Phyl's Academy Preparatory School

3520 Tilden Avenue, Brooklyn, New York, 11203, (718) 469-9400 Fax (718) 284-1438

Adventurers Summer Registration Form

Please check one:

❑ **New Student**

❑ **Current Student**

Child's Name (last) _______________________________ (first)_____________________ (mi)____ Birthdate ____ / ____ /____ ❑ M ❑ F

Grade in Sept' 22 __ Address: ____ Apt # _____ City ____________ State____ Zip_________

New Students, please fill in information below and submit a valid medical at registration.

Current Students, please update any changed information.

Mother's Information

Name ____

Home address *(if different from student)*

____

Apt #______ City _________________ State ____ Zip ______________

Home phone *(if different from student)* ____________________________

Business / Daytime phone ___________________________________

Ext ___________________ Occupation_________________________

For Emergency Use Only:

Cell phone ____

Father's Information

Name ____

Home address *(if different from student)*

____

Apt #______ City _________________ State ____ Zip ______________

Home phone *(if different from student)* ____________________________

Business / Daytime phone ___________________________________

Ext ___________________ Occupation_________________________

For Emergency Use Only:

Cell phone ____

Emergency Contact 1 *(Person other than parents/guardians)*

Full name ____

Relationship________________Cell # __________________________

Additional phone ____

Emergency Contact 2 *(Person other than parents/guardians)*

Full name ____

Relationship________________Cell # __________________________

Additional phone ____

Student Information

Name of person(s) other than parent authorized to pick up child____

Name of physician ____ Phone ____

Health/ Physical condition(s) of which the staff should be aware ____

Learning / Emotional concern(s) of which the staff should be aware ____

Does your child have an IEP(Individual Education Plan)? ❑ No ❑ Yes **If yes, please attach a copy.**

Life-threatening allergies ❑ No ❑ Yes (describe) ____

Allergies to foods or juices ❑ No ❑ Yes (describe) ____

Any permanent disability or chronic or recurring illness? ❑ No ❑ Yes (describe) ____

____

Is there any activity in which your child cannot participate? ❑ No ❑ Yes (describe) ____

____

(please complete back)

Current and New Applicants, please fill the contract below:

Terms and Contract Agreement
(Initial each statement)

I, ______________________________, am the parent/ legal guardian of _________________________________.
(*Print Parent's/ Legal Guardian's Name)* (*Print Child's Name)*

Authorization For Medical Treatment: I understand that my child must have a valid medical on file, is in good health and able to participate in Phyl's Academy's Summer Program. I give permission for my child to participate in all activities offered by Phyl's Academy, except those prohibited by my child's physician. I confirm that I will make the school aware of any prohibited activities prior to the start of the program.

I give permission to Phyl's Academy Preparatory School, its agents, representatives, and employees to take any necessary steps to obtain proper treatment for my child in the event of sudden illness or injury if they can not contact me. I understand that if Phyl's Academy has to obtain emergency medical treatment for my child, my family will be notified as soon as possible. ______

Assumption of Risks: I understand that my child's participation in activities is voluntary and that no environment is risk-free. Though we will take all recommended precautions, I understand that COVID-19 infection is still possible in social environments, and I assume this risk by allowing my child to attend. My child may participate in new activities despite knowledge of inherent risks, and I will instruct my child about the importance of abiding by all school and safety rules. ______

Skates, Skateboards, Scooters: I understand that skates, skate boards and scooters are not allowed in the building or the surrounding premises of Phyl's Academy. I am aware that Phyl's Academy will not accept responsibility for any injuries to anyone not abiding by this guidance, wearing skates, or using skate boards or scooters. _______

Behavior: I understand that Phyl's Academy reserves the unquestionable right to suspend or expel any student for inappropriate behaviors, such as and not exclusive to, bullying, continuous disruptiveness, disrespectfulness, damaging the property of the school or others, violence, unsafe behaviors or causing physical or mental harm to others. ______

Pick up Time: I am aware that all students must be picked up promptly at the dismissal time for their enrolled program. I understand that if I am late to pick up my child, I will be charged late fees of $20 for the first 15 minutes & $1.00 for each minute after that. I understand that Phyl's Academy reserves the right to suspend or expel any student for habitual lateness.

