KINGS BAY Y (AVENUE W)
AFTER SCHOOL ACADEMY 2026-2027

3043 AVE W BROOKLYN NY 11229
TEL: (718) 648-7703

STUDENT INFORMATION

LAST NAME: _____ FIRST NAME: _____ GENDER: _____

DATE OF BIRTH: _____/_____/_____ AGE: _____ GRADE: _____ SCHOOL: _____

HOME ADDRESS: _____ CITY: _____ STATE: _____ ZIP: _____

HOW DID YOU HEAR ABOUT US? _____

PARENT/GUARDIAN #1 INFORMATION

LAST NAME: _____ FIRST NAME: _____ RELATIONSHIP: _____

PLACE OF EMPLOYMENT: _____ OCCUPATION: _____

HOME PHONE: _____ CELL PHONE: _____ WORK PHONE: _____

EMAIL ADDRESS: _____

PARENT/GUARDIAN #2 INFORMATION

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
FULL WEEK	M T W TH F (CIRCLE 4 DAYS)	M T W TH F (CIRCLE 3 DAYS)	M T W TH F (CIRCLE 2 DAYS)	M T W TH F (CIRCLE 1 DAY)
$525 PER MONTH	$475 PER MONTH	$440 PER MONTH	$55 PER DAY	$55 PER DAY

EXTENDED HOURS (UNTIL 7 PM): ☐ $70/1 DAY ☐ $80/2 DAYS ☐ $95/3 DAYS ☐ $105/4 DAYS ☐ $115/5 DAYS

HRA/ACD 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:

_____

_____

LIST ANY DIETARY RESTRICTIONS YOUR CHILD HAS:

_____

_____

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 $55/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)

I hereby give permission to the Kings Bay YM-YWHA (KBY) to transfer information from this paper form to an electronic form within the applicable secure online Customer Relationship Management software used and operated by KBY.

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AFTER SCHOOL ACADEMY 2026-2027

3043 AVE W BROOKLYN NY 11229
TEL: (718) 648-7703

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 #2:

Full Name: _____

Contact Number: _____

Relationship: _____

Authorized Adult #3:

Full Name: _____

Contact Number: _____

Relationship: _____

Authorized Adult #4:

Full Name: _____

Contact Number: _____

Relationship: _____

Authorized Adult #5:

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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Date: _____ /_____ /_____ School Name: _____

Dear Teacher,

I have enrolled my child _____, class _____ in the Kings Bay Y After School Academy for the 2026-2026 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: _____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 ☐ Female ☐ Male	Date of Birth *(Month/Day/Year)* ___ ___/___ ___/___ ___ ___ ___

Child's Address	Hispanic/Latino? ☐ Yes ☐ No	Race *(Check ALL that apply)* ☐ American Indian ☐ Asian ☐ Black ☐ White ☐ Native Hawaiian/Pacific Islander ☐ Other ______

City/Borough	State	Zip Code	School/Center/Camp Name	District Number __ __ __	Phone Numbers Home ______ Cell ______ Work ______

Health insurance (including Medicaid)? ☐ Yes ☐ No	☐ Parent/Guardian ☐ Foster Parent	Last Name	First Name	Email

TO BE COMPLETED BY THE HEALTH CARE PRACTITIONER

Birth history *(age 0-6 yrs)*

☐ Uncomplicated ☐ Premature: ______ weeks gestation

☐ Complicated by ______

Allergies ☐ None ☐ Epi pen prescribed

☐ Drugs *(list)* ______

☐ Foods *(list)* ______

☐ Other *(list)* ______

Attach MAF if in-school medications needed

Does the child/adolescent have a past or present medical history of the following?

☐ Asthma ***(check severity and attach MAF)***: ☐ Intermittent ☐ Mild Persistent ☐ Moderate Persistent ☐ Severe Persistent

If persistent, check all current medication(s): ☐ Quick Relief Medication ☐ Inhaled Corticosteroid ☐ Oral Steroid ☐ Other Controller ☐ None

Asthma Control Status ☐ Well-controlled ☐ Poorly Controlled or Not Controlled

☐ Anaphylaxis
☐ Behavioral/mental health disorder
☐ Congenital or acquired heart disorder
☐ Developmental/learning problem
☐ Diabetes ***(attach MAF)***
☐ Orthopedic injury/disability

Explain all checked items above.

☐ Seizure disorder
☐ Speech, hearing, or visual impairment
☐ Tuberculosis *(latent infection or disease)*
☐ Hospitalization
☐ Surgery
☐ Other (specify) ______
☐ ***Addendum attached.***

Medications ***(attach MAF if in-school medication needed)*** ☐ None ☐ Yes *(list below)*

______

PHYSICAL EXAM **Date of Exam:** ___/___/___

Height	______ **cm**	(___ ___ %ile)
Weight	______ **kg**	(___ ___ %ile)
BMI	______ **kg/m²**	(___ ___ %ile)
Head Circumference *(age ≤2 yrs)*	______ **cm**	(___ ___ %ile)
Blood Pressure *(age ≥3 yrs)*	______ / ______	

General Appearance:

