



**KINGS BAY Y (MAIN SITE)**  
**AFTER SCHOOL (INCLUSION) ACADEMY 2022-2023**  
**3495 NOSTRAND AVENUE**  
**(718) 648-7703**

**STUDENT INFORMATION**

LAST NAME: \_\_\_\_\_ FIRST NAME: \_\_\_\_\_ GENDER: \_\_\_\_\_  
 DATE OF BIRTH: \_\_\_\_/\_\_\_\_/\_\_\_\_ AGE: \_\_\_\_\_ GRADE: \_\_\_\_\_ SCHOOL: \_\_\_\_\_  
 ADDRESS: \_\_\_\_\_ CITY: \_\_\_\_\_ STATE: \_\_\_\_\_ ZIP: \_\_\_\_\_  
 HOW DID YOU HEAR ABOUT US? \_\_\_\_\_

**PARENT/GUARDIAN #1 INFORMATION**

LAST NAME: \_\_\_\_\_ FIRST NAME: \_\_\_\_\_ RELATIONSHIP: \_\_\_\_\_  
 PLACE OF EMPLOYMENT: \_\_\_\_\_ OCCUPATION: \_\_\_\_\_  
 CELL PHONE: \_\_\_\_\_ WORK PHONE: \_\_\_\_\_  
 EMAIL ADDRESS: \_\_\_\_\_

**PARENT/GUARDIAN #2 INFORMATION**

LAST NAME: \_\_\_\_\_ FIRST NAME: \_\_\_\_\_ RELATIONSHIP: \_\_\_\_\_  
 PLACE OF EMPLOYMENT: \_\_\_\_\_ OCCUPATION: \_\_\_\_\_  
 CELL PHONE: \_\_\_\_\_ WORK PHONE: \_\_\_\_\_  
 EMAIL ADDRESS: \_\_\_\_\_

**SCHEDULING & PAYMENT OPTIONS**

**PROGRAM DATES: SEPTEMBER 8 – JUNE 23, 2023**

**PROGRAM HOURS: DISMISSAL UNTIL 6:00 PM, MONDAY TO FRIDAY**

<b>5 DAYS</b>	<b>1-4 DAYS</b>
<b>\$675</b>	<b>\$55 PER DAY</b>

EXTENDED HOURS (UNTIL 7 PM): \_\_ \$65/1 DAY \_\_ \$75/2 DAYS \_\_ \$90/3 DAYS \_\_ \$100/4 DAYS \_\_ \$110/5 DAYS

**SELF-DIRECTION/OPWDD FUNDING IS ACCEPTED. IF THIS APPLIES TO YOU, CHECK HERE \_\_\_\_\_ AND SUBMIT YOUR APPLICATION WITHOUT A DEPOSIT.**

## TELL US ABOUT YOUR CHILD

LIST ANY ALLERGIES YOUR CHILD HAS:

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LIST ANY DIETARY RESTRICTIONS YOUR CHILD HAS:

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DOES YOUR CHILD HAVE AN IEP OR RECEIVE ANY ADDITIONAL SERVICE (ST, SEIT, OT, PT, ABA, ETC.)? YES NO

IF YES, PLEASE EXPLAIN: \_\_\_\_\_

## TERMS OF ENROLLMENT

PLEASE READ THE FOLLOWING TERMS CAREFULLY AND INITIAL TO INDICATE YOUR UNDERSTANDING AND ACCEPTANCE OF THE TERMS SET FORTH BELOW.

1. TUITION ACCOUNTS FOR THE FULL SCHOOL YEAR (SEPTEMBER TO JUNE) AND DOES NOT INCLUDE ANY SCHOOL CLOSINGS LISTED BY THE DEPARTMENT OF EDUCATION. MONTHLY AMOUNT WILL REMAIN THE SAME REGARDLESS OF NUMBER OF SCHOOL DAYS LISTED IN THE MONTH. \_\_\_\_\_ (INITIAL HERE)
2. PAYMENT FOR FIRST MONTH YOUR CHILD ATTENDS AND JUNE DUE UPON REGISTRATION. \_\_\_\_\_ (INITIAL HERE)
3. ADDITIONAL DAYS CAN BE ADDED 24 HOURS PRIOR FOR \$30/DAY FOR THOSE REGISTERED FOR 1-4 DAYS PER MONTH. \_\_\_\_\_ (INITIAL HERE)
4. DAILY DROP-IN RATE IS \$50/DAY. PLEASE NOTE YOU MUST NOTIFY OUR OFFICE BY 10:00 AM. \_\_\_\_\_ (INITIAL HERE)
5. A MEDICAL FORM MUST BE COMPLETED (VALID WITHIN ONE YEAR) AND SUBMITTED PRIOR TO THE START OF THE PROGRAM. \_\_\_\_\_ (INITIAL HERE)
6. KINGS BAY YM-YWHA, INC. IS NOT RESPONSIBLE FOR DAMAGE TO OR LOSS OF PERSONAL PROPERTY. \_\_\_\_\_ (INITIAL HERE)
7. NO REFUNDS OR TRANSFERS WILL BE ISSUED FOR DAYS MISSED OR CANCELLED. \_\_\_\_\_ (INITIAL HERE)