I am aware that if my child is left beyond closing time and I am unreachable, all emergency contacts will be called. If Phyl's Academy is unable to contact anyone, I understand that, as required by New York State Law, my child will be taken to the nearest precinct – the 67th precinct on Snyder Avenue. ______

Photography: I understand that Phyl's Academy reserves the right to record students' voices and film or photograph students for school newsletters, websites, displays, social media, handbooks, advertisement, and professional development. If a child's image is selected for public advertisement, his/her parents will be asked for their consent before it is used. ______

I have read, understand and agree to abide by the terms of this contract.

Signature ______________________________ Relationship_________________ Date ____________________

School Use Only

❑ Current Student ❑ New Student, Medical Received ❑ No ❑ Yes, submitted Summer Lunch Form Received ❑ No ❑ Yes

Enrolled Program(s): ❑ Academic Mornings ❑ Weekly ❑ 3-Week Session ❑ Late Day ❑ Early Bird

Payments: ❑ Registration Fee: $175 ❑ Tuition Payment(s) _________________ Total Paid __________________

Payment Type: ❑ ACH debit ❑ cash ❑ credit card/atm ❑ money order ❑ Zelle

Receipt # _____________________$ ____________________ Date _____________________ Balance Due __________________

Receipt # _____________________$ ____________________ Date _____________________ Balance Due __________________

Summer Group Assignment ______________________________ Rm # _________________

Sibling(s) /Notes ____

Adventurers Summer Program Information

Phyl's Academy's Summer Program runs for six weeks from July 5th to August 12th. For children entering grades 2 through 5, we offer Full Day, Academic Mornings & Extended Day options. Register to attend weekly or 3 week sessions.

All our programs include daily academic review, enrichment activities, most materials, lunch and snacks.

Students are required to wear our summer uniform daily, which is a Phyl's Academy t-shirt with jeans or walking shorts and sneakers. *(No sandals please.)*

Program Options, Fees and Hours

The registration fee for summer is $175.00 per child. This fee is NON-REFUNDABLE and NON-TRANSFERABLE.

Programs and Hours	Daily Fee	Weekly Fee	3-Week Session Fee
Academic Mornings (Mon. to Fri., 8:30 am to 12:00 pm)	N/A	N/A	$ 675.00
Full Day (Mon. to Fri., 8:30 am to 4:00 pm)	N/A	$375.00	$ 1,100.00
Early Bird (Mon. to Fri., 7:15 am to 8:30 am)	$20.00	$ 65.00	$ 195.00
Late Day* (Mon. to Fri., 4:00 pm to 6:00 pm)	$25.00	$ 85.00	$ 255.00

Please select your desired program and dates. *(Please check only what applies:)*

❑ Weekly: $375 per week per child

Select the weeks your child will attend:

❑ 7/5-7/8 ❑ 7/11-7/15 ❑7/18-7/22 ❑7/25-7/29 ❑ 8/1-8/5 ❑8/8-8/12

❑ 3 Week Sessions:

❑ Full Day Program — Hours from 8:30 am to 4:00 pm — $1,100 per session per child

❑ Academic Mornings — Hours from 8:30 am to 12:00 pm — $675 per session per child

Select the sessions your child will attend:

❑ Session 1: 7/5 to 7/22 ❑ Session 2: 7/25 to 8/12 ❑ Both Sessions: 7/5 to 8/12

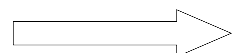
Additional Services:

Select the additional services your child will attend:

❑ Early Bird -- Hours from 7:15 am to 8:30 am -- Add $65.00 per week per child

❑ Late Day -- Hours from 4:00 pm to 6:00 pm -- Add $85.00 per week per child* (Full Day Program Only)

❑ Early Bird + Late Day -- Add $150.00 per week per child



Adventurers Summer Payment Agreement

Fill in the names of the child or children you are registering for the 2022 Summer Program:

Child's Name__________________________, Grade ____ Child's Name __________________________, Grade ____

The registration fee for summer is $175.00 per child. This fee is NON-REFUNDABLE and NON-TRANSFERABLE. The first tuition payment is due at the time of registration.

