Kings Bay Y AT WINDSOR TERRACE
1224 Prospect Ave., Brooklyn N.Y. 11218
(T) 718. 407. 6377 (F) 718. 709. 7485
Email: info@ywindsorterrace.org

KINGS BAY Y AT WINDSOR TERRACE
AFTER SCHOOL PROGRAM 2016-2017

REGISTRATION APPLICATION

FIRST NAME: _____ **LAST NAME:** _____**GENDER:** _____

DATE OF BIRTH: ___/___/____ **AGE:** _____ **CURRENT GRADE:** _____

HOME ADDRESS: _____ **APT:** _____ **ZIP CODE:** _____

EMAIL ADDRESS: _____**CELL PHONE:** _____ **HOME PHONE:** _____

PARENT/GUARDIAN NAME: _____ **RELATIONSHIP:** _____

NUMBER: (_____) _____ **EMAIL ADDRESS:** _____

PARENT/GUARDIAN NAME: _____ **RELATIONSHIP:** _____

NUMBER: (_____) _____ **EMAIL ADDRESS:** _____

EMERGENCY CONTACT NAME: _____ **RELATIONSHIP:** _____

NUMBER: (_____) _____

How did you hear about us? ❑ Friends ❑ Flyer ❑TV ❑Blog/Yahoo Group ❑ Event ❑ PTA ❑Other_____

Are you registered for PJ Library ®, a free Jewish book program? ❑Yes ❑No

SCHEDULING & PAYMENT OPTIONS

PROGRAM DATES - Sept 8th thru June 27th (Kindergarten Sept.9th and Pre-Kindergarten Sept. 13th)
Program Hours: 2:30 – 6:00 Pm Monday thru Friday

❑ 5 Days /wk = $390/month ☒MON ☒TUES ☒WED ☒THURS ☒FRI
❑ 4 Days/ wk = $360/ month ❑MON ❑TUES ❑WED ❑THURS ❑FRI
❑ 3 Days/ wk = $350/ month ❑MON ❑TUES ❑WED ❑THURS ❑FRI
❑ 2 Days/wk = $320/ month ❑MON ❑TUES ❑WED ❑THURS ❑FRI

HRA/ACS FUNDING ACCEPTED. CHECK HERE IF THIS APPLIES TO YOU AND SUBMIT THIS APPPLICATION WITHOUT A DEPOSIT_____

DISCOUNTS

- **Annual discount –** 5% off payment for the full year (Sept-June).
- **Sibling discount-** oldest child pays full price, each additional sibling receives $25.00 off monthly fee.
- **Bring a friend discount-** $25.00 off the next month fee.

LATE FEE: $50.00 if payment is not received BEFORE the 1st of each month

TELL US ABOUT YOUR CHILD

Please list any allergies and/or medical conditions that we should know about: _____

Please list any dietary restrictions: _____

TERMS OF ENROLLMENT

Please note the following:

- **TUITION IS FOR A FULL SCHOOL YEAR - SCHOOL CLOSINGS HAVE BEEN TAKEN INTO ACCOUNT IN COMPUTING THESE FEES. THEREFORE, THE MONTHLY AMOUNT ALWAYS REMAINS THE SAME REGARDLESS OF THE NUMBER OF SCHOOL DAYS.** If a refund is requested a **$35.00 cancelation fee** will be deducted from the refund.

- **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. ONCE AGAIN, PAYMENT FOR THE FIRST MONTH & FOR JUNE IS DUE UPON REGISTRATION.**

1. All payments are due on or before the first of each month, for the upcoming month.
2. For school closures/holidays, Mini Camps are offered for an additional fee.
3. Medical forms must be completed and submitted prior to the child's admission to the program.
4. The Kings Bay Y will not be responsible for damage to, or loss of, personal property.
5. I hereby give permission for my child to be photographed/videotaped for promotional purposes.
6. I hereby give permission for my child to participate in all general program activities.
7. Our program hours are Monday thru Friday, from 2:30PM to 6:00 PM.
8. Late arrival policy fee: For arrival after 6pm, a fee of $1 per minute will be charged.
9. 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 participants 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 situations.

