Kings Bay YM-YHWA - 3495 Nostrand Ave, Brooklyn, NY 11229
Ave W Annex - 3043 Ave W, Brooklyn, NY 11229
Phone: (718) 648-7703 Fax: (718) 648-0758
Email: info@kingsbayy.org

Kings Bay Y Ave W Annex
After School Academy 2021-2022
Registration Application

First Name: _____ Last Name: _____ Gender: _____

Date of Birth: ___/___/___ Age: _____ Grade: _____ School: _____

Home Address: _____

Parent/Guardian Name: _____ Relationship to Child: _____

Place of Employment: _____ Occupation: _____

Home Phone: _____ Cell Phone: _____ Work Phone: _____

Email Address: _____

Parent/Guardian Name: _____ Relationship to Child: _____

Place of Employment: _____ Occupation: _____

Home Phone: _____ Cell Phone: _____ Work Phone: _____

Email Address: _____

Emergency Contact Name: _____ Phone Number: _____

Scheduling & Payment Options

Program Dates: September 13, 2021 - June 24, 2022
Program Hours: Dismissal - 6:00 PM; Monday - 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)
School Year: $5500 Monthly: $550	School Year: $4950 Monthly: $495	School Year: $4450 Monthly: $445	School Year: $3350 Monthly: $335	School Year: $2250 Monthly: $225

Extended Hours (until 7:00 PM): ____ $60/1 day ____ $70/2 days ____ $80/3 days ____ $90/4 days ____ $100/5 days

HRA/ACD Funding Accepted. Check here if this applies to you and submit this application without a deposit ____

Discounts for families opting out of transportation - 10% off cost of month
Single Day Program Drop Off - $50 per day
LATE FEE: $50 if payment is not received ON or BEFORE the 1st of each month

Tell Us About Your Child

Allergies: _____

Dietary Restrictions: _____

Does your child have an IEP or receive any additional services (including speech, SEIT, OT, PT Psychology, etc.)? If yes, please explain: _____

Terms of Enrollment

Please note and initial the following to indicate your understanding:

Tuition is for the full school year (September - June) and school closings have been taken into account in computing these fees. Therefore, the month amount always remains the same regardless of the number of school days. If a refund is requested, a $100.00 cancellation fee will be deducted from the refund. **Initial Here:** _____

You may register your child at any time during the course of the year. You will pay only for those months that your child attends. Payment for the first month and for June is due upon registration. **Initial Here:** _____

1. All payments are due on or before the first of each month for the upcoming month. **Initial Here:** _____
2. For school closures/holidays, Mini Camps are offered for an additional fee. **Initial Here:** _____
3. An additional day is $25.00 if you sign up for 1 to 3-days registration and would like to add a pick-up day. The daily rate is $50 per day. **Initial Here:** _____
4. Medical forms must be completed and submitted prior to the child's admission to the program **Initial Here:** _____
5. The Kings Bay Y will not be responsible for damage to, or loss of, personal property. **Initial Here:** _____
6. I hereby give permission for my child to be photographed/videographed for promotional purposes. **Initial Here:** _____
7. I hereby give permission for my childto participate in all general activities. **Initial Here:** _____
8. Our program hours are Monday through Friday from 2:30pm to 6:00pm; extended day is available Monday through Friday from 6:00pm - 7:00pm at an additional fee. **Initial Here:** _____
9. Late Arrival Policy: For arrival after 6pm, a fee of $1 per minute will be charged. **Initial Here:** _____
10. It is the goal of our program to provide a healthy and safe environment for all participants. If a participant displays any inappropriate behavior, or endangers the health and safety of other participants and/or staff, we will contact the parent/guardian to immediately come to the site. We may suspend the participant from the program or consider permanent termination in extreme cases. In the event of suspension or expulsion, no refunds will be granted. **Initial Here:** _____

Release: I hereby give my permission for my child to participate in all programs, swimming activities, and trips. I understand and fully recognize that risks are involved and I hereby release the Kings Bay Y and any of its sponsors, benefactors, and employees from any liability arising out of any injury to my child in the event of a medical or surgical emergency. I do hereby give authority to the after-school program and staff to obtain necessary emergency medical treatment for my child with the understanding that the family will be notified as soon as possible. I grant permission to the physician designated by the Kings Bay Y to hospitalize, secure proper treatment for, and order injections, anesthesia or surgery for my child. Furthermore, I understand that payment for medical services is solely the family's responsibility. I hereby give permission to the Kings Bay YM-YWHA Inc. to take photographs of me and.or my child to be shown in a video, brochure, advertisement, or internet display for purposes of promoting interest in the Kings Bay Y. I release the Kinsg Bay YM-YWHA Inc. from any claims resulting from the pictures taken on, before, or after the date of this communication. I do hereby give permission for my child to participate in all camp activities, including off-ground activities. I authorize the Kings Bay YM-YWHA Inc. to act as a parent surrogate on my behalf. I realize that itineraries and/or programs are subject to change prior to, and during, the school year.

