



KINGS BAY Y (MAIN SITE)
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

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 ☐ 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 ☐ Yes (including Medicaid)? ☐ 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 _____					Does the child/adolescent have a past or present medical history of the following? ☐ Asthma (check severity and attach MAF): If persistent, check all current medication(s): Asthma Control Status ☐ Anaphylaxis ☐ Behavioral/mental health disorder ☐ Congenital or acquired heart disorder ☐ Developmental/learning problem ☐ Diabetes (attach MAF) ☐ Orthopedic injury/disability Explain all checked items above.																																																																																																																																																			
Allergies ☐ None ☐ Epi pen prescribed ☐ Drugs (list) _____ ☐ Foods (list) _____ ☐ Other (list) _____					☐ Intermittent ☐ Quick Relief Medication ☐ Well-controlled ☐ Seizure disorder ☐ Speech, hearing, or visual impairment ☐ Tuberculosis (latent infection or disease) ☐ Hospitalization ☐ Surgery ☐ Other (specify) _____ Addendum attached.					☐ Mild Persistent ☐ Inhaled Corticosteroid ☐ Poorly Controlled or Not Controlled ☐ Moderate Persistent ☐ Oral Steroid ☐ Other Controller ☐ None Medications (attach MAF if in-school medication needed) ☐ None ☐ Yes (list below) _____ _____ _____																																																																																																																																														
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PHYSICAL EXAM Date of Exam: ____/____/____					General Appearance: ☐ 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>☐ Psychosocial Development</td><td>☐ HEENT</td><td>☐ Lymph nodes</td><td>☐ Abdomen</td><td>☐ Skin</td></tr><tr><td>☐ Language</td><td>☐ Dental</td><td>☐ Lungs</td><td>☐ Genitourinary</td><td>☐ Neurological</td></tr><tr><td>☐ Behavioral</td><td>☐ Neck</td><td>☐ Cardiovascular</td><td>☐ Extremities</td><td>☐ Back/spine</td></tr></table>												Ni Abnl	Ni Abnl	Ni Abnl	Ni Abnl	Ni Abnl	☐ Psychosocial Development	☐ HEENT	☐ Lymph nodes	☐ Abdomen	☐ Skin	☐ Language	☐ Dental	☐ Lungs	☐ Genitourinary	☐ Neurological	☐ Behavioral	☐ Neck	☐ Cardiovascular	☐ Extremities	☐ 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 ____/____/____ ☐ Yes ☐ No 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: _____					Nutrition < 1 year ☐ Breastfed ☐ Formula ☐ Both ≥ 1 year ☐ Well-balanced ☐ Needs guidance ☐ Counseled ☐ Referred Dietary Restrictions ☐ None ☐ Yes (list below) _____ _____					Hearing Date Done Results < 4 years: gross hearing ____/____/____ ☐ NI ☐ Abnl ☐ Referred OAE ____/____/____ ☐ NI ☐ Abnl ☐ Referred ≥ 4 yrs: pure tone audiometry ____/____/____ ☐ NI ☐ Abnl ☐ 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: ____/____/____ ☐ NI ☐ Abnl Acuity (required for new entrants and children age 3-7 years) ____/____/____ Right ____/____/____ Left ____/____/____ ☐ Unable to test																																																																																																																																														
					Lead Risk Assessment (annually, age 6 mo-6 yrs) ____/____/____ ☐ At risk (do BLL) ☐ Not at risk					Screened with Glasses? ☐ Yes ☐ No Strabismus? ☐ Yes ☐ No																																																																																																																																														
					Child Care Only					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																																																																																																																																														
Child Receives EI/CPSE/CSE services ☐ Yes ☐ No					CIR Number _____					Physician Confirmed History of Varicella Infection ☐					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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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 ____/____/____			DOHMH ONLY PRACTITIONER I.D. _____																																																																																																																																											
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