



Phyl's Academy Preparatory School

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

Young Explorers Summer Registration Form

Please check one:

New Student

Current Student

Child's Name (last) _____ (first) _____ (mi) _____ Birthdate ____ / ____ / ____ M F

Address: _____ Apt # _____ City _____ State _____

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 _____

Emergency Contact 1 (Person other than parents/guardians)

Full name _____

Relationship _____ Cell # _____

Additional 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 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): 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 _____

Young Explorers Summer Program 2022

Phyl's Academy's Summer Program runs for six weeks from July 5th to August 12th. We offer Full Day, Extended Day & Academic Mornings options. Register to attend weekly or by 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.

<u>Programs and Hours</u>	<u>Daily Fee</u>	<u>Weekly Fee</u>	<u>3-Week Session Fee</u>
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: \$1,100 per session per child

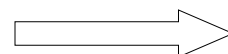
Select the sessions your child will attend:

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



Young Explorers Summer Payment Agreement

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

Child's Name _____, Age _____ Child's Name _____, Age _____

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 child per 3-week session for the Summer Program, and I have selected which session(s) my child / children will attend. I understand that the second session payment is due by 7/21/2022. I understand that regardless of the number of days or weeks my child/ children attend during the session, I am responsible for the full fee. _____

Extended Day Plans:

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 <input type="checkbox"/> Female <input type="checkbox"/> Male	Date of Birth (Month/Day/Year) ____/____/____	
Child's Address				Hispanic/Latino? <input type="checkbox"/> Yes <input type="checkbox"/> No	Race (Check ALL that apply) <input type="checkbox"/> American Indian <input type="checkbox"/> Asian <input type="checkbox"/> Black <input type="checkbox"/> White <input type="checkbox"/> Native Hawaiian/Pacific Islander <input type="checkbox"/> Other _____			
City/Borough	State	Zip Code	School/Center/Camp Name			District Number _____	Phone Numbers Home _____ Cell _____ Work _____	
Health insurance (including Medicaid)? <input type="checkbox"/> Yes <input type="checkbox"/> No	Parent/Guardian Last Name		First Name		Email			
		<input type="checkbox"/> Foster Parent						

TO BE COMPLETED BY THE HEALTH CARE PRACTITIONER

Birth history (age 0-6 yrs) <input type="checkbox"/> Uncomplicated <input type="checkbox"/> Premature: _____ weeks gestation <input type="checkbox"/> Complicated by _____		Does the child/adolescent have a past or present medical history of the following? <input type="checkbox"/> Asthma (check severity and attach MAF): <input type="checkbox"/> Intermittent <input type="checkbox"/> Mild Persistent <input type="checkbox"/> Moderate Persistent <input type="checkbox"/> Severe Persistent If persistent, check all current medication(s): <input type="checkbox"/> Quick Relief Medication <input type="checkbox"/> Inhaled Corticosteroid <input type="checkbox"/> Oral Steroid <input type="checkbox"/> Other Controller <input type="checkbox"/> None <input type="checkbox"/> Asthma Control Status <input type="checkbox"/> Well-controlled <input type="checkbox"/> Poorly Controlled or Not Controlled					
Allergies <input type="checkbox"/> None <input type="checkbox"/> Epi pen prescribed <input type="checkbox"/> Drugs (list) _____ <input type="checkbox"/> Foods (list) _____ <input type="checkbox"/> Other (list) _____		<input type="checkbox"/> Anaphylaxis <input type="checkbox"/> Behavioral/mental health disorder <input type="checkbox"/> Congenital or acquired heart disorder <input type="checkbox"/> Developmental/learning problem <input type="checkbox"/> Diabetes (attach MAF) <input type="checkbox"/> Orthopedic injury/disability Explain all checked items above.			<input type="checkbox"/> Seizure disorder <input type="checkbox"/> Speech, hearing, or visual impairment <input type="checkbox"/> Tuberculosis (latent infection or disease) <input type="checkbox"/> Hospitalization <input type="checkbox"/> Surgery <input type="checkbox"/> Other (specify) _____ Addendum attached.		
Attach MAF if in-school medications needed		Medications (attach MAF if in-school medication needed) <input type="checkbox"/> None <input type="checkbox"/> Yes (list below)					

