Kings Bay Y After School Program

3495 Nostrand Avenue, Brooklyn, NY, 11229

718-648-7703

Participant Information

Child's Name: _____ School the Child Attends: _____ Grade: _____

Date of Birth: _____ Age: _____ Gender (Circle One): M F Do Not Wish To Disclose

Home Address: _____ Apt: _____

City: _____ State: _____ Zip Code: _____

Parent/Guardian 1

Full Name: _____

Contact Number: _____

Email Address: _____

Parent/Guardian 2

Full Name: _____

Contact Number: _____

Email Address: _____

Emergency Contact 1

Full Name: _____

Contact Number: _____

Email Address: _____

Emergency Contact 2 (Optional)

Full Name: _____

Contact Number: _____

Email Address: _____

KINGS BAY Y AFTER SCHOOL PROGRAM

Thursday, September 4, 2025 to Friday, June 26, 2026

MONTHLY OPTIONS

5 Days	4 Days	3 Days	2 Days	1 Day
$655	$605	$545	$495	$370

Late Stay (Until 7 p.m.): ☐ **5 Days ($110)** ☐ **4 Days ($100)** ☐ **3 Days ($90)** ☐ **2 Days ($75)** ☐ **1 Day ($65)**

Please select the days: ☐ Monday ☐ Tuesday ☐Wednesday ☐ Thursday ☐Friday

**Please note we do accept HRA/ACS vouchers. If you have a current voucher that is active, contact our office by emailing office@kingsbayy.org with a completed application and circle the number of days needed above.

Does your child have an Individualized Education Program (IEP)? If yes, please be aware that we may request a copy for our records. _____

Does your child have any allergies? If so, please provide details as we need this information for health and safety considerations. _____

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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. Please be informed that all autopay billing transactions will be processed on the first day of each month. Until September 1st, you can reserve a spot in the afterschool program by paying a $100 deposit, which will be applied as a non-refundable June deposit. The regular monthly payment will begin on September 1st.
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. Please be advised that the dates for Mini Camp sessions are separate from the schedule for our After School program. Our program adheres to the calendar established by the Department of Education for the Public School year 2025-2026. Kindly be aware that a separate application will be required for participation in Mini Camp sessions.
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 72 hours prior for $50.00 per day for those registered for 1-4 days per month.
10. Daily Drop-In Rate (with less than 48 hours' notice) is $75.00 daily. Please note that you must notify our office of any pick-up changes by 10:00 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 and full application **MUST** be submitted minimally 24 hours in advance 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 YM-YWHA. Any remainder will then be applied toward current invoices.

By signing below, I acknowledge that I have carefully read the contract and hereby agree to accept all terms set forth above.

Parent/Guardian Full Name: _____ Child's Full Name: _____

Parent/Guardian Signature: _____ Date: _____/_____/_____

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Risk and Liability/Photo Release

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 YM-YWHA programming. I release the Kings Bay YM-YWHA, Inc. from any claims resulting from the 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 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.

By signing below, I acknowledge that I have carefully read the contract and hereby agree to accept all terms set forth above.

Parent/Guardian Full Name: _____ Child's Full Name: _____

Parent/Guardian Signature: _____ Date: ____/____/____

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Risk and Liability/Photo Release

Dear Parents and Guardians,

We are requesting families to authorize specific adults for child pick-up from our program.

Please note, individuals not listed on the authorized pick-up list or those who are under the age of eighteen will not be permitted to sign out a child without following proper procedures. No exceptions will be made to ensure the safety of our students.

Valid Federal or State Issued photo identification is mandatory for all student pick-ups and will be verified.

Authorized Grown Up #1

Full Name: _____ Age: _____

Contact Number: (_____) _____ - _____

Relationship: _____

Authorized Grown Up #2

Full Name: _____ Age: _____

Contact Number: (_____) _____ - _____

Relationship: _____

Authorized Grown Up #3

Full Name: _____ Age: _____

Contact Number: (_____) _____ - _____

Relationship: _____

Authorized Grown Up #4

Full Name: _____ Age: _____

Contact Number: (_____) _____ - _____

Relationship: _____

Authorized Grown Up #5

Full Name: _____ Age: _____

Contact Number: (_____) _____ - _____

Relationship: _____

Authorized Grown Up #6

Full Name: _____ Age: _____

Contact Number: (_____) _____ - _____

Relationship: _____

By signing below, I confirm that I have read and acknowledge the above statement and authorize the listed individuals to pick up my child from the Kings Bay Y After School Program.