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 at Windsor Terrace or any of its sponsors, benefactors, or employees from any liability arising out of any injury to my child in the event of a medical emergency 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 Yat Windsor Terrace 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 Y 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 Kings Bay Y 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 Y 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 read the terms of enrollment and agree to abide by them.

Parent/Guardian Signature: _____Staff: _____ Date: _____

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 of discrimination, 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

In accordance with Federal law and U.S. Department of Agriculture policy, this institution is prohibited from discriminating on the basis of race, color, national origin, sex, age or disability. To file a complaint of discrimination, write USDA, Director, Office of Civil Rights, 1400 Independence Avenue, S.W., Washington, D.C. 20250-9410, or call (866) 632-9992 (voice) or (800) 877-8339(TDD). USDA is an equal opportunity provider and employer.

FOR OFFICE USE ONLY | DATE: _____ RECEIPT #: _____ AMOUNT PAID: _____ ENTERED: _____ **CHILDS START DATE:** _____

KINGS BAY Y at Windsor Terrace
1224 Prospect Avenue
BROOKLYN, NEW YORK 11218
718. 407. 6377

TRIP AUTHORIZATION FORM

Dear Parents /Guardians:
We are asking you to complete this consent form, to be used in the event of an emergency and to be used as a general trip/activity authorization. It is our hope and expectation that we will never have to use this form for a medical emergency, but in the event that we do, please be reassured that we will make every effort to contact you or your designee as soon as possible.

AUTHORIZATION FOR EMERGENCY MEDICAL AND/OR SURGICAL TREATMENT

In case of an emergency during my child's enrollment in the King Bay Y After School, Mini Camp, or Day Camp Program, 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.

AUTHORIZATION FOR TRIPS

I give my child permission to go on all trips and to participate in all program activities.
I HAVE READ THE ABOVE AUTHORIZATIONS AND AGREE TO ABIDE BY THEM.
Signed_____Date_____
Relationship to child_____Telephone #_____
Name of child_____
Date of birth_____ Gender F
Address_____Apt#_____ Zip code_____
Name of insurance plan_____Policy #_____Policy holder_____
Person to be contacted in case of emergency_____
Telephone #_____Relationship to child_____

PRINT

EMAIL

PRINT

HEALTH RECORD FOR CHILDREN IN DAY CAMPS & AFTERSCHOOL & YOUTH CENTERS

(This side to be filled in by parent before presentation to physician)

NAME OF PROGRAM _____

_____ CHILD'S LAST NAME _____ FIRST NAME _____ / / BIRTHDATE M☐ F☐ SEX

Home Address: _____ Phone: _____

Parent or Guardian: _____ Phone: _____

Place of Employment: Father (Guardian) _____ Phone: _____

Mother (Guardian) _____ Phone: _____

In case of emergency, notify: _____ Phone: _____

If Parent, Guardian are not available in an emergency, notify:

1. _____ Phone: _____

or 2. _____ Phone: _____

Important: Has this camper been exposed to any communicable disease during the three weeks prior to camp attendance:
Yes ☐ No ☐ (If yes, state type of exposure: _____)

HEALTH HISTORY: (Check, giving approximate dates)

	Allergies	**Diseases**
Ear Infections _____	Hay Fever _____	Chicken Pox _____
Rheumatic Fever _____	Ivy Poisoning, etc. _____	Measles _____
Convulsion _____	Insect Stings _____	German Measles _____
Diabetes _____	Penicillin _____	Mumps _____
Behavior _____	Other Drugs _____	Other Contagious Illnesses _____
Asthma _____		

Other Past Illnesses _____

Operations or Serious Injuries (Dates) _____

Hospitalization (Dates) _____

Chronic or Recurring Illness _____

Any specific activities to be encouraged? _____

Conditions that require activity to be restricted? _____

Permission for all program activities unless otherwise noted by Dr. _____

Appliance worn (glasses, contacts, etc.) _____

Medication taken _____

Suggestion from Parent/Guardian _____

CONSENT FOR EMERGENCY MEDICAL TREATMENT

I do hereby give authority to the Day Camp and Year Round Afterschool and Youth Center Program staff to obtain necessary emergency medical treatment for my child with the understanding that the family will be notified as soon as possible.

