Student Photo Here

STUDENT APPLICATION AFTER SCHOOL 2019-2020

Success After School Program 2019-2020 (Grades 6-12)

Dates: August 20, 2019- May 29, 2020 (**Tuesday, Wednesday, Thursday, Friday from** 2:30PM-5:30PM)

Success Program

☐ **Miami Central High**: 1781 NW 95th St Miami, Fl 33147 ☐ **Ferguson High:** 15900 SW 56th St Miami, Fl 33185

How did you hear about our Organization/Program?

☐ Childcare
☐ Other TCT Programs
☐ Internal Referral
☐ Helpline (211/Switchboard)
☐ Faith Based Partners
☐ Community Based Organizations
☐ Walk-ins
☐ Self-referral
☐ DCF/ Our kids/ Child Welfare
☐ Health care provider
☐ DJJ/Juvenile Services
☐ Natural Helpers
☐ Early Steps
☐ FDLRS
☐ Family and Neighborhood Supports Partnerships
☐ MDCPS Truancy Intervention

CHILD INFORMATION:

Child's First Name: _____ **Middle:** _____ **Last Name:** _____

Child's Gender: ☐ Male ☐ Female

Child's Date of Birth (mm/dd/yyyy) ☐☐ ☐☐ ☐☐☐☐

Miami-Dade County Public School ID Number: ☐☐☐☐☐☐☐ ☐ Private School

Child's Current School Name: _____ **Child's Current Grade** ☐☐
(2019-2020 School Year)

Is your Child Proficient in English? ☐ Yes ☐ No

Other Language(s) Spoken in the Home: ☐ Spanish ☐ Haitian-Creole ☐ Sign Language ☐ Other_____ ☐ None

Child's Home Address: _____ **Apt/ Unit #:** _____ **City:** _____ **ZIP Code:**_____

Child's Ethnicity: ☐ Hispanic ☐ Haitian ☐ Other, please specify:_____

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

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CHILD INFORMATION (Continued):

Family Status: (select only one): ☐ Married ☐ Not Married ☐ Single Female
☐ Single Male ☐ Guardianship/Foster Care ☐ Other:_____

Is child a part of the dependency system? ☐ Yes ☐ No
(Ex. DCF, Our Kids, Full Case Management Agencies, Family Courts etc.)

Is child a part of the delinquency system? ☐ YES ☐ NO
(Ex. Department of Juvenile Justice, Civil Citation Programs, etc.)

Does child receive free or reduced lunch at school?: ☐ Yes ☐ No

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

Current Insurance Information (If child has insurance coverage). If no insurance, please skip.

Carrier:_____ **Doctor's Name:**_____ **Phone Number:**_____

PARENT/ GUARDIAN INFORMATION:
(Please be aware that you may be contacted by the Children's Trust to ask about your satisfaction with these services)

Child's Primary Caregiver (full name)**:** _____

Primary Phone Number: _____ **Is this a cell/mobile phone?** ☐ Yes ☐ No **(used for text-based emergency contact system)**

Primary Caregiver E-Mail: _____

Child's Secondary Caregiver (full name)**:** _____

Primary Phone Number: _____ **Is this a cell/mobile phone?** ☐ Yes ☐ No **(used for text-based emergency contact system)**

CHILD'S MEDICAL INFORMATION:

We want to get to know your child better so we can provide the best possible experience for your child.
Please tell us more about your child. I give permission for this information to be submitted to the Trust for program quality/evaluation purposes.

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1) What are the main ways 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 gestures like pointing, pulling, smiling, frowning or blinking
- ☐ Uses sign language
- ☐ Uses sounds that are not words like laughing, crying or grunting

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

- ☐ Behavioral therapy or services
- ☐ Counseling for emotional concerns
- ☐ Daily medication (not including vitamins)
- ☐ Occupational Therapy (OT)
- ☐ Physical Therapy (PT)
- ☐ Special Education services in school
- ☐ Speech/Language Therapy
- ☐ None of the above

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

- ☐Autism Spectrum Disorder
- ☐ Hard of Hearing, deaf, or hearing impaired
- ☐ Intellectual/developmental disability (over 5)
- ☐ Learning Disability (school age)
- ☐ Medical Condition or illness
- ☐ Physical disability or impairment
- ☐ Problems with aggression or temper
- ☐ Problems with attention or hyperactivity (ADHD/ADD)
- ☐ Problems with depression or anxiety
- ☐ Speech or language condition
- ☐ Visual impairment or blind
- ☐ None of the above

4) Does Child have an Individualized Education Plan (IEP) or 504 plan?

☐ Yes (Please attach) ☐ No

5) 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

6) 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 _____

7) Please **circle** if anything applies to your child in the chart below. If nothing applies please **write N/A.**

Medication which affect: Learning, Physical Fitness Activities and Social Engagement	**Food Allergies**	**Other Serious Allergies**	**Chronic Health Conditions**	**Physical Limitations which affect:** Learning, Physical Fitness Activities and Social Engagement
• Antibiotics • Medication for chronic Health • Hyper Activity Medication • Other: _____ • _____	• _____ • _____ • _____ • _____ • _____	• Grass • Mosquitoes • Bee Stings • Penicillin • Other: _____ • _____	• Asthma • Diabetes • Sickle Cell Anemia • Seizