Child/Youth Photo Here

# AFTERSCHOOL 2025-2026 PARTICIPANT APPLICATION

**Dates:** August 14, 2025 – June 4, 2026

**Operating Hours**: Monday to Friday: 2:00 pm-6:00 pm (K-5th); 3:45 pm-6 pm (6-8th); 2:30 pm-6:00 pm (9th-12th)

☐ **Bel-Aire (K-5th): 10250 SW 194th St. Cutler Bay, FL 33157**
☐ **West Flagler Park (K-5th): 5911 W Flagler St. Miami, FL 33144**
☐ **Estrella de Belen (K-5th): 510 East 41st Street Hialeah, FL 33013**
☐ **Miami Central (9th-12th): 1781 N.W. 95th St., Miami, FL 33147**
☐ **Pinelands (K-5th): 10201 Bahia Dr. Miami, FL 33189**
☐ **John A. Ferguson (9th -12th): 15900 SW 56th St. Miami, FL 33185**
☐ **Pneuma (K-8th): 7205 SW 125th Ave. Miami, FL 33183**
☐ **Felix Varela (9th -12th): 15255 SW 96th St. Miami, FL 33196**
☐ **Wayside (K-8th): 7701 SW 98th St. Kendall, FL 33156**

**Child/Youth Name** _____
**Last** **First** **Middle**

| **Child/Youth Date of Birth** | **Child/Youth Gender** | **Child/Youth Race/Ethnicity** (please select only one) |
|---|---|---|
| _____/_____/_____<br>Month / Day / Year | ☐ Female ☐ Male<br>☐ Prefer not to answer | ☐ Biracial or Multiracial ☐ Hispanic<br>☐ Black non-Hispanic/African American ☐ Haitian<br>☐ White non-Hispanic ☐ Other<br>☐ Prefer not to answer |

**Mark all languages your child/youth speaks**
☐ English ☐ Spanish ☐ Haitian Creole ☐ Other:_____

| **What is the child/youth 2025-2026 school year grade level:** | **Miami-Dade County Public Schools ID#** *(all students attending public or charter schools must have a school ID#)* |
|---|---|
| ☐ Kindergarten<br>☐ Grade 1-12 (specify) _____ | _____ _____ _____ _____ _____ _____ _____<br>☐ No M-DCPS ID # |

**Current School** _____

**Home Address** _____
**Street** **City** **ZIP Code**

**Caregiver Name** _____
**Last** **First**

| **Caregiver Phone Number** | **Caregiver Email address** |
|---|---|
| (_____) _____ -_____<br>**Is this a cell/mobile phone?** ☐ Yes ☐ No | |

**Caregiver's preferred language for contact from The Children's Trust** (please select only one)

☐ English ☐ Spanish ☐ Haitian Creole

Hope for Miami
5911 W. Flagler St., Miami, FL 33144
**Tel**: 786-388-3000

Please note that The Children's Trust may contact you via postal mail, email and/or text to ask about your satisfaction with services, and to make you aware of other Trust-funded programs, initiatives and events that may interest you.

How did you hear about this program?_____

As part of my child's voluntary participation in this program, I give my permission for the information collected through this program to be submitted to The Children's Trust for program evaluation and quality purposes. The Children's Trust provides funding for the program to operate and follows strict data privacy protections for the information collected (for example, following the Family Educational Rights and Privacy Act/FERPA guidelines).

| **Parent/Guardian Signature** | **Date Signed**<br><br>_____/_____/_____<br>Month / Day / Year |
|---|---|

We want to get to know your child better so that we can provide the best possible experience in our programs. The questions on the next page address your child's need for assistance, any conditions or challenges, their communication methods, and the support they receive. **This information is used to ensure that children and youth of all abilities are welcomed and supported in programs funded by The Children's Trust.**

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**To support your child/youth's successful participation in this program, in what areas might they need extra assistance?**

- ☐ Academic and learning supports, such as reading or understanding basic instructions
- ☐ Managing feelings and behavior, such as needing extra support or structure
- ☐ Chronic health condition management, such as using an epi pen, inhaler, or other medications
- ☐ Fine motor tasks, such as holding a crayon/pencil, writing, or using scissors
- ☐ Gross motor tasks, such as sports or physical activities like running
- ☐ Adapting activities to consider visual, speech, or hearing needs
- ☐ Using assistive device(s) like a wheelchair, crutches, brace, or walker
- ☐ Personal services, such as help with feeding, toileting, or changing clothes
- ☐ Other _____

☐ No specific help needed

**If you noted any areas of extra assistance needed, please be sure to speak individually with the program staff about your child's needs and how the program can meet them.**

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

- ☐ Developmental delay (only if under age 5)
- ☐ Intellectual/developmental disability (over age 5)
- ☐ Learning disability (over age 5)
- ☐ Autism spectrum disorder
- ☐ Deaf or hard of hearing
- ☐ Medical condition or illness (like asthma, diabetes, epilepsy/seizures, severe allergies)
- ☐ Physical disability or impairment
- ☐ Managing aggression or temper
- ☐ Managing attention and hyperactivity (ADHD)
- ☐ Depression or anxiety
- ☐ Speech or language condition
- ☐ Blind or low vision
- ☐ Other condition lasting one year or more (please specify) _____
- ☐ No conditions lasting one year or more

Do any of the conditions noted make it harder for your child/youth to do things that others of the same age can do?

☐ Yes, it is harder for them ☐ No, it is not harder for them ☐ N/A, no conditions noted

**What are the main ways in which your child communicates?** (mark all that apply)

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

**What, if any, help does your child/youth receive at this time?** (mark all that apply)

- ☐ Behavioral therapy or services
- ☐ Counseling for emotional concerns
- ☐ Daily medication (not including vitamins)
- ☐ Exceptional student education services in school through an IEP or 504 plan (If so, please attach)
- ☐ Occupational therapy (OT)
- ☐ Physical therapy (PT)
- ☐ Speech/language therapy
- ☐ None of the above are needed at this time
- ☐ At least one of these services are needed but not received

If you are interested in other community services or resources, you can call the **211 Miami Helpline, visit** 211miami.org, or learn more about **The Children's Trust programs at** www.thechildrenstrust.org. For special needs resources for individuals with disabilities and their families, visit **www.advocacynetwork.org/services/individual-family-support or** www.thechildrenstrust.org/cwd.

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**STAFF USE ONLY *(MUST BE COMPLETED)***

**Sibling(s) names in our program:**

**1.** _____ **2.** _____

**3.** _____ **4.** _____

**Sibling definition:** One or more children having one or both parents in common or legally adopted.

**Fees Collected:**

**Please Note**: **Only Money Orders and Credit Card payments are accepted**. No checks or cash
**Accident Insurance fee: $10 collected**: ☐ Yes ☐ No
**Registration Fee: $90.00 collected**: ☐ Yes ☐ No

**Application Verified by:** _____

**Date of Completion:** _____ **Tentative Start Date:** _____

# "Getting to Know Me" YD K-5 / CWD

Child's Name _____

D.O.B._____ Date_____

**We want to get to know your child better so that we can provide the best possible educational experience. No one knows your child better than you. Tell us more about your child.**

1. **What are your child's favorite/least favorite toys/activities/rewards**?

| **Least Favorite** | **Favorite** |
|---|---|
| _____ | _____ |
| _____ | _____ |
| _____ | _____ |

2. **What calms your child and what upsets your child?**

| **Calms** | **Upsets** |
|---|---|
| _____ | _____ |
| _____ | _____ |
| _____ | _____ |

3. **What are your child's strengths and challenges?**

| **Strengths** | **Challenges** |
|---|---|
| _____ | _____ |
| _____ | _____ |
| _____ | _____ |

4. **How does your child communicate?**

❑ Verbally ❑ Through gestures (i.e., pointing, pulling, blinking) ❑ American Sign Language (ASL)
❑ With vocalizations ❑ With communication devices (i.e., pictures)
❑ Other (please specify) _____

5. **What services does your child receive?**

❑ Speech/Language Therapy ❑ Behavioral ❑ Physical Therapy
❑ Mental Health Counseling ❑ Occupational Therapy ❑ None

May we contact your service provider to better support your child? ❑ Yes ❑ No (Signed authorization form required)

6. **Does your child require assistive devices or equipment?** (i.e., braces, walker, wheelchair, communication device, insulin, nebulizer)

❑ Yes ❑ No If yes, please describe _____

# "Getting to Know Me" YD K-5 / CWD

Child's Name _____

**7. Do you suspect your child has a hearing or vision problem?** ❑ Yes ❑ No

If yes, please describe _____

**8. Which statement best describes your child's ability to move from one activity to another?**

❑ Easily moves from one activity to another ❑ Needs assistance to move from one activity to another

Please explain _____

**9. Does your child play/interact best** (please check all that apply):

❑ Independently ❑ With another child ❑ Small group ❑ Large group ❑ Outdoors

❑ Indoors ❑ With adults ❑ Additional comments: _____

**10. Do any of the following bother your child?**

❑ Noise ❑ Texture (i.e., sand, water) ❑ Lights ❑ Touch (i.e., hugs)