Parent/Guardian Full Name: _____ Child's Full Name: _____

Parent/Guardian Signature: _____ Date: _____/_____/_____

OCFS-LDSS-0792 (08/2019) FRONT

NEW YORK STATE
OFFICE OF CHILDREN AND FAMILY SERVICES

DAY CARE ENROLLMENT

PHOTO OF CHILD (Optional)

PROGRAM NAME:	ADDRESS:	PHONE NUMBER: ( ) -

CHILD'S FULL NAME: PREFERRED NAME/NICKNAME:	DATE OF BIRTH: / /	GENDER:

CHILD'S HOME ADDRESS:

NAME OF PERSON ENROLLING CHILD:	RELATIONSHIP TO CHILD: ☐ Parent ☐ Guardian ☐ Caretaker ☐ Relative _____ ☐ Other _____
PHONE NUMBER(S) OF PERSON ENROLLING CHILD: ( ) - ☐ ok to text **EMAIL ADDRESS:**	ADDRESS OF PERSON ENROLLING CHILD (IF DIFFERENT THAN CHILD):

EMERGENCY INFO

EMERGENCY CONTACT NAMES / ADDRESSES	Authorized to Pick Up Child	PRIMARY PHONE NUMBER	OTHER PHONE NUMBER / EMAIL
PRIMARY CONTACT:	☐ Yes ☐ No	( ) - ☐ ok to text	( ) - ☐ ok to text
	☐ Yes ☐ No	( ) - ☐ ok to text	( ) - ☐ ok to text
	☐ Yes ☐ No	( ) - ☐ ok to text	( ) - ☐ ok to text

FOR PROGRAM USE ONLY DATE OF ENROLLMENT: / /	***FOR PROGRAM USE ONLY*** DATE OF DISENROLLMENT: / /

OCFS-LDSS-0792 (08/2019) REVERSE

CHILD'S FULL NAME:	DATE OF BIRTH: / /

Check boxes below to indicate if your child has any special needs/services: ☐ None

☐ Early Intervention/Special Education ☐ Occupational Therapy ☐ Speech/Language ☐ Physical Therapy

☐ Allergies (Please list) _____

☐ Other _____

Please provide information here **AND** discuss with your child care provider:

CHILD'S PRIMARY CARE PHYSICIAN'S NAME/ GROUP:	PHONE NUMBER: ( ) -
PREFERRED HOSPITAL:	PHONE NUMBER: ( ) -
CHILD'S DENTAL CARE:	PHONE NUMBER: ( ) -

Child health care information is available by calling toll-free 1-800-698-4543 or the NYS Health Marketplace website: https://nystateofhealth.ny.gov/

AGREEMENTS

- I consent to emergency medical treatment for my child…… ☐ Yes ☐ No
- I consent for my child to take part in neighborhood trips (i.e., library, park and playground) away from the program under proper supervision…… ☐ Yes ☐ No
- I understand the program may need additional permissions for situations such as transportation, medication, release of information, and field trips…… ☐ Yes ☐ No
- I provided information on my child's special needs to the program to assist in caring for my child…… ☐ Yes ☐ No
- I understand the program must give parents, at the time of enrollment of a child, a written policy statement as required by regulation…… ☐ Yes ☐ No
- I agree to review and update this information whenever a change occurs and at least once every year…… ☐ Yes ☐ No

SIGNATURE – PARENT OR PERSON(S) LEGALLY RESPONSIBLE:	DATE: / /

CHILD & ADOLESCENT HEALTH EXAMINATION FORM

NYC DEPARTMENT OF HEALTH & MENTAL HYGIENE — DEPARTMENT OF EDUCATION

Please Print Clearly Press Hard

STUDENT ID NUMBER OSIS

TO BE COMPLETED BY 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

TO BE COMPLETED BY HEALTH CARE PROVIDER *If "yes" to any item, please explain (attach addendum, if needed)*

Birth history *(age 0-6 yrs)*

☐ Uncomplicated ☐ Premature: _____ weeks gestation

☐ Complicated by _____

Allergies ☐ None ☐ Epi pen prescribed

☐ Drugs *(list)* _____

☐ Foods *(list)* _____

☐ Other *(list)* _____

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

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

If persistent, check all current medication(s): ☐ Inhaled corticosteriod ☐ Other controller ☐ Quick relief med ☐ Oral steroid ☐ None