Relationship _____ Signature _____ Date _____ Tele.# _____

PHYSICAL EXAMINATION

(To be filled out by Physician - please note information on reverse side)

The purpose of this health record is to provide the staff with pertinent information which will help to serve the needs of this child in Day Camps and Afterschool and Youth Center programs.

IMMUNIZATION HISTORY - This is a record of dates of basic immunization and most recent booster doses.

DPaP, DTP or TD	Date _____	Date _____	Date _____	Date _____	Date _____
Polio	Date _____	Date _____	Date _____	Date _____	Date _____
MMR	Date _____	Date _____			
Hemophilus Influenzae type b		Date _____	Date _____	Date _____	Date _____
Hepatitis B	Date _____	Date _____	Date _____		
Varicella	Date _____	Date _____			
Other _____				Date _____	Date _____

MEDICAL EXAMINATION – To be filled out by licensed physician.

Examination is acceptable when performed no more than 12 months prior to arrival at camp.

Code: S = Satisfactory
X = Not Satisfactory (Explain)
0 = Not Examined

General Appearance _____

Height _____ Weight _____ Blood Pressure _____ Hgb. Test (Date) _____

Urinalysis (Date) _____ Posture & Spine _____ Throat - Tonsils _____

Eyes _____ Vision _____ w/Glasses _____ Extremities _____ Heart _____

Ears _____ Hearing _____ Feet _____ Lungs _____ Skin _____

Nose _____ Teeth _____ Abdomen _____ Hernia _____

Genitalia _____

Neurological Findings _____

Describe Abnormal Findings and/or Handicapping Conditions _____

_____

Has child ever received products containing horse serum? _____

Allergy: *(Please specify)* _____

Recommendations and restrictions while in camp.

Special Diet _____

Special Medicine (name it) _____

Is parent/guardian sending special medicine? _____

Swimming _____ Diving _____

Activity Restrictions _____

General Appraisal: _____

_____

_____

I have examined the person herein described, reviewed his/her health history and it is my opinion that he/she is physically able to engage in Day Camp/Year Round Afterschool and Youth Center activities, except as noted above.

_____ M.D.
EXAMINING PHYSICIAN (SIGNATURE)

_____
PHYSICIAN'S NAME (PLEASE PRINT)

Telephone _____ Address _____

Date of Examination _____ _____
ZIP CODE

PRINT

KINGS BAY Y AT WINDSOR TERRACE

PICK-UP AUTHORIZATION FORM

Dear Parents/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 afterschool program, mini-camp, summer day camp. Please be as thorough as possible with this list, as we will not allow your child to leave with anyone whose name isn't below. Also, please be advised that the person picking up your child must have a valid form of photo ID. There will be NO exceptions.

Thank you!

1. Name: _____ Phone Number: _____ Relationship:_____
2. Name: _____ Phone Number: _____ Relationship:_____
3. Name: _____ Phone Number: _____ Relationship:_____
4. Name: _____ Phone Number: _____ Relationship:_____
5. Name: _____ Phone Number: _____ Relationship:_____
6. Name: _____ Phone Number: _____ Relationship:_____
7. Name: _____ Phone Number: _____ Relationship:_____
8. Name: _____ Phone Number: _____ Relationship:_____
9. Name: _____ Phone Number: _____ Relationship:_____
10. Name: _____ Phone Number: _____ Relationship:_____

I have read the above authorizations and agree to abide by them.

Signed: _____ Relationship to Child: _____ Date: _____
Telephone Number: _____
Name of Child: _____

PRINT EMAIL