KINGS BAY Y KOCHAVIM AFTER SCHOOL ACADEMY 2024-2025

STUDENT INFORMATION

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 5th, 2024 – June 26th, 2025

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 Y

AFTER SCHOOL ACADEMY 2023-2024

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 #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: _____

KINGS BAY Y

AFTER SCHOOL ACADEMY 2023-2024

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 2023-2024 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)

TO BE COMPLETED BY THE PARENT OR GUARDIAN

Child's Last Name	**First Name**	**Middle Name**	**Sex** M Female M Male	**Date of Birth** *(Month/Day/Year)* ___ ___ / ___ ___ / ___ ___ ___ ___
Child's Address		**Hispanic/Latino?** 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 _____	
City/Borough	**State**	**Zip Code**	**School/Center/Camp Name**	**District** __ __ **Number** __ __ __ / **Phone Numbers** Home _____
Health insurance M Yes **(including Medicaid)?** M No	**Last Name First Name** M **Parent/Guardian** M **Foster Parent**	**Email**		Cell _____ Work

Birth history *(age 0-6 yrs)*

M Uncomplicated M Premature: _____ weeks gestation M Complicated by _____

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

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 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 ***(attach MAF)*** M Surgery
M Orthopedic injury/disability M Other (specify)
Explain all checked items above. M ***Addendum attached.***

Medications ***(attach MAF if in-school medication needed)*** M None M 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:

Nl Abnl
M M Psychosocial Development M M Language
M M Behavioral

M Physical Exam WNL
Nl Abnl Nl Abnl Nl Abnl Nl Abnl 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

Describe abnormalities:

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 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 _____

Describe Suspected Delay or Concern:

Nutrition

< **1 year** M Breastfed M Formula M Both
≥ **1 year** M Well-balanced M Needs guidance M Counseled M Referred **Dietary Restrictions** M None M 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)*	M At risk *(do BLL)* ____ /____ /____ M Not at risk

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

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

				Dental	
	— — Child Care Only — —			Visible Tooth Decay	M Yes M No
Child Receives EI/CPSE/CSE services M Yes M No	**Hemoglobin or Hematocrit**	____ /____ /____	_____ g/dL _____ %	Urgent ne dental	*(pain, swelling, infection)* M Yes M t within the past 12 months M Yes M No

CIR Number Physician Confirmed History of Varicella Infection Report only positive immunity:

IMMUNIZATIONS – DATES		IgG Titers
DTP/DTaP/DT ___ /___ /___ ___ /___ /___ ___ /___ /___ ___ /___ /___ ___ /___ /___ ___ /___ /___ Tdap ___ /___ /___ ___ /___ /___ Td ___ /___ /___ ___ /___ /___ ___ /___ /___ ___ /___ /___ ___ /___ /___ ___ /___ /___ ___ /___ /___ ___ /___ /___ MMR ___ /___ /___ ___ /___ /___ ___ /___ /___ Polio ___ /___ /___ ___ /___ /___ ___ /___ /___ ___ /___ /___ ___ /___ /___ ___ /___ /___ Varicella ___ /___ /___ ___ /___ /___ ___ /___ /___ Hep B ___ /___ /___ ___ /___ /___ ___ /___ /___ ___ /___ /___ ___ /___ /___ Mening ACWY ___ /___ /___ ___ /___ /___ ___ /___ /___ Hib ___ /___ /___ ___ /___ /___ ___ /___ /___ ___ /___ /___ ___ /___ /___ Hep A ___ /___ /___ ___ /___ /___ /___ PCV ___ /___ /___ ___ /___ /___ ___ /___ /___ ___ /___ /___ ___ /___ /___ Rotavirus ___ /___ /___ ___ /___ /___ ___ /___ /___ Influenza ___ /___ /___ ___ /___ /___ ___ /___ /___ ___ /___ /___ ___ /___ /___ ___ /___ /___ Mening B ___ /___ /___ ___ /___ /___ ___ /___ /___ HPV ___ /___ /___ ___ /___ /___ ___ /___ /___ ___ /___ /___ ___ /___ /___ Other__ ___ /___ /___ _ ___ /___ /___	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
	M Restrictions (*specify)* _____ **F** No M Yes, for _____ Appt. Date: __ __ / __ __ / __ __ **Referral(s):** M None M IEP M Dental M Vision M Other _____

Health Care Practitioner Signature	Date Form Completed _____ /_____ /_____	**I. D.** **P TI**

Health Care Practitioner Name and Degree *(print)*	Practitioner License No. and State	**TYPE OF EXAM:** NAE Current NAE Prior Year(s)
Facility Name	National Provider Identifier (NPI)	D Review
Address City State Zip		___

Telephone	Fax	Email	**FORM ID#**