2025-2026
H.E.S. AFTERSCHOOL
REGISTRATION BOOKLET

- Fully licensed, trained and certified staff
- Vacation Programs available for school holidays
- Private pay and vouchers accepted

REGISTER ONLINE

Our Program provides:

- Bus pick-up from local schools
- Homework support
- Academic enrichment and NYC test prep
- Fun-filled activities
- Daily nutritious dinner

All packet documents and the online registration must be completed prior to starting the program

Need help with registration?
Contact us at 718-241-3000 ext. 122 or registration@thehes.org

H.E.S. JCC
YOUR Community Center!

UJA Federation NEW YORK

HEBREW EDUCATIONAL SOCIETY | 9502 SEAVIEW AVENUE, BROOKLYN, N.Y. 11236 | 718.241.3000

THE H.E.S. AFTER SCHOOL REGISTRATION FORM

PARTICIPANT INFORMATION

First Name:_____ Last Name: _____

Gender: _____ DOB: _____ Grade in the Fall: _____

School Attending in the Fall: _____

Does your child have an IEP?: Yes / No

PARENT/GUARDIAN INFORMATION

First Name: _____ Last Name: _____

Phone: _____ Email: _____

Address: _____ Apt/Fl: _____

City: _____ State: _____ Zip Code: _____

AUTHORIZED PICK-UP AND EMERGENCY CONTACT INFORMATION

Full Name: _____ Relationship: _____

Role: Emergency Contact | Pick-up Cell Phone Number_____

Full Name: _____ Relationship: _____

Role: Emergency Contact | Pick-up Cell Phone Number_____

Full Name: _____ Relationship: _____

Role: Emergency Contact | Pick-up Cell Phone Number_____

Child Care Program *(Please Circle Program)*

- ◯ Public School ASP
- ◯ Charter School ASP
- ◯ SONYC *(Grades 6th-8th)*
- ◯ R.A.P. Room

Fee Category *(Please fill bubble)*

- ◯ Private Pay
- ◯ 1199
- ◯ Voucher
- ◯ OPWDD
- ◯ Other _____

Child Care Add-ons *(Please Circle Program)*

- ◯ Vacation Program
- ◯ Extended Day

Billing Cycle (Please Circle)

- ◯ Weekly
- ◯ Bi-Weekly
- ◯ Monthly
- ◯ Other

Fee Amount _____

Payments/Discounts _____

CONSENT FOR EMERGENCY MEDICAL TREATMENT AND TRANSPORTATION:

☐ *I hereby give authority to the Hebrew Educational Society Year-Round After School and Staff to obtain necessary emergency medical treatment for my child/ren with the understanding that the family will be notified as soon as possible.*

☐ *I give permission for my children to use the HES bus as transportation for the After-School programs.*

Signature: _____ **Date:** _____

H.E.S. JCC
YOUR Community Center!

PARENT TO SCHOOL OFFICE PERMISSION LETTER

Dear Sir or Madam,

This is to inform you that my child, _____ of class _____ will be attending the After School Program at the Hebrew Educational Society for the 2025-2026 school term.

Please dismiss this child with the regular bus children at the end of the school day to the H.E.S. bus counselor.

Thank you for your attention to this matter. If you have any questions, please call the H.E.S. at 718-241-3000 and ask for our After School Program Staff.

Parent's Signature: _____

Date: _____

H.E.S. JCC
YOUR Community Center!

PARENT TO TEACHER PERMISSION LETTER

Dear Sir or Madam,

This is to inform you that my child, _____ of class _____ will be attending the After School Program at the Hebrew Educational Society for the 2025 - 2026 school term.

Please dismiss this child with the regular bus children at the end of the school day to the H.E.S. bus counselor.

Thank you for your attention to this matter. If you have any questions, please call the H.E.S. at 718-241-3000 and ask for our After School Program Staff.

Parent's Signature: _____

Date: _____

H.E.S. JCC
YOUR Community Center!

Consent to Walk Home

FOR GRADES 6TH-8TH ONLY

To H.E.S. ,

I, _____ give my child,

_____ permission to walk home alone from the H.E.S. After School Program without being signed out by a parent / guardian.

This will be in effect from September 4, 2025 through June 26, 2026.

Parent's Print Name : _____

Parent's Signature: _____

Date: _____

H.E.S. JCC
YOUR Community Center!

Dear Parents and Guardians,

While attending programs at the Hebrew Educational Society, we want to provide a safe environment that promotes appropriate social growth and interactions. In order to do this, we have established the behavior policy below:

1. Self-Respect: We expect students to follow rules and directions.
2. Mutual Respect: We expect students to express their feelings and thoughts to others with appropriate words.
3. Respect for Materials and Property: Materials and equipment are to be used with care.

* Please Note- Immediate removal from the program will occur if a student exhibits physical behaviors that risks the safety of his/her self, peers or staff members.

The Hebrew Educational Society uses a three-point system to encourage positive behavior in our programs; students who exhibit positive behavior will be recognized.

The following actions may be taken if rules are not followed:

1. A verbal warning to the student. His/her parent(s) or guardian(s) will be notified.
2. Suspension from the program for a designated number of days (at the discretion of the after school director.)
3. Permanent Removal from the program with parent(s) or guardian(s) notification.

Ifyou have any questions, please call the After School Program Director (718) 241-3000.

_____ _____

Parent/Guardian (Print) Date

_____ _____

Parent/Guardian (Print) Date

2025-26 School Year
New York State Immunization Requirements
for School Entrance/Attendance[1]

NOTES:
Allchildren must be age-appropriately immunized to attend school in New York State. The number of doses depends on the schedule recommended by the Advisory Committee on Immunization Practices (ACIP). Intervals between doses of vaccine must be in accordance with the "ACIP-Recommended Child and Adolescent Immunization Schedule." Doses received before the minimum age or intervals shown on the schedule are not valid and do not count toward the number of doses listed below. See footnotes for specific information for each vaccine. Children who are enrolling in gradeless classes must meet the immunization requirements of the grades for which they are age equivalent.

Dose requirements MUST be read with the footnotes of this schedule

Vaccines	Pre-Kindergarten (Day Care, Head Start, Nursery or Pre-K)	Kindergarten and Grades 1, 2, 3, 4 and 5	Grades 6, 7, 8, 9, 10 and 11	Grade 12
Diphtheria and Tetanus toxoid-containing vaccine and Pertussis vaccine (DTaP/DTP/Tdap/Td)[2]	**4 doses**	**5 doses or 4 doses** if the 4th dose was received at 4 years or older and the series was started at less than 1 year of age or **3 doses** if 7 years or older and the series was started at 1 year or older	**3 doses**	
Tetanus and Diphtheria toxoid-containing vaccine and Pertussis vaccine adolescent booster (Tdap)[3]	**Not applicable**		**1 dose** given after age 10 years	
Polio vaccine (IPV/OPV)[4]	**3 doses**	**4 doses or 3 doses** if the 3rd dose was received at 4 years or older		
Measles, Mumps and Rubella vaccine (MMR)[5]	**1 dose**	**2 doses**		
Hepatitis B vaccine[6]	**3 doses**	**3 doses or 2 doses** of **adult hepatitis B vaccine** (Recombivax) for children who received the doses at least 4 months apart and between the ages of 11 years through 15 years		
Varicella (Chickenpox) vaccine[7]	**1 dose**	**2 doses**		
Meningococcal conjugate vaccine (MenACWY)[8]	**Not applicable**		**Grades 7, 8, 9, 10 and 11: 1 dose**	**Grade 12: 2 doses or 1 dose** if the dose was received at 16 years or older
Haemophilus influenzae type b conjugate vaccine (Hib)[9]	**1 to 4 doses**	**Not applicable**		
Pneumococcal Conjugate vaccine (PCV)[10]	**1 to 4 doses**	**Not applicable**		

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:

	Nl	Abnl
HEENT	☐	☐
Dental	☐	☐
Neck	☐	☐
Lymph nodes	☐	☐
Lungs	☐	☐
Cardiovascular	☐	☐
Abdomen	☐	☐
Genitourinary	☐	☐
Extremities	☐	☐
Skin	☐	☐
Neurological	☐	☐
Back/spine	☐	☐
Psychosocial Development	☐	☐
Language	☐	☐
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)*	__ __ / __ __ / __ __	☐ Nl ☐ 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 __ __ / __ __ / __ __

DOHMH ONLY **PROVIDER I.D.**

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

Facility Name | National Provider Identifier (NPI)

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

Address | City | State | Zip

Telephone (__ __ __) __ __ __ – __ __ __ __

Fax (__ __ __) __ __ __ – __ __ __ __

Date Reviewed: __ __ / __ __ / __ __

I.D. NUMBER

REVIEWER:

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