



P.S. 188 MYAP ENROLLMENT FORM 2021/2022

(Enrollment forms must be fully completed and signed for EACH child)

Student Name: _____ Class _____ Date: _____

Address: _____

Parent Name: _____

Contact Phone Number: _____

Email Address: _____

Note ALL Credit / Debit Card transactions will incur a service fee of 4% per transaction

Please note, MYAP tuition is prorated and easily broken down with 10 installments. You only pay for days that school is in session.

Late tuition will incur a \$25.00 per week fee, beginning on the 14th of each month. MYAP is in session on full days of school and there is no afterschool on 1/2 days. **There are no make-up days and there is NO credit for days that your child is absent.**

I release MYAP Inc. and or anyone who is affiliated with MYAP Inc. from any and all liabilities that may occur. I fully and completely understand that at no time can or will MYAP Inc. and or its affiliates be personally or professionally held accountable or responsible at any time. I fully understand that my child and or my participation in or at MYAP Inc. events or anything affiliated with MYAP Inc. will always be at my or my child's own risk. I also understand that there are no refunds of any kind. I consent to pay the full amount that I agreed upon when I signed this contract for my child to participate in MYAP Inc. I grant permission to MYAP Inc. the right to use photographs and videos of my child in advertising materials. We reserve the right to remove your child from the program if your child behaves in a disrespectful manner. There will be absolutely no refunds under any circumstance. There will be absolutely no refunds or credits applied due to COVID-19 shut down, or any type of interruption that may occur due to circumstances that are enforced by

the NYC Department of Health, the NYC Department of Education and or any other affiliates including the MYAP Inc. Afterschool.

Parent Signature: _____ Date: _____



	Child's Full Name:		Date of Birth: / /	Gender:	
	Preferred Name/Nickname:				
	Child's Home Address:				
	Name of Person Enrolling Child:		Relationship to Child: <input type="checkbox"/> Parent <input type="checkbox"/> Guardian <input type="checkbox"/> Caretaker <input type="checkbox"/> Relative _____ <input type="checkbox"/> Other _____		
Phone Number(s) of Person Enrolling Child: () - <input type="checkbox"/> ok to text			Address of Person Enrolling Child (if different than child):		
Email Address:					
EMERGENCY INFO	EMERGENCY CONTACT NAMES / ADDRESSES		Authorized to Pick Up	PRIMARY PHONE NUMBER	OTHER PHONE NUMBER / EMAIL
	Primary Contact:		<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> ok to text	<input type="checkbox"/> ok to text
			<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> ok to text	<input type="checkbox"/> ok to text
			<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> ok to text	<input type="checkbox"/> ok to text
For Program Use Only Date of Enrollment: / /			For Program Use Only Date of Disenrollment: / /		

Child's Full Name:		Date of Birth: / /
Check boxes below to indicate if your child has any special needs/services: <input type="checkbox"/> None <input type="checkbox"/> Early Intervention/Special Education <input type="checkbox"/> Occupational Therapy <input type="checkbox"/> Speech/Language <input type="checkbox"/> Physical Therapy <input type="checkbox"/> Allergies (list) _____ <input type="checkbox"/> Other _____		
Please provide information here AND discuss with your child care provider:		
Child's Primary Care Physician's Name/ Group:		Phone Number: () -
Preferred Hospital:		Phone Number: () -
Child's Dental Care:		Phone Number: () -
Child health insurance information is available by calling toll-free 1-800-698-4543 or the NYS Health Marketplace website: https://nystateofhealth.ny.gov/		
AGREEMENTS		
• I consent to emergency medical treatment for my child.....		<input type="checkbox"/> Yes <input type="checkbox"/> No
• I consent for my child to take part in neighborhood trips (i.e., library, park and playground) away from the program under proper supervision.....		<input type="checkbox"/> Yes <input type="checkbox"/> No
• I understand the program may need additional permissions for situations such as transportation, medication, release of information, and field trips.....		<input type="checkbox"/> Yes <input type="checkbox"/> No
• I provided information on my child's special needs to the program to assist in caring for my child.....		<input type="checkbox"/> Yes <input type="checkbox"/> No
• I understand the program must give parents, at the time of enrollment of a child, a written policy statement as required by regulation.....		<input type="checkbox"/> Yes <input type="checkbox"/> No
• I agree to review and update this information whenever a change occurs and at least once every year.....		<input type="checkbox"/> Yes <input type="checkbox"/> No
SIGNATURE -- PARENT OR PERSON(S) LEGALLY RESPONSIBLE:		DATE: / /