

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](mailto:info@ywindsorterrace.org)



## KINGS BAY Y AT WINDSOR TERRACE AFTER SCHOOL PROGRAM 2017-2018

### 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 7<sup>th</sup> thru June 25<sup>th</sup> (Kindergarten Sept.8<sup>th</sup> and Pre-Kindergarten Sept. 11<sup>th</sup>)**

**Program Hours: 2:30 – 6:00 Pm Monday thru Friday**

- 5 Days /wk. = \$415/month  MON  TUES  WED  THURS  FRI  
 4 Days/ wk. = \$385/ month  MON  TUES  WED  THURS  FRI  
 3 Days/ wk. = \$375/ month  MON  TUES  WED  THURS  FRI  
 2 Days/wk. = \$345/ month  MON  TUES  WED  THURS  FRI

**HRA/ACS FUNDING ACCEPTED. CHECK HERE IF THIS APPLIES TO YOU AND SUBMIT THIS APPLICATION 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 ON or 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 Y at 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 SUMMER DAY CAMP  
3495 NOSTRAND AVENUE  
BROOKLYN, NEW YORK 11229

KINGS BAY Y AT WINDSOR TERRACE CAMP  
1224 PROSPECT AVE  
BROOKLYN, NEW YORK 11218

Dear Parents:

We are asking you to complete this form, stating the names of the individuals who are allowed to pick up your child from the summer day camp. Please be as thorough as possible with this list, as we will not allow your child to leave with anyone that isn't named below. Also, please be advised that the person picking up your child must have a valid form of photo ID on them, such as a driver's license, a passport or current school issued ID. There will be **NO** exceptions.

Thank you,  
Summer Camp Administration

Parent/Guardian (1): \_\_\_\_\_ Phone #: \_\_\_\_\_ Relationship: \_\_\_\_\_

Parent/Guardian (2): \_\_\_\_\_ Phone #: \_\_\_\_\_ Relationship: \_\_\_\_\_

**ADDITIONAL NAMES:**

Name: \_\_\_\_\_ Phone #: \_\_\_\_\_ Relationship: \_\_\_\_\_

Name: \_\_\_\_\_ Phone #: \_\_\_\_\_ Relationship: \_\_\_\_\_

Name: \_\_\_\_\_ Phone #: \_\_\_\_\_ Relationship: \_\_\_\_\_

Name: \_\_\_\_\_ Phone #: \_\_\_\_\_ Relationship: \_\_\_\_\_

Name: \_\_\_\_\_ Phone #: \_\_\_\_\_ Relationship: \_\_\_\_\_

Name: \_\_\_\_\_ Phone #: \_\_\_\_\_ Relationship: \_\_\_\_\_

Name: \_\_\_\_\_ Phone #: \_\_\_\_\_ Relationship: \_\_\_\_\_

Name: \_\_\_\_\_ Phone #: \_\_\_\_\_ Relationship: \_\_\_\_\_

**I HAVE READ THE ABOVE AUTHORIZATIONS AND AGREE TO ABIDE BY THEM.**

Signed \_\_\_\_\_ Date \_\_\_\_\_

Relationship to child \_\_\_\_\_ Telephone # \_\_\_\_\_

Name of child \_\_\_\_\_

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## Trip & Aquatics Authorization Form

COMPLETE ALL SECTIONS – PLEASE PRINT OR TYPE

Dear Parents:

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/ aquatics 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 emergency during my child's enrollment in the Kings Bay Y After-School 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.

I give my child permission to go on all trips and to participate in all program activities, including but not limited to swimming, diving, hiking, basketball, baseball, sports, races, obstacle courses, carnival rides, "jumping/bouncing, gymnastics and other physical activities that may cause bodily injury.

**I HAVE READ THE ABOVE AUTHORIZATIONS AND AGREE TO ABIDE BY THEM AND ASSUME THE RISKS INHERENT IN THE PHYSICAL ACTIVITIES THAT MY CHILD WILL PARTICIPATE IN, ON MY BEHALF AND ON THE BEHALF OF MY CHILD, AND I AGREE, TO THE MAXIMUM EXTENT ALLOWED BY LAW, TO RELEASE AND HOLD HARMLESS THE Y FROM ANY CLAIMS OR LIABILITY IN CONNECTION WITH MY CHILD'S PARTICIPATION**

Name of Parent/Guardian: \_\_\_\_\_

Signature: \_\_\_\_\_

Date: \_\_\_\_\_

Relationship to Child: \_\_\_\_\_

Telephone #: \_\_\_\_\_

Name of Child: \_\_\_\_\_



### Recurring Payment Authorization Form

New       Delete       Change

Schedule your payments to be automatically charged to your credit/debit card. Just complete and sign this form to get started!

**Here's How Recurring Payments Work:**

By signing this form, you authorize regularly scheduled charges to your credit/debit card. You will be charged the total amount due for that period. Bank account debit will appear on your bank statement as "KINGS BAY YM-YWHA INC BROOKLYN NY" or, if credit card or debit card payment method is selected, you will see a recurring charge to your card. You agree that no prior notification will be provided for recurring payments. **Initially, and anytime your account information changes, we may run a pre-authorization to make sure the card is valid at no cost to you. A pre-authorization is a temporary funds hold, not a true charge. You may see a charge of .10 cents that will get reversed after your account validation. Pre-authorizations will usually only show up on your credit card or banking statement as "pending charges."** A receipt will be emailed or mailed to you based on selected preference.

**Credit Card Processing Fee:**

Yes \_\_\_ Please include 3% optional processing fee for credit card transactions

**Please complete the information below:**

I \_\_\_\_\_, authorize Kings Bay Y to charge credit/debit card as indicated below on the 1<sup>st</sup> day of each month in the amount of \_\_\_\_\_, as listed in my program registration documents, as payments for \_\_\_\_\_. *(Please print full name of attendee)*

I understand that if the above noted payment date falls on a weekend or holiday, the payment may be executed on the next business day.

Billing Address \_\_\_\_\_  
City, State, Zip \_\_\_\_\_  
Phone# \_\_\_\_\_  
E-mail \_\_\_\_\_

Notification Preference  E-mail     Mail     No Notification Needed

In consideration for the services provided by Kings Bay Y to me or program attendees I designate, I hereby authorize the above named organization to initiate credit and, if necessary, debit entries and adjustments for any credit entries in error to my account as indicated in this authorization form according to the terms outlined herewith. I understand that the above named organization will provide services as requested by me from time to time and I agree to pay the purchase price for such services, and acknowledge, such amounts shall be collected by electronic debits or deductions by the above named organization. I understand that because this is an electronic transaction, these funds may be withdrawn from my account as soon as the above noted periodic transaction dates. In the case of transaction being rejected for Non-Sufficient Funds (NSF), I understand that Kings Bay Y may, at its discretion, attempt to process the charge again within 30 days, and agree to an additional \$20 charge for each attempt returned NSF which will be initiated as a separate transaction from the authorized recurring payment. I acknowledge that the origination of ACH transactions to my account must comply with the provisions of U.S. law. This payment authorization is for the type of bill indicated above. I certify that I am an authorized user of this debit card/credit card (as applicable), and that I will not dispute the scheduled payments with my financial institution/credit card company, provided the transactions correspond to the terms of our agreement. This authorization is to remain in full force and effect until Kings Bay Y has received written notification from me of its termination in such time, and in such manner as to afford Kings Bay Y and Financial Institution a reasonable opportunity to act on it. I may only revoke this authorization by contacting Kings Bay Y directly at the address and phone number listed above, and only in the case that I return the goods, product and/or service provided to me by Kings Bay Y pursuant to their particular return policy in effect on the date this authorization is granted.

SIGNATURE \_\_\_\_\_ DATE \_\_\_\_\_  
*(Account Owner Authorized Representative Signature)*

*Please retain top portion for record keeping*

Charge my Credit Card     Charge my Debit Card

Account Type:  Visa     MasterCard     Discover     American Express     Debit Card

Cardholder Name \_\_\_\_\_

Cardholder Billing Address \_\_\_\_\_

Credit /Debit Card # \_\_\_\_\_ Exp. Date \_\_\_\_\_  
Mo. / Yr.

CVV (3 digit number on back of Visa/MasterCard or 4 digit number on front of American Express Card) \_\_\_\_\_

*Note: Destroy this account information stub and/ card imprints by crosscut or strip-cut shredding, pulping, burning or equivalent*

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, Date of Birth, Child's Address, Hispanic/Latino?, Race, City/Borough, State, Zip Code, School/Center/Camp Name, District Number, Phone Numbers, Health insurance, Parent/Guardian Last Name, First Name, Email

TO BE COMPLETED BY THE HEALTH CARE PRACTITIONER

Birth history, Allergies, Attach MAF in in-school medications needed, Does the child/adolescent have a past or present medical history of the following?, Medications

PHYSICAL EXAM, Date of Exam, General Appearance, Describe abnormalities

DEVELOPMENTAL, Nutrition, Hearing, Vision, Acuity, Dietary Restrictions, SCREENING TESTS, Blood Lead Level (BLL), Lead Risk Assessment, Hemoglobin or Hematocrit, Dental

Child Receives EI/CPSE/CSE services, CIR Number, Physician Confirmed History of Varicella Infection, Report only positive immunity

IMMUNIZATIONS - DATES, DTP/DTaP/DT, Tdap, Hep B, Hib, PCV, Influenza, HPV, MMR, Varicella, Mening ACWY, Hep A, Rotavirus, Mening B, Other, IgG Titers, Date

ASSESSMENT, Well Child (Z00.129), Diagnoses/Problems (list), ICD-10 Code, RECOMMENDATIONS, Full physical activity, Restrictions (specify), Follow-up Needed, Referral(s)

Health Care Practitioner Signature, Date Form Completed, Health Care Practitioner Name and Degree (print), Practitioner License No. and State, Facility Name, National Provider Identifier (NPI), Address, City, State, Zip, Telephone, Fax, Email, DOHMH ONLY PRACTITIONER I.D., TYPE OF EXAM, Date Reviewed, REVIEWER, FORM ID#