



Child/Youth Photo Here

### SUMMER 2026 PARTICIPANT APPLICATION

Dates: June 8, 2026 – July 24, 2026

Operating Hours: Monday to Friday: 8:00 am-6:00 pm (K-8<sup>th</sup>); 8:30 am-4:30 pm (9<sup>th</sup>-12<sup>th</sup>)

- 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

<b>Child/Youth Date of Birth</b>  _____ / _____ / _____ Month / Day / Year	<b>Child/Youth Gender</b>  <input type="checkbox"/> Female <input type="checkbox"/> Male <input type="checkbox"/> Prefer not to answer	<b>Child/Youth Race/Ethnicity</b> (please select only one) <input type="checkbox"/> Biracial or Multiracial <input type="checkbox"/> Hispanic <input type="checkbox"/> Black non-Hispanic/African American <input type="checkbox"/> Haitian <input type="checkbox"/> White non-Hispanic <input type="checkbox"/> Other <input type="checkbox"/> Prefer not to answer
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Mark all languages your child/youth speaks

- English    Spanish    Haitian Creole    Other: \_\_\_\_\_

<b>What is the child/youth 2025-2026 school year grade level:</b>  <input type="checkbox"/> Kindergarten <input type="checkbox"/> Grade 1-12 (specify) _____	<b>Miami-Dade County Public Schools ID#</b> ( <i>all students attending public or charter schools must have a school ID#</i> )  _____ <input type="checkbox"/> No M-DCPS ID #
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Current School \_\_\_\_\_

Home

Address \_\_\_\_\_  
Street City ZIP Code

Caregiver Name \_\_\_\_\_  
Last First

<b>Caregiver Phone Number</b> (____) _____ - _____ Is this a cell/mobile phone? <input type="checkbox"/> Yes <input type="checkbox"/> No	<b>Caregiver Email address</b>  _____
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Caregiver's preferred language for contact from The Children's Trust (please select only one)

- English    Spanish    Haitian Creole



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).

<b>Parent/Guardian Signature</b>	<b>Date Signed</b>  _____/_____/_____ Month / Day / Year
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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.**

**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.**

<b>What conditions does your child/youth have that are expected to last for a year or more?</b> (mark all that apply)	
<input type="checkbox"/> Developmental delay (only if under age 5)	<input type="checkbox"/> Managing aggression or temper
<input type="checkbox"/> Intellectual/developmental disability (over age 5)	<input type="checkbox"/> Managing attention and hyperactivity (ADHD)
<input type="checkbox"/> Learning disability (over age 5)	<input type="checkbox"/> Depression or anxiety
<input type="checkbox"/> Autism spectrum disorder	<input type="checkbox"/> Speech or language condition
<input type="checkbox"/> Deaf or hard of hearing	<input type="checkbox"/> Blind or low vision
<input type="checkbox"/> Medical condition or illness (like asthma, diabetes, epilepsy/seizures, severe allergies)	<input type="checkbox"/> Other condition lasting one year or more (please specify) _____
<input type="checkbox"/> Physical disability or impairment	<input type="checkbox"/> 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?	
<input type="checkbox"/> Yes, it is harder for them	<input type="checkbox"/> No, it is not harder for them
<input type="checkbox"/> N/A, no conditions noted	

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

- |  |  |
|--|--|
| <input type="checkbox"/> Speaks and is easily understood                     | <input type="checkbox"/> Uses gestures or expressions like pointing, pulling, smiling, frowning, or blinking |
| <input type="checkbox"/> Speaks but is difficult to understand               | <input type="checkbox"/> Uses sounds that are not words like laughing, crying, or grunting                   |
| <input type="checkbox"/> Uses communication devices like pictures or a board |  |
| <input type="checkbox"/> Uses sign language                                  |  |

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

- |   |   |
|---|---|
| <input type="checkbox"/> Behavioral therapy or services   | <input type="checkbox"/> Occupational therapy (OT)                                  |
| <input type="checkbox"/> Counseling for emotional concerns  | <input type="checkbox"/> Physical therapy (PT)                                      |
| <input type="checkbox"/> Daily medication (not including vitamins)  | <input type="checkbox"/> Speech/language therapy                                    |
| <input type="checkbox"/> Exceptional student education services in school through an IEP or 504 plan (If so, please attach) | <input type="checkbox"/> None of the above are needed at this time                  |
|   | <input type="checkbox"/> 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](http://211miami.org), or learn more about **The Children's Trust** programs at [www.thechildrenstrust.org](http://www.thechildrenstrust.org). For special needs resources for individuals with disabilities and their families, visit [www.advocacynetwork.org/services/individual-family-support](http://www.advocacynetwork.org/services/individual-family-support) or [www.thechildrenstrust.org/cwd](http://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

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

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)?

\_\_\_\_\_  
\_\_\_\_\_