Full Name:	Authorized Adult #2: Authorized Adult #5: Full Name: Contact Number:
Contact Number:Relationship:	Relationship:
	Authorized Adult #3: Authorized Adult #6: Full Name:
Full Name:	Contact Number:
Contact Number:	Relationship:
Relationship:	
	e above statement and authorize the listed individuals to take my child e care of the Kings Bay Y After School Program.
Child's Name:	Grade:
Parent/Guardian Name:	Contact Number:
Parent/Guardian Signature:	Date:



KINGS BAY Y AFTER SCHOOL ACADEMY 2025-2026

3495 NOSTRAND AVENUE

TEL: 718-648-7703 FAX: 718-648-0758

)ate:		School Name:				
	Dear Teacher,					
	I have enrolled my	child	, class		_ in the Kings Bay Y After	
	School Academy fo	r the 2023-2024 school ye	ear.			
le/She will l	be picked up by an Af	ter School Counselor on t	he following days (C	ircle all days that a	apply):	
londay, Tu	esday, Wednesday, [.]	Thursday, and Friday.				
he start da	te for my child is:	//	<u>.</u> .			
Please allow	my child to be dismis	ssed to the Kings Bay Y A	fter School Academy	y staff at the time o	of dismissal.	
	If you have any qu 648-7703 ext. 0.	estions about the progran	n, please contact Kin	ngs Bay Y After Scl	hool Academy office at (718)
	Thank you,					
	Parent/Guardian N	ame:		Contact Number: _		
	Parent/Guardian Si	gnature:		Date:		

TO BE COMPLETED BY THE PARENT OR GUARDIAN Child's Last Name First Name Middle Name Sex M Female M Male Child's Address Hispanic/L atino? M Yes M No Race (Check ALL that apply) M American Indian M Asian M Black M White M Native Hawaiian/Pacific Islander M Other	CHILD & ADOLE NYC DEPARTMENT OF EDUCATION		Please NYC ID (OSIS)										
Child's Address Hispanic/L atino? M Race (Check ALL that apply) M American Indian M Asian M Black M White M Native Hawaiian/Pacific Islander M Other	TO BE COMPLETED	BY THE PARENT											
atino? M White M Native Hawaiian/Pacific Islander M Other	Child's Last Name		Middle Name	,	Female M					n/Day/Y	'ear)		
	Child's Address				atino? M						ack M	I	
City/Borough State Zip Code School/Center/Camp Name District _ Phone Numbers Home Home	City/Borough	School/Ce	nter/Camp Na	ne		Numbe		Phone					
Health insurance M Yes (including Medicaid)? M No Health insurance M Yes (including M Parent/Guardian M Foster Parent M Foster Parent Health insurance M M Parent/Guardian M Foster Parent Health insurance M M Parent/Guardian M Foster Parent Health insurance M M Parent/Guardian M Foster Parent	Yes (including M Parent/Guardian					Email	•			_		-	

Birth history (age 0-6 yrs)	Does the child/adolescent have a past or present medical history of the following?								
M Uncomplicated M Premature: weeks gestation M Complicated by	M Asthma (check severity and attach MAF): M Intermittent M Mild Persistent M Moderate Persistent M Severe Persistent If persistent, check all current medication(s): M Quick Relief Medication M Inhaled Corticosteroid M Oral Steroid M Other Controller M None Asthma Control Status M Well-controlled M Poorly Controlled or Not Controlled								
Allergies M None M Epi pen prescribed M Drugs (list) M Foods M Other Attach MAF if in-school medications needed	M Anaphylaxis M Seizu M Behavioral/mental he impairment M Congeni (latent infection or disease) Hospitalization M Diabetes (attach MAF M Orthopedic injury/dis Explain all checked its	orculosis below)							
PHYSICAL EXAM Date of Exam://	General Appearance:								
Height cm (%ile) Weight kg (%ile) BMI kg/m² (%ile) Head Circumference (age ≤2 yrs) cm (M M Psychosocial Development M M Language M M Behavioral	M M Dental M M Lungs M M Gen Cardiovascular M M Extremities N	HEENT M M Lymph nodes M M Abdomen M M Skin nitourinary M M Neurological M M Neck M M M M Back/spine						
%ile) Blood Pressure (age ≥3 yrs) / /	Describe abnormalitie	es:							
DEVELOPMENTAL (age 0-6 yrs) Validated Screening Tool Used? Date Screened M Yes M No// Screening Results: M WNL M Delay or Concern Suspected/Confirmed (specify area(s) below):		M Formula M Both ced M Needs guidance M Dietary Restrictions M None M	Hearing Date Done Results < 4 years: gross hearing // MN/ MAbn/ MReferre OAE ≥ 4 yrs: pure tone audiometry// MN/ MAbn/ MReferred						
M Cognitive/Problem Solving M Adaptive/Self-Help M Communication/Language M Gross Motor/Fine Motor M Other Area of	SCREENING TESTS	Date Done Results	Vision Date Do Abnl	one Results <3 years: Vision appears: N/ M					
M Social-Emotional or Personal-Social	Blood Lead Level (BLL) (required at age 1 yr and 2 yrs and for those at risk)	µg/dL // µg/dL	Acuity (require	Right/ ed for new entrants Left/ ige 3-7 years) M Unable to test					
Describe Suspected Delay or Concern:	Lead Risk Assessment (annually, age 6 mo-6 yrs)	Screened with Strabismus?							

				Dental				
	c	child Care Only ——		Visible M Tooth Decay				
Child Receives El/CPSE/CSE services M Yes M No	Hemoglobin or Hematocrit	/	g/dL 	Urgent ne denta	(pain, swelling, infection) M Yes M t within the past 12 months M Yes M No			

IMMUNIZATIONS - DATES		CIR Nu	mber Physician Confirmed History of Vari	cella Infec	tion I	Repo	rt only	/ posi	tive im	munity: IgG Ti				
DTP/DTaP/DT			//////Hep A Rotavirus///////	/	/_ / Ir /_	/_ Meni /_ ifluen /_	ng		epatiti Measl Mum Rube Varice Polic Polic	s B es ps Illa Illa 1	lers			
ASSESSMENT Well Child (Z00.129) Dia	agnoses/Problems (list) ICD-10 Code	REC	RECOMMENDATIONS Full physical activity											
	No I	estrictions (specify)/ Widely Yes, for/ Midely Dental Midely Wision Midely Other/	Appt. Date	e:	/				(s): M N	lone M				
Health Care Practitioner Signature			Date Form Completed//		I D	F TI								
Health Care Practitioner Name and Degree	Practitio	ner License No. and State	TYPE OF EXAM: NAE Current NAE Prior Yea					Year(s)						
Facility Name			National Provider Identifier (NPI)											
Address City State Zip														
Telephone Fax			Email											
				FORM ID#										