☐ Physical Exam WNL

Nl Abnl	*Nl Abnl*	*Nl Abnl*	*Nl Abnl*	*Nl Abnl*
☐ ☐ Psychosocial Development	☐ ☐ HEENT	☐ ☐ Lymph nodes	☐ ☐ Abdomen	☐ ☐ Skin
☐ ☐ Language	☐ ☐ Dental	☐ ☐ Lungs	☐ ☐ Genitourinary	☐ ☐ Neurological
☐ ☐ Behavioral	☐ ☐ Neck	☐ ☐ Cardiovascular	☐ ☐ Extremities	☐ ☐ Back/spine

Describe abnormalities:

DEVELOPMENTAL *(age 0-6 yrs)*

Validated Screening Tool Used? ☐ Yes ☐ No — Date Screened ___/___/___

Screening Results: ☐ WNL

☐ Delay or Concern Suspected/Confirmed (specify area(s) below):

☐ Cognitive/Problem Solving ☐ Adaptive/Self-Help
☐ Communication/Language ☐ Gross Motor/Fine Motor
☐ Social-Emotional or Personal-Social ☐ Other Area of Concern: ______

Describe Suspected Delay or Concern:

Child Receives EI/CPSE/CSE services ☐ Yes ☐ No

Nutrition

< **1 year** ☐ Breastfed ☐ Formula ☐ Both

≥ **1 year** ☐ Well-balanced ☐ Needs guidance ☐ Counseled ☐ Referred

Dietary Restrictions ☐ None ☐ Yes *(list below)*

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
Lead Risk Assessment *(annually, age 6 mo-6 yrs)*	___/___/___	☐ At risk *(do BLL)* ☐ Not at risk
—— Child Care Only ——		
Hemoglobin or Hematocrit	___/___/___	______ g/dL ______ %

Hearing	*Date Done*	*Results*
< 4 years: gross hearing	___/___/___	☐*Nl* ☐*Abnl* ☐*Referred*
OAE	___/___/___	☐*Nl* ☐*Abnl* ☐*Referred*
≥ 4 yrs: pure tone audiometry	___/___/___	☐*Nl* ☐*Abnl* ☐*Referred*

Vision	*Date Done*	*Results*
<3 years: Vision appears:	___/___/___	☐ *Nl* ☐ *Abnl*
Acuity (required for new entrants and children age 3-7 years)	___/___/___	Right ____/____ Left ____/____ ☐ Unable to test
Screened with Glasses?		☐ Yes ☐ No
Strabismus?		☐ Yes ☐ No

Dental	
Visible Tooth Decay	☐ Yes ☐ No
Urgent need for dental referral *(pain, swelling, infection)*	☐ Yes ☐ No
Dental Visit within the past 12 months	☐ Yes ☐ No

CIR Number ☐☐☐☐☐☐☐☐☐☐

Physician Confirmed History of Varicella Infection ☐

Report only positive immunity:

IMMUNIZATIONS – DATES

DTP/DTaP/DT	___/___/___	___/___/___	___/___/___	___/___/___	___/___/___	___/___/___	Tdap	___/___/___	___/___/___		
Td	___/___/___	___/___/___	___/___/___	___/___/___	___/___/___		MMR	___/___/___	___/___/___	___/___/___	
Polio	___/___/___	___/___/___	___/___/___	___/___/___	___/___/___		Varicella	___/___/___	___/___/___	___/___/___	
Hep B	___/___/___	___/___/___	___/___/___	___/___/___	___/___/___		Mening ACWY	___/___/___	___/___/___	___/___/___	
Hib	___/___/___	___/___/___	___/___/___	___/___/___	___/___/___		Hep A	___/___/___	___/___/___	___/___/___	
PCV	___/___/___	___/___/___	___/___/___	___/___/___	___/___/___		Rotavirus	___/___/___	___/___/___	___/___/___	
Influenza	___/___/___	___/___/___	___/___/___	___/___/___	___/___/___		Mening B	___/___/___	___/___/___	___/___/___	
HPV	___/___/___	___/___/___	___/___/___	___/___/___	___/___/___		Other ______	___/___/___	______	___/___/___	

IgG Titers	Date
Hepatitis B	___/___/___
Measles	___/___/___
Mumps	___/___/___
Rubella	___/___/___
Varicella	___/___/___
Polio 1	___/___/___
Polio 2	___/___/___
Polio 3	___/___/___

ASSESSMENT ☐ **Well Child** (Z00.129) ☐ **Diagnoses/Problems** *(list)* **ICD-10 Code**

______

RECOMMENDATIONS ☐ Full physical activity

☐ Restrictions *(specify)* ______

Follow-up Needed ☐ No ☐ Yes, for ______ Appt. date: __ __/__ __/__ __

Referral(s): ☐ None ☐ Early Intervention ☐ IEP ☐ Dental ☐ Vision

☐ Other ______

Health Care Practitioner Signature	Date Form Completed ____/____/____
Health Care Practitioner Name and Degree *(print)*	Practitioner License No. and State
Facility Name	National Provider Identifier (NPI)

Address	City	State	Zip

Telephone	Fax	Email

DOHMH ONLY

PRACTITIONER I.D. ☐☐☐☐☐☐

TYPE OF EXAM: ☐ NAE Current ☐ NAE Prior Year(s)

Comments:

Date Reviewed: ____/____/____ **I.D. NUMBER** ☐☐☐☐☐☐

REVIEWER:

FORM ID# ☐☐☐☐☐☐☐☐☐☐