I hereby attest that I am (we are) the legal parent\guardian(s) of the child and hereby consent to the child's participation in all programs, trips, and activities, both general and aquatics, provided by Kings Bay YM-YWHA, Inc. I fully understand and recognize the risks involved and I hereby release the Kings Bay YM-YWHA, Inc. and any of its sponsors, benefactors, and employees from any liability arising out of any injury to my child.

If my child requires any emergency medical treatment or procedures during the activities, I hereby consent to and authorize the Kings Bay Y After School Program to make any decision and take any action to arrange for such procedures or treatments at the discretion of the supervisor(s) with the intention that the family will be notified as soon as possible. I hereby authorize the doctor or the hospital to which my child may be brought (and whomever they may designate as their assistants) to perform any emergency procedure or operation, to give treatment, and to administer anesthetic to my child, as deemed necessary.

I release and waive, and further agree to indemnify, hold harmless or reimburse the Kings Bay Y After School Program and the individual members, agents, employees, and representatives thereof, as well as activity supervisors, from and against, any claim which I, any other parent or guardian, any sibling, the child, or any other person, firm or corporation may have or claim to have, known or unknown, directly or indirectly, for any losses, damages or injuries arising out of, during, or in connection with the child's participation in the activities (including all forms of transportation) or the rendering of emergency medical procedures or treatment, if any.

I hereby give permission to the Kings Bay YM-YWHA, Inc. to take photographs of me and/or my child to be shown in videos, brochures, advertisements, or internet displays for the purpose of promoting interest in the Kings Bay Y programming. I release the Kings Bay YM-YWHA, Inc. from any claims resulting from the pictures taken on, before, or after the date of this communication. I understand that itineraries and programs are subject to change prior to and during the school year.

**I HAVE CAREFULLY READ THE CONTRACT AND AGREE TO ACCEPT ALL TERMS SET FORTH ABOVE.**

NAME OF CHILD: \_\_\_\_\_ DATE: \_\_\_\_\_

PARENT/GUARDIAN NAME: \_\_\_\_\_ SIGNATURE: \_\_\_\_\_

STAFF SIGNATURE AND TITLE: \_\_\_\_\_ DATE: \_\_\_\_\_

Kings Bay YM-YWHA is an equal opportunity employer and does not discriminate any person based on 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, 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)



**KINGS BAY Y (MAIN SITE)  
AFTER SCHOOL ACADEMY 2022-2023**

**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,

Kings Bay Y After School Administration

**Authorized Adult #1:**

Full Name: \_\_\_\_\_

Contact Number: \_\_\_\_\_

Relationship: \_\_\_\_\_

**Authorized Adult #4:**

Full Name: \_\_\_\_\_

Contact Number: \_\_\_\_\_

Relationship: \_\_\_\_\_

**Authorized Adult #2:**

Full Name: \_\_\_\_\_

Contact Number: \_\_\_\_\_

Relationship: \_\_\_\_\_

**Authorized Adult #5:**

Full Name: \_\_\_\_\_

Contact Number: \_\_\_\_\_

Relationship: \_\_\_\_\_

**Authorized Adult #3:**

Full Name: \_\_\_\_\_

Contact Number: \_\_\_\_\_

Relationship: \_\_\_\_\_

**Authorized Adult #6:**

Full Name: \_\_\_\_\_

Contact Number: \_\_\_\_\_

Relationship: \_\_\_\_\_

**I have read and acknowledge the above statement and authorize the listed individuals to take my child out of the care of the Kings Bay Y After School Program.**

Child's Name: \_\_\_\_\_ Grade: \_\_\_\_\_

Parent/Guardian Name: \_\_\_\_\_ Contact Number: \_\_\_\_\_

Parent/Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_



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**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 2022-2023 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: \_\_\_\_\_ 1 \_\_\_\_\_ 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 (including Medicaid)? <input type="checkbox"/> Yes <input type="checkbox"/> No	Parent/Guardian Last Name		First Name		Email			
<input type="checkbox"/> Foster Parent								