The Full Day program is held from to M –F, 8:30 am to 4:00 pm. All students must be picked up by 4:00 pm sharp.

Please indicate your selected payment plan(s) and initial the terms: (check your choice)

❑ **Weekly**: I agree to pay $375.00 per week per child and I have selected the weeks my child / children will attend. I understand that all weekly fees are due by the first day of the week. A late fee of $15.00 is applied to all unpaid weekly accounts by the Tuesday evening of each week my child attends. I understand that my child/ children will not be allowed to continue in the Summer Program if the previous week is not paid. I understand that I am responsible for the full fee if my child / children attend one (1) day or more of a week and that daily rates do not apply. ______

❑ **3-Week Session Payment Plan**: I agree to pay $1,100 per 3-week session per child for the Summer Enrichment Program, and I have selected which session(s) my child / children will attend. I understand that for enrollment in the second session full payment of $1,100 per child is due by 7/21/2022. I understand that I am responsible for the full fee once my child / children attend no matter how many days or weeks are in the session. ______

❑ **Academic Mornings** *are held from to M –F, 8:30 am to 12:00 pm. All students must be picked up by 12:00 pm sharp.*

I agree to pay $675 per 3-week session per child for the Academic Mornings Program, and understand that there no weekly or daily rates for this program. I have selected the session (s) my child / children will attend. I understand that for enrollment in the second session full payment of $675 per child is due by 7/21/2022. I understand that I am responsible for the full fee once my child / children attend no matter how many days or weeks are in the session. _____

Extended Day Plans: ***(Indicate which extended day program & payment plan you will use, check your choice)*****:**

❑ **Early Bird,** Mon. to Fri., 7:15 am—8:30pm. I agree to pay $65 per week per child.

❑ **Late Day,** Mon. to Fri., 4:00 pm to 6:00 pm. sharp I agree to pay $85 per week per child.

❑ **Early Bird + Late Day,** I agree to pay $150 per week per child for both Early Bird and Late Day.

General Payment Terms: ***(please initial)***

I understand that credits or refunds will not be issued if the program has a shut down due to a natural disaster, a newly occurring pandemic, or resurgence of COVID-19. I understand that credits will not be issued for absence due to illness. ________

I agree to make the appropriate payments in accordance with the terms of this contract. I am aware that payments are accepted via ACH debit, Zelle, cash, credit card, money order, or certified check. I understand that credit card payments incur a processing fee and that personal checks are not accepted. I understand that Phyl's Academy reserves the unquestionable right to suspend or expel my child if my account is delinquent.________

I, ____, understand and agree to abide by all payment

(Print Parent's/ Legal Guardian's Name)

terms as outlined in this payment contract.

Signature :____ Date_________________________________

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** ☐ **Foster Parent** **Last Name** | **First Name** | **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 if 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
Explain all checked items above.

☐ Seizure disorder
☐ Speech, hearing, or visual impairment
☐ Tuberculosis *(latent infection or disease)*
☐ Hospitalization
☐ Surgery
☐ Other (specify) ______________
☐ ***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	*Nl Abnl*	*Nl Abnl*	*Nl Abnl*	*Nl Abnl*
☐ ☐ Psychosocial Development	☐ ☐ HEENT	☐ ☐ Lymph nodes	☐ ☐ Abdomen	☐ ☐ Skin
☐ ☐ Language	☐ ☐ Dental	☐ ☐ Lungs	☐ ☐ Genitourinary	☐ ☐ Neurological
☐ ☐ Behavioral	☐ ☐ Neck	☐ ☐ Cardiovascular	☐ ☐ Extremities	☐ ☐ 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 _____ /_____ /_____

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: ☐ NAE Current ☐ NAE Prior Year(s)

Comments:

Date Reviewed: _____ / _____ / _____   **I.D. NUMBER** ☐☐☐☐☐☐☐

REVIEWER:

FORM ID# ☐☐☐☐☐☐☐☐☐☐