PHYSICAL EXAM Date of Exam: ____/____/____		General Appearance: <input type="checkbox"/> Physical Exam WNL NI Abnl <input type="checkbox"/> Psychosocial Development <input type="checkbox"/> HEENT <input type="checkbox"/> Lymph nodes <input type="checkbox"/> Abdomen <input type="checkbox"/> Skin <input type="checkbox"/> Language <input type="checkbox"/> Dental <input type="checkbox"/> Lungs <input type="checkbox"/> Genitourinary <input type="checkbox"/> Neurological <input type="checkbox"/> Behavioral <input type="checkbox"/> Neck <input type="checkbox"/> Cardiovascular <input type="checkbox"/> Extremities <input type="checkbox"/> Back/spine					
Height _____ cm (____ %ile)	Weight _____ kg (____ %ile)	BMI _____ kg/m ² (____ %ile)	Head Circumference (age ≤2 yrs) _____ cm (____ %ile)	Describe abnormalities:			
Blood Pressure (age ≥3 yrs) _____ / _____							

DEVELOPMENTAL (age 0-6 yrs) Validated Screening Tool Used? _____ Date Screened ____/____/____ <input type="checkbox"/> Yes <input type="checkbox"/> No Screening Results: <input type="checkbox"/> WNL <input type="checkbox"/> Delay or Concern Suspected/Confirmed (specify area(s) below): <input type="checkbox"/> Cognitive/Problem Solving <input type="checkbox"/> Adaptive/Self-Help <input type="checkbox"/> Communication/Language <input type="checkbox"/> Gross Motor/Fine Motor <input type="checkbox"/> Social-Emotional or Personal-Social <input type="checkbox"/> Other Area of Concern: _____		Nutrition <input type="checkbox"/> < 1 year <input type="checkbox"/> Breastfed <input type="checkbox"/> Formula <input type="checkbox"/> Both <input type="checkbox"/> ≥ 1 year <input type="checkbox"/> Well-balanced <input type="checkbox"/> Needs guidance <input type="checkbox"/> Counseled <input type="checkbox"/> Referred Dietary Restrictions <input type="checkbox"/> None <input type="checkbox"/> Yes (list below)		Hearing Date Done ____/____/____ Results < 4 years: gross hearing ____/____/____ <input type="checkbox"/> NI <input type="checkbox"/> Abnl <input type="checkbox"/> Referred OAE ____/____/____ <input type="checkbox"/> NI <input type="checkbox"/> Abnl <input type="checkbox"/> Referred ≥ 4 yrs: pure tone audiometry ____/____/____ <input type="checkbox"/> NI <input type="checkbox"/> Abnl <input type="checkbox"/> Referred	
Describe Suspected Delay or Concern: _____		SCREENING TESTS Date Done ____/____/____ Results Blood Lead Level (BLL) (required at age 1 yr and 2 yrs and for those at risk) ____/____/____ _____ µg/dL Lead Risk Assessment (annually, age 6 mo-6 yrs) _____ <input type="checkbox"/> At risk (do BLL) <input type="checkbox"/> Not at risk		Vision Date Done ____/____/____ Results <3 years: Vision appears: ____/____/____ <input type="checkbox"/> NI <input type="checkbox"/> Abnl Acuity (required for new entrants and children age 3-7 years) Right ____/____/____ Left ____/____/____ <input type="checkbox"/> Unable to test Screened with Glasses? <input type="checkbox"/> Yes <input type="checkbox"/> No Strabismus? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Child Receives EI/CPSE/CSE services <input type="checkbox"/> Yes <input type="checkbox"/> No		Hemoglobin or Hematocrit _____ g/dL _____ %		Dental Visible Tooth Decay <input type="checkbox"/> Yes <input type="checkbox"/> No Urgent need for dental referral (pain, swelling, infection) <input type="checkbox"/> Yes <input type="checkbox"/> No Dental Visit within the past 12 months <input type="checkbox"/> Yes <input type="checkbox"/> No	

CIR Number		Physician Confirmed History of Varicella Infection <input type="checkbox"/>		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 <input type="checkbox"/> Well Child (Z00.129) <input type="checkbox"/> Diagnoses/Problems (list) _____ ICD-10 Code _____		RECOMMENDATIONS <input type="checkbox"/> Full physical activity <input type="checkbox"/> Restrictions (specify) _____ Follow-up Needed <input type="checkbox"/> No <input type="checkbox"/> Yes, for _____ Appt. date: ____/____/____ Referral(s): <input type="checkbox"/> None <input type="checkbox"/> Early Intervention <input type="checkbox"/> IEP <input type="checkbox"/> Dental <input type="checkbox"/> Vision <input type="checkbox"/> Other _____	
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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: <input type="checkbox"/> NAE Current <input type="checkbox"/> NAE Prior Year(s) Comments: _____	
Facility Name		National Provider Identifier (NPI)		Date Reviewed: ____/____/____ I.D. NUMBER _____	
Address		City		State	
Telephone		Fax		Email	
				FORM ID# _____	