## TO BE COMPLETED BY THE HEALTH CARE PRACTITIONER

<b>Birth history (age 0-6 yrs)</b> <input type="checkbox"/> Uncomplicated <input type="checkbox"/> Premature: _____ weeks gestation <input type="checkbox"/> Complicated by _____		<b>Does the child/adolescent have a past or present medical history of the following?</b> <input type="checkbox"/> Asthma (check severity and attach MAF): <input type="checkbox"/> Intermittent <input type="checkbox"/> Mild Persistent <input type="checkbox"/> Moderate Persistent <input type="checkbox"/> Severe Persistent If persistent, check all current medication(s): <input type="checkbox"/> Quick Relief Medication <input type="checkbox"/> Inhaled Corticosteroid <input type="checkbox"/> Oral Steroid <input type="checkbox"/> Other Controller <input type="checkbox"/> None <input type="checkbox"/> Asthma Control Status <input type="checkbox"/> Well-controlled <input type="checkbox"/> Poorly Controlled or Not Controlled					
<b>Allergies</b> <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) _____		<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 <b>Explain all checked items above.</b>			<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) _____ <b>Addendum attached.</b>		
<b>Attach MAF if in-school medications needed</b>		<b>Medications (attach MAF if in-school medication needed)</b> <input type="checkbox"/> None <input type="checkbox"/> Yes (list below)					

<b>PHYSICAL EXAM</b> Date of Exam: ____/____/____		<b>General Appearance:</b> <input type="checkbox"/> Physical Exam WNL 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					
Height _____ cm (____ %ile)	Weight _____ kg (____ %ile)	BMI _____ kg/m <sup>2</sup> (____ %ile)	Head Circumference (age ≤2 yrs) _____ cm (____ %ile)	Blood Pressure (age ≥3 yrs) _____ / _____		Describe abnormalities:	

<b>DEVELOPMENTAL (age 0-6 yrs)</b> 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: _____		<b>Nutrition</b> <input type="checkbox"/> < 1 year <input type="checkbox"/> Breastfed <input type="checkbox"/> Formula <input type="checkbox"/> Both <input type="checkbox"/> ≥ 1 year <input type="checkbox"/> Well-balanced <input type="checkbox"/> Needs guidance <input type="checkbox"/> Counseled <input type="checkbox"/> Referred <b>Dietary Restrictions</b> <input type="checkbox"/> None <input type="checkbox"/> Yes (list below)		<b>Hearing</b> 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:		<b>SCREENING TESTS</b> Date Done Results <b>Blood Lead Level (BLL)</b> (required at age 1 yr and 2 yrs and for those at risk) _____ μg/dL _____ μg/dL		<b>Vision</b> Date Done Results <3 years: Vision appears: ____/____/____ <input type="checkbox"/> NI <input type="checkbox"/> Abnl <b>Acuity (required for new entrants and children age 3-7 years)</b> Right ____/____/____ Left ____/____/____ <input type="checkbox"/> Unable to test	
Child Receives EI/CPSE/CSE services <input type="checkbox"/> Yes <input type="checkbox"/> No		<b>Lead Risk Assessment</b> (annually, age 6 mo-6 yrs) _____ <input type="checkbox"/> At risk (do BLL) _____ <input type="checkbox"/> Not at risk		<b>Dental</b> Screened with Glasses? _____ <input type="checkbox"/> Yes <input type="checkbox"/> No Strabismus? _____ <input type="checkbox"/> Yes <input type="checkbox"/> No 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	

CIR Number		Physician Confirmed History of Varicella Infection <input type="checkbox"/>		Report only positive immunity:	
<b>IMMUNIZATIONS - DATES</b>				IgG Titers	Date
DTP/DTaP/DT	Tdap	Hepatitis B			
Td	MMR	Measles			
Polio	Varicella	Mumps			
Hep B	Mening ACWY	Rubella			
Hib	Hep A	Varicella			
PCV	Rotavirus	Polio 1			
Influenza	Mening B	Polio 2			
HPV	Other	Polio 3			

<b>ASSESSMENT</b> <input type="checkbox"/> Well Child (Z00.129) <input type="checkbox"/> Diagnoses/Problems (list) _____ ICD-10 Code _____	<b>RECOMMENDATIONS</b> <input type="checkbox"/> Full physical activity <input type="checkbox"/> Restrictions (specify) _____ <b>Follow-up Needed</b> <input type="checkbox"/> No <input type="checkbox"/> Yes, for _____ Appt. date: ____/____/____ <b>Referral(s):</b> <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 _____
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Health Care Practitioner Signature	Date Form Completed	<b>DOHMH ONLY</b> PRACTITIONER I.D. _____
Health Care Practitioner Name and Degree (print)	Practitioner License No. and State	<b>TYPE OF EXAM:</b> <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
Telephone	Fax	Email
FORM ID#		_____