❑ Smells ❑ Other _____

**11. Does your child wander, run away or bolt?** ❑ Yes ❑ No

If yes, what situations precede this behavior? _____

**12. Is your child able to do the following activities by him/herself?**

Use the toilet ❑ Yes ❑ No Walk/move about ❑ Yes ❑ No

Eat ❑ Yes ❑ No Wash his/her hands ❑ Yes ❑ No

If no, please describe what assistance is needed: _____

**13. Does your child take medication?** ❑ Yes ❑ No

Medication side effects staff should be aware of: _____

**Is there anything else you would like to share about your child** (i.e., allergies, diet, seizures, nosebleeds)?

_____

_____

# Getting to Know Me

## YD 6 -12

**Name: _____**

**D.O.B. _____ Date: _____**

**Please tell us about yourself. This form will not be shared with others, please answer it truthfully. Letting us know your strengths and challenges helps us to better assist you.**

1. **Which best describes you? (Check all that apply)**

**I would rather read instructions than listen to the teacher explain them.**

☐Almost Never ☐Once in a While ☐Sometimes ☐Frequently ☐Almost all the time

**I like having someone explain directions aloud.**

☐Almost Never ☐Once in a While ☐Sometimes ☐Frequently ☐Almost all the time

**When I study, I have to take a lot of breaks to get up and walk around.**

☐Almost Never ☐Once in a While ☐Sometimes ☐Frequently ☐Almost all the time

**I like to draw/doodle during class.**

☐Almost Never ☐Once in a While ☐Sometimes ☐Frequently ☐Almost all the time

**I remember things better when I write them down.**

☐Almost Never ☐Once in a While ☐Sometimes ☐Frequently ☐Almost all the time

**I study by saying things aloud.**

☐Almost Never ☐Once in a While ☐Sometimes ☐Frequently ☐Almost all the time

**Charts, pictures and maps help me understand what I am reading.**

☐Almost Never ☐Once in a While ☐Sometimes ☐Frequently ☐Almost all the time

**I can pay attention better if I have a snack while I study.**

☐Almost Never ☐Once in a While ☐Sometimes ☐Frequently ☐Almost all the time

**I like to listen to music while I am studying.**

☐Almost Never ☐Once in a While ☐Sometimes ☐Frequently ☐Almost all the time

**I am good at seeing pictures in my mind of what I am studying.**

☐Almost Never ☐Once in a While ☐Sometimes ☐Frequently ☐Almost all the time

**Name: _____**

**It is easy for me to remember jokes.**

☐ Almost Never ☐ Once in a While ☐ Sometimes ☐ Frequently ☐ Almost all the time

**I can think better if I fidget by tapping my foot, playing with a pencil, or moving a little.**

☐ Almost Never ☐ Once in a While ☐ Sometimes ☐ Frequently ☐ Almost all the time

**I prefer working by myself.**

☐ Almost Never ☐ Once in a While ☐ Sometimes ☐ Frequently ☐ Almost all the time

**I prefer working with a friend.**

☐ Almost Never ☐ Once in a While ☐ Sometimes ☐ Frequently ☐ Almost all the time

**I prefer working in a group of 3 or more.**

☐ Almost Never ☐ Once in a While ☐ Sometimes ☐ Frequently ☐ Almost all the time

**I find it hard to speak up in class and/or participate in discussions.**

☐ Almost Never ☐ Once in a While ☐ Sometimes ☐ Frequently ☐ Almost all the time

**I find it hard to read aloud.**

☐ Almost Never ☐ Once in a While ☐ Sometimes ☐ Frequently ☐ Almost all the time

**I find it hard to control my temper.**

☐ Almost Never ☐ Once in a While ☐ Sometimes ☐ Frequently ☐ Almost all the time

**It is easier for me to control my temper if I try the following:**

_____

_____

**2. Have you ever received or are you receiving any of the following? (Check all that apply)**

- ☐ Speech/Language Therapy
- ☐ Occupational Therapy
- ☐ Physical Therapy
- ☐ Daily Medication (not including vitamins)
- ☐ Exceptional Student Education services in school
- ☐ Counseling
- ☐ IEP or 504 Plan
- ☐ Other

**3. I learn best when I:**

_____

_____

**Name: _____**

4. **I do not like it when I am asked to:**

_____

_____

5. **Activities/things that motivate me:**

_____

_____

6. **Activities I do not like to do:**

_____

_____

7. **School subjects I am good at:**

_____

_____

8. **School subjects I find hard:**

_____

_____

9. **After I complete high school, I want to:**

_____

_____

10. **Is there anything else you'd like to share about yourself?**

_____

_____

***If you would like to talk to someone about these questions check here.*** ☐