



# KINGS BAY Y KOCHAVIM AFTER SCHOOL ACADEMY 2026-2027

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

## PARENT INFORMATION

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

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

## SCHEDULING & PAYMENT OPTIONS

PROGRAM DATES: September 10th, 2026 – June 28th, 2027

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

5 DAYS	4 Days	3 Days	2 Days	1 Day
\$685 PER MONTH	\$655 PER MONTH	\$600 PER MONTH	\$575 PER MONTH	\$485 PER MONTH

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

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

**\*Program rates are \$55.00 per class for those utilizing Self Direction Funding.**

## TELL US ABOUT YOUR CHILD

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

\_\_\_\_\_

**\* Please submit a copy of their most recent Individualized Education Program (IEP) to determine if our program fits your child. Upon receiving and evaluating the IEP, our staff will contact you for follow-up questions or to schedule an in-person interview with you and your child.**

**LIST ANY ALLERGIES YOUR CHILD HAS:** \_\_\_\_\_

**LIST ANY DIETARY RESTRICTIONS YOUR CHILD HAS:** \_\_\_\_\_

3495 NOSTRAND AVENUE, BROOKLYN, NY 11229

TEL. 718-648-7703 FAX. 718-648-0758

**TERMS OF ENROLLMENT**

1. Tuition accounts for the **full school year (September to June)** and **does not** include any school closings or half-days listed by the Department of Education. The monthly amount will remain unchanged regardless of the number of school days listed. \_\_\_\_\_
2. Payment for the first month your child attends and June is due upon registration. June payment will be a non-refundable deposit to secure your child's spot for the school year and cannot be transferred to other months or outside programs. \_\_\_\_\_
3. An increase in days will result in an increase of the non-refundable June deposit, with the balance due immediately. \_\_\_\_\_
4. All autopay billing will be completed on the first of the month. \_\_\_\_\_
5. Previous pricing and discounts will not apply to any pauses or cancellations in enrollment. \_\_\_\_\_
6. Any applicable early bird registration discounts will only apply to the first month your child attends. \_\_\_\_\_
7. Mini Camp dates are separate from the After School tuition. \_\_\_\_\_
8. Payment is due by the first of the month. Any payments received **on or after** the first of the month will incur a \$100.00 late fee. Late payments will result in your child not being picked up on their designated days. \_\_\_\_\_
9. Additional days can be added 24 hours prior for \$75.00 per day for those registered for 1-4 days per month. \_\_\_\_\_ 10. Daily Drop-In Rate (with less than 24 hours' notice) is \$90.00 daily. Please note that you must notify our office of any pick-up changes by 11:00 am. \_\_\_\_\_
11. Children will be charged a **\$1.00 per minute rate for late pick-ups** past the 6:00 pm dismissal time (**7:00 pm for registered late stay**). \_\_\_\_\_
12. A standard Department of Health Medical Form **MUST** be submitted before the program start. Medical Forms **MUST** be dated within one year from your child's start date to be valid. Children can only attend with valid, completed Medical and Emergency Authorization forms. \_\_\_\_\_
13. Kings Bay YM-YWHA, Inc. is not responsible for damage to or loss of personal property. \_\_\_\_\_
14. There are no refunds or transfers for days missed or canceled. \_\_\_\_\_
15. When a payment is received, the system, by default, will apply for the payment first to the oldest unpaid invoice with the Kings Bay Y. Any remainder will then be applied toward current invoices. \_\_\_\_\_

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 read and acknowledge the above statement and agree to accept all the above terms.**

NAME OF CHILD: \_\_\_\_\_ PARENT/GUARDIAN NAME: \_\_\_\_\_

SIGNATURE: \_\_\_\_\_ DATE: \_\_\_\_\_

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

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 2026-2027

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: Authorized Adult #4:**

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

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

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

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

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

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

**Authorized Adult #2: Authorized Adult #5:**

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

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

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

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

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

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

**Authorized Adult #3: Authorized Adult #6:**

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

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

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

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: \_\_\_\_\_



**KINGS BAY Y**  
**AFTER SCHOOL ACADEMY 2026-2027**

**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 2026-2027 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, and 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 FROM  
NYC DEPARTMENT OF HEALTH & MENTAL HYGIENE — DEPARTMENT OF  
EDUCATION**

Please  
Print  
Clearly

**NYC ID  
(OSIS)**

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**TO BE COMPLETED BY THE PARENT OR GUARDIAN**

<b>Child's Last Name</b>		<b>First Name</b>		<b>Middle Name</b>		<b>Sex</b> M Female M Male	<b>Date of Birth</b> (Month/Day/Year) ____ / ____ / ____		
<b>Child's Address</b>				<b>Hispanic/Latino?</b> M Yes M No		<b>Race</b> (Check ALL that apply) M American Indian M Asian M Black M White M Native Hawaiian/Pacific Islander M Other			
<b>City/Borough</b>		<b>State</b>	<b>Zip Code</b>	<b>School/Center/Camp Name</b>			<b>District</b> ____ <b>Number</b> ____	<b>Phone Numbers</b> Home _____	
<b>Health insurance</b> M Yes (including Medicaid)? M No	<b>Last Name First Name</b> M Parent/Guardian M Foster Parent			<b>Email</b>			<b>Cell</b> _____ Work _____		

<b>Birth history</b> (age 0-6 yrs)		<b>Does the child/adolescent have a past or present medical history of the following?</b>			
M Uncomplicated M Premature: ____ weeks gestation M Complicated by _____		M Asthma ( <b>check severity and attach MAF</b> ): 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			
<b>Allergies</b> M None M Epi pen prescribed M _____ Drugs _____ (list) _____ M Foods _____ M Other _____ <b>Attach</b> <b>MAF if in-school medications needed</b>		M Anaphylaxis M Seizure disorder M Behavioral/mental health disorder M Speech, hearing, or visual impairment M Congenital or acquired heart disorder M Tuberculosis (latent infection or disease) M Developmental/learning problem M Hospitalization M Diabetes ( <b>attach MAF</b> ) M Surgery M Orthopedic injury/disability M Other (specify) <b>Explain all checked items above. M Addendum attached.</b>			
<b>PHYSICAL EXAM</b> Date of Exam: ____ / ____ / ____		<b>General Appearance:</b>			
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) _____ / _____		<table border="1"> <tr> <td><i>Ni Abnl</i> M M Psychosocial Development M M Language M M Behavioral</td> <td>M Physical Exam WNL <i>Ni Abnl Ni Abnl Ni Abnl Ni Abnl</i> M M HEENT M M Lymph nodes M M Abdomen M M Skin M M Dental M M Lungs M M Genitourinary M M Neurological M M Neck M M Cardiovascular M M Extremities M M Back/spine</td> </tr> </table>		<i>Ni Abnl</i> M M Psychosocial Development M M Language M M Behavioral	M Physical Exam WNL <i>Ni Abnl Ni Abnl Ni Abnl Ni Abnl</i> M M HEENT M M Lymph nodes M M Abdomen M M Skin M M Dental M M Lungs M M Genitourinary M M Neurological M M Neck M M Cardiovascular M M Extremities M M Back/spine
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<b>DEVELOPMENTAL</b> (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):		<b>Nutrition</b> < 1 year M Breastfed M Formula M Both ≥ 1 year M Well-balanced M Needs guidance M Counseled M Referred <b>Dietary Restrictions</b> M None M Yes (list below)			
M Cognitive/Problem Solving M Adaptive/Self-Help M Communication/Language M Gross Motor/Fine Motor M Other Area of Concern: M Social-Emotional or Personal-Social _____		<b>SCREENING TESTS</b>			
Describe Suspected Delay or Concern:		<b>Blood Lead Level (BLL)</b> (required at age 1 yr and 2 yrs and for those at risk) _____ / ____ / ____ _____ μg/dL _____ / ____ / ____ _____ μg/dL			
		<b>Lead Risk Assessment</b> (annually, age 6 mo-6 yrs) _____ / ____ / ____ M At risk (do BLL) _____ / ____ / ____ M Not at risk			
		<b>Hearing</b> Date Done Results < 4 years: gross hearing ____ / ____ / ____ MNI MAbnl MReferred OAE ____ / ____ / ____ MNI MAbnl MReferred ≥ 4 yrs: pure tone audiometry ____ / ____ / ____ MNI MAbnl MReferred			
		<b>Vision</b> Date Done Results <3 years: Vision appears: <i>Ni M</i> <i>Abnl</i> _____ M _____ / ____ / ____ Right _____ / ____ <b>Acuity (required for new entrants</b> _____ / ____ / ____ Left _____ / ____ <b>and children age 3-7 years)</b> M Unable to test			
		Screened with Glasses? _____ M Yes M No Strabismus? _____ M Yes M No			