I have carefully read the contract and other related information and agree to accept all terms set forth above.
Refund Policy: No refunds or make-up days will be issued for any days missed or cancelled. (Initial Here: _____)

Name of Child: _____ Start Date: _____

Parent/Guardian Name: _____ Parent/Guardian Signature: _____

Staff Signature and Title: _____ Date: _____

How did you hear about us? (Circle One) **Social Media** **Word of Mouth** **Google Search** **Other**: _____

Kings Bay YM-YWHA is an equal opportunity employer and 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, 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

FOR OFFICE USE ONLY | DATE: | RECEIPT # | AMOUNT PAID | ENTERED

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General Information Sheet

CHILD'S INFORMATION

Child's Name: _____ Child's Grade: _____

Child's School: _____

Home Address: _____

PARENT/GUARDIAN INFORMATION

Parent/Guardian #1 Name: _____

Mobile Number: _____ Work Number: _____

Parent/Guardian #2 Name: _____

Mobile Number: _____ Work Number: _____

EMERGENCY CONTACT(S)

Name: _____ Relation to Child: _____

Contact Number: _____

Name: _____ Relation to Child: _____

Contact Number: _____

AUTHORIZED PICK-UP PERSONNEL

Name: _____ Relation to Child: _____

Name: _____ Relation to Child: _____

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Dear Parents and Guardians,

We are asking you to complete this form stating the names of the individuals who are allowed to pick up your child from the Kings Bay Y Afterschool Academy program. Please be as thorough as possible with this list as we will not allow your child to leave with anyone who is not named below. Please be advised that the person picking up your child must have a valid form of photo identification (ie. state issued driver's license or identification card, nationally issued passport, or school issued ID card). There will be NO EXCEPTIONS!

Thank you,
Kings Bay YM-YWHA

Name: _____ Number: _____ Relation to Child: _____

Name: _____ Number: _____ Relation to Child: _____

Name: _____ Number: _____ Relation to Child: _____

Name: _____ Number: _____ Relation to Child: _____

Name: _____ Number: _____ Relation to Child: _____

Name: _____ Number: _____ Relation to Child: _____

Name: _____ Number: _____ Relation to Child: _____

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 YM-YWHA.

Child's Name: _____ Child's Grade: _____

Parent/Guardian Name: _____ Mobile Number: _____

Parent/Guardian Signature: _____ Date: _____

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Trip Authorization Form

Dear Parents and Guardians,

Please complete this consent form which will be used for general trip/activity authorization but also in the event of an emergency. It is our hope to never use this form for a medical emergency but in the event that we do, please know that we will make every effort to contact you and your designee as soon as possible.

AUTHORIZATION FOR EMERGENCY MEDICAL AND/OR SURGICAL TREATMENT

In the case of an emergency during my child's enrollment, presence, or association with the Kings Bay YM-YWHA, I hereby authorize the doctor or 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 give my child permission to go on all trips and to participate in all program activities.

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 YM-YWHA.

Child's Name: _____ Child's Grade: _____

Parent/Guardian Name: _____ Mobile Number: _____

Parent/Guardian Signature: _____ Date: _____

Address: _____

INSURANCE INFORMATION

Name of Insurance Plan: _____ Policy #: _____

Policy Holder Name: _____ Relation to Child: _____

Emergency Contact Name: _____ Relation to Child: _____

Emergency Contact Number: _____

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Assumption of the Risk and Waiver of Liability
Relation to the Coronavirus (COVID-19)

The coronavirus (COVID-19) has been declared a worldwide pandemic by the World Health Organization (WHO). COVID-19 is extremely contagious and can spread from person-to-person contact. THe Kings Bay YM-YWHA has and will continue to use its best efforts to institute and implement preventative measures to reduce the spread of COVID-19; however, the Kings Bay YM-YWHA cannot guarantee that you or your child(ren) may not become infected, exposed, or otherwise contract COVID-19 while attending, participating in or otherwise engaging in any activities at or in connection with the Kings Bay YM-YWHA.

By signing this waiver and release, I acknowledge and agree that I, on behalf of my child(ren): a) understand the contagious nature of COVID-19; b)voluntarily assume the risk that me, my child(ren) or anyone for whom I may be responsible may become infected, exposed, or otherwise contract COVID-19 while attending, participating in, or otherwise engaging in any activities at or in connection with the Kings Bay YM-YWHA; and c) hereby waive, release, and discharge the Kings Bay YM-YWHA from and against any claims or injuries arising out of, relating to, or in any way connected to COVID-19 and the subject of this Waiver and Release.

Participant Name: _____

Participant Signature: _____ Date: _____

If you have a child under the age of 18 attending the Kings Bay YM-YWHA for any purpose, please complete the following:

Child's Name: _____

Parent/Guardian Signature: _____ Date: _____

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PLEASE FILL OUT THIS FORM AND GIVE TO YOUR CHILD'S TEACHER

Date: _____

Dear: _____

This communication is to inform you that my child _____

Grade _____ Class _____ Room # _____

She/He will be picked up by a counselor from the school and taken by bus to the Kings Bay YM-YWHA located at 3495 Nostrand Avenue (between Avenue U and V).

DAYS IN THE KINGS BAY Y AFTERSCHOOL PROGRAM

Monday _____ Tuesday _____ Wednesday _____ Thursday _____ Friday _____

The phone number (718) 648-7703, ext. 216.

Thank you in advance,

Name: _____

Address: _____

Phone Number: _____

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** **Last Name** **First Name** | ☐ **Foster Parent** | **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 in 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
☐ Seizure disorder
☐ Speech, hearing, or visual impairment
☐ Tuberculosis *(latent infection or disease)*
☐ Hospitalization
☐ Surgery
☐ Other (specify) _____
Explain all checked items above.
☐ ***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
Psychosocial Development	☐	☐
Language	☐	☐
Behavioral	☐	☐
HEENT	☐	☐
Dental	☐	☐
Neck	☐	☐
Lymph nodes	☐	☐
Lungs	☐	☐
Cardiovascular	☐	☐
Abdomen	☐	☐
Genitourinary	☐	☐
Extremities	☐	☐
Skin	☐	☐
Neurological	☐	☐
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 ___/___/___

DOHMH ONLY **PRACTITIONER I.D.**

Health Care Practitioner Name and Degree *(print)*

Practitioner License No. and State

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

Comments:

Facility Name

National Provider Identifier (NPI)

Date Reviewed: ___/___/___ **I.D. NUMBER**

Address City State Zip

REVIEWER:

Telephone Fax Email

FORM ID#