☐ Attention Deficit Hyperactivity Disorder
☐ Chronic or recurrent otitis media
☐ 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)*
☐ **Other** *(specify)* _____

Explain all checked items above or on addendum

Medications *(attach MAF if in-school medication needed)*

☐ None ☐ Yes *(list below)*

Dietary Restrictions

☐ None ☐ Yes *(list below)*

PHYSICAL EXAMINATION

Height _____ **cm** (__ __ %ile)

Weight _____ **kg** (__ __ %ile)

BMI _____ **kg/m²** (__ __ %ile)

Head Circumference *(age ≤2 yrs)* _____ **cm** (__ __ %ile)

Blood Pressure *(age ≥3 yrs)* _____ / _____

General Appearance:

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

Describe abnormalities:

DEVELOPMENTAL *(age 0-6 yrs)* ☐ Within normal limits

If delay suspected, specify below

☐ Cognitive *(e.g., play skills)* _____

☐ Communication/Language _____

☐ Social/Emotional _____

☐ Adaptive/Self-Help _____

☐ Motor _____

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
Hearing ☐ Pure tone audiometry ☐ OAE	__/__/__	☐ Normal ☐ Abnormal
Head Start Only		
Hemoglobin or Hematocrit *(age 9–12 mo)*	__/__/__	_____ g/dL _____ %

	Date Done	*Results*
Tuberculosis *Only required for students entering intermediate/middle/junior or high school who have not previously attended any NYC public or private school*		
PPD/Mantoux *placed*	__/__/__	Induration _____mm
PPD/Mantoux *read*	__/__/__	☐ Neg ☐ Pos
Interferon Test	__/__/__	☐ Neg ☐ Pos
Chest x-ray *(if PPD or Interferon positive)*	__/__/__	☐ NI ☐ Abnl ☐ Not Indicated
Vision *(required for new school entrants and children age 4–7 yrs)*	__/__/__ ☐ with glasses	Acuity *Right* ___/___ *Left* ___/___ Strabismus ☐ No ☐ Yes

IMMUNIZATIONS – DATES CIR Number of Child

Hep B	__/__/__	__/__/__	__/__/__	__/__/__
Rotavirus	__/__/__	__/__/__	__/__/__	__/__/__
DTP/DTaP/DT	__/__/__	__/__/__	__/__/__	__/__/__
	__/__/__	__/__/__	__/__/__	__/__/__
Hib	__/__/__	__/__/__	__/__/__	__/__/__
PCV	__/__/__	__/__/__	__/__/__	__/__/__
Polio	__/__/__	__/__/__	__/__/__	__/__/__

Influenza	__/__/__	__/__/__	__/__/__	__/__/__
MMR	__/__/__	__/__/__	__/__/__	__/__/__
Varicella	__/__/__	__/__/__		
Td	__/__/__	__/__/__	__/__/__	__/__/__
Tdap __/__/__	Hep A	__/__/__	__/__/__	
Meningococcal	__/__/__	__/__/__		
HPV	__/__/__	__/__/__	__/__/__	
Other, *specify:* _____	__/__/__	; _____		__/__/__

RECOMMENDATIONS ☐ Full physical activity ☐ Full diet

☐ Restrictions *(specify)* _____

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

Referral(s): ☐ None ☐ Early Intervention ☐ Special Education ☐ Dental ☐ Vision

☐ Other _____

ASSESSMENT ☐ **Well Child** (V20.2) ☐ **Diagnoses/Problems** *(list)* **ICD-9 Code**

_____ __ __ __ __

_____ __ __ __ __

_____ __ __ __ __

Health Care Provider Signature | Date __ __ / __ __ / __ __ __

Health Care Provider Name and Degree *(print)* | Provider License No. and State

Facility Name | National Provider Identifier (NPI)

Address | City | State | Zip

Telephone (__ __ __) __ __ __ – __ __ __ __ | Fax (__ __ __) __ __ __ – __ __ __ __

DOHMH ONLY **PROVIDER I.D.**

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

Comments

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

REVIEWER:

Copies: **White** School/Child Care/Early Intervention/Camp, **Canary** Health Care Provider, **Pink** Parent/Guardian