AFTERSCHOOL CARE REGISTRATION 2017-2018

Child's Last Name_______________________, **First** _____________________ **Middle** ______________

Child's Date of Birth (mo/day/yr) ☐☐ ☐☐ ☐☐☐☐ **Child's Gender** ☐ Male ☐ Female

Last 4 Digits ONLY of Child's Social Security# ☐☐☐☐ ☐ No SSN ☐ Prefer not to give

Miami-Dade County Public School ID# ☐☐☐☐☐☐☐ ☐ No MDCPS ID ☐ Prefer not to give

Child's Current School ____

Is your Child Proficient in English? ☐ Yes ☐ No

Other Language(s) Spoken in the Home ☐ Spanish ☐ Haitian-Creole ☐ Other___________ ☐ None

Street Address ___________________________________ **City** ________________ **ZIP Code** _________

Child's Ethnicity ☐ Hispanic ☐ Haitian ☐ Other

Child's Race (select only one) ☐ American Indian or Alaskan ☐ Asian ☐ Black or African American
☐ Pacific Islander ☐ White ☐ Other ☐ Multiracial

Child's Current Grade ☐☐

Does Child Have Health Insurance (ex., private insurance, KidCare, Medicaid)**?** ☐ Yes ☐ No
(If not, we may be able to help you find affordable coverage-call 211 or visit www.thechildrenstrust.org)

Child's Primary Caregiver (full name) ____

Primary Caregiver Email ____

Primary Phone ☐☐☐ ☐☐☐ ☐☐☐☐

(You may be contacted by The Children's Trust to ask about your satisfaction with these services)

*Required fields

Revised 01/09/17

We want to get to know your child better so we can provide the best possible experience in our programs. Please tell us more about your child…

What are the main ways your child communicates? (Mark all that apply)

☐ Speaks and is easily understood
☐ Speaks but is difficult to understand
☐ Uses sign language
☐ Uses communication devices like pictures or a board
☐ Uses gestures like pointing, pulling or blinking
☐ Uses sounds that are not words like grunting

What, if any, help does your child receive at this time? (Mark all that apply)

☐ Speech/language therapy
☐ Occupational therapy (OT)
☐ Physical therapy (PT)
☐ Daily medication (not including vitamins)
☐ Special education services in school
☐ Behavioral therapy or services
☐ Counseling for emotional concerns
☐ None

What conditions does your child have that are expected to last for a year or more? (Mark all that apply)

☐ Physical disability or impairment
☐ Medical condition or illness
☐ Hearing impairment or deaf
☐ Visual impairment or blind
☐ Speech or language condition
☐ Autism spectrum disorder
☐ Developmental delay (only if under age 5)
☐ Problems with learning (if school-age)
☐ Problems with attention or hyperactivity (ADHD/ADD)
☐ Problems with depression or anxiety
☐ Problems with aggression or temper
☐ None of the above

If you marked "None of the above" on the question above, please skip the next two questions and sign below. If you marked any other answer above, please answer the remaining questions and sign below.

Do any of the conditions marked above make it harder for your child to do things that other children of the same age can do? ☐ Yes ☐ No

To support your child's successful participation in this program, in what areas might s/he need extra assistance? ☐ No specific help needed

☐ Holding a crayon/pencil, writing, using scissors or other fine motor tasks
☐ Sports or physical activities like running or other gross motor tasks
☐ Managing feelings and behavior
☐ Academic, learning or reading activities
☐ Adapting activities to take into account a visual or hearing impairment
☐ Using assistive device(s) like a wheelchair, crutches, brace or walker
☐ Personal services like help with feeding, toileting or changing clothes
☐ Other ____

Please tell us anything else you think it is important for us to know about your child

____

If you are interested in other services funded by The Children's Trust, please call 211 or visit www.thechildrenstrust.org

I give my permission for this information to be submitted to The Children's Trust for program quality and evaluation purposes. The Children's Trust provides funding for the program.

PARENT/GUARDIAN SIGNATURE ______________________________________ **DATE**_______________

FOR STAFF USE ONLY (*MUST BE COMPLETED*) Site ____

*Required fields

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Emergency Contact

Name__________________________Relation ____________________Phone #___________________

Name__________________________Relation ____________________Phone #___________________

Name__________________________Relation ____________________Phone #___________________

Authorized Person/s For Pick Up

Name__________________________Relation ____________________Phone #___________________

Name__________________________Relation ____________________Phone #___________________

CAUTION!!!

Unauthorized Person/s For Pick Up

Name__________________________Relation ____________________Phone #___________________

Name__________________________Relation ____________________Phone #___________________

Additional Information:____

____

Parent/Guardian Signature: ______________________________________Date: ______________________

*Required fields

Revised 01/09/17

The Children's Trust The Resource Room

AUTHORIZATION FOR PHOTOGRAPHY/VIDEO

I, ____, the parent or guardian of ____ hereby authorize and give consent to service providers and the staff of The Children's Trust of Miami-Dade County as follows:

I hereby:

❐ consent and authorize **or** **❐ do not consent and authorize**

the staff of The Children's Trust of Miami-Dade County to take/use still photographs, digital photographs, motion pictures, television transmission, and/or videotaped recordings (hereinafter "Recordings") of me, my children, or my wards for educational, research, documentary, and public relations purposes.

________________________________ ________________________
Signature of Parent or Guardian Signature of Witness

_________________________________ ________________________
Date Date

Any such Recordings may reveal your identity through the image itself without any compensation to you, your children or wards.

Any and all Recordings taken of you, your children or wards shall be the sole property of The Children's Trust.

With regard to the use of any Recordings taken of you, your children or wards, you hereby waive any and all present and future claims you may have against The Children's Trust of Miami-Dade County, their staff, service providers, employees, agents, affiliates and Board members.

Medical Information

Parent/Legal Guardian's Name: ____

Address: ____

Phone #s: Home (________) _____________ - _________________________

Work (________) _____________ - _________________________

Cell   (________) _____________ - _________________________

Others (________) _____________ - _________________________

Children's Names	List all Known Medical Conditions, Including Food Allergies and/or Drug Allergies. In Addition, Include Any and All Over-the-Counter and/or Prescription Drugs Taken Regularly.

In an emergency, please contact: ____

Relationship to child/children: ____

Phone #s: (________) _____________ - _________________________

(________) _____________ - _________________________

Or contact: ____

Relationship to child/children: ____

Phone #s: (_______) __________ - ___________ (______) _________ - _________

(_______) __________ - ___________ (______) _________ - _________

Parent/Guardian Signature: ____________________________________Date: _____________________

*Required fields

Revised 01/09/17

Medical Information

Physician's Name: ____

Address: ____

Phone #s: (_______) __________ - ___________ (______) _________ - _________

(_______) __________ - ___________ (______) _________ - _________

Dentist's Name: ____

Address: ____

Phone #s: (_______) __________ - ___________ (______) _________ - _________

(_______) __________ - ___________ (______) _________ - _________

Primary Insurance Company: _______________________________________

Phone #s: (_______) __________ - ___________ (______) _________ - _________

Billing Address: ____

Policy Holder's Name: ____

Address: ____

Relationship to child/children: ______________________________________

ID #: ___________________________ Group/Policy #: __________________________

Parent/Guardian Signature: ______________________________________Date: ______________________

*Required fields

Medical Release Authorization

Statement of Consent: (To be signed in the presence of a legalized notary public.)

In the event of an emergency or non-emergency situation requiring medical treatment, I, ____, hereby grant permission for any and all medical and/or dental attention to be administered to my child/children, in the event of an accidental injury or illness, until such time as I can be contacted. This permission includes, but is not limited to, the administration of first aid, the use of an ambulance, and the administration of anesthesia and/or surgery, under the recommendation of qualified medical personnel.

Signature:____ Date____________

Notarization:

On this _________ day of ________________, ______________, ________________________________
(Date) (Month) (Year) (Name of Parent)

personally appeared before me in ___________________ County (in the state of_____________________)

and, in my presence, signed this medical release form.

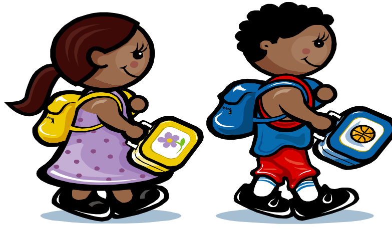
Name of Notary Official: ____

Signature: ____

Commission Expires: ____

3150 SW 3rd Avenue, 8th Floor ● Miami, FL 33129
(305) 571-5700 ● Fax: (305) 860-2328
www.thechildrenstrust.org

The Children's Trust   The Resource Room



Walking Home From Permission Form 2017-18

Name of child/children: ____

My child/children will be walking home daily: _________________ Occasionally: _____________

If your child is walking home on an occasional basis you must call the office by 3:00pm on that day or they will have to be picked up and will not be released until parent or authorized person comes in to retrieve their child/children.

My child/children may walk home unescorted: ______________________
My child/children may walk home with:
Name: ____
Grade: ________________

Name: ____
Grade: ______________

Please note, if your child is walking home with a middle school student, they will be held until middle school students dismiss at 6:00pm
My child/children have my permission to walk to/from The Resource Room

______________________________ ________________________________
Parent Name Phone

______________________________ ________________________________
Signature Date

Parent Acknowledgements

- Section 65C-22.006(2), F.A.C., requires a current physical examination (Form 3040) and immunization record (Form 680 or 681) within 30 days of enrollment.

- Section 402.3125(5), F.S., requires that parents receive a copy of the Child Care Facility Brochure, "Know Your Child Care Facility" (CF/PI 175-24), **or**

- Section 65C-20.11(2)(c)(1), F.A.C., requires that parent(s) receive a copy of the family day care home brochure, "Selecting A Family Day Care Home Provider" (CF/PI 175-28).

- Section 65C-22.006(3)(c)2., F.A.C., requires that parents are notified in writing of the disciplinary practices used by the child care facility, **or**

- Section 65C-20.010(6)(c), F.A.C., requires that a written a copy of the family day care provider's discipline policy be available for review by the parent(s).

- The Resource Room Welcome Package which included our behavior and data confidentiality policy

Your signature below indicates that you have received the above items and that the information on this enrollment form is complete and accurate.

____ __________________________

Signature of Parent/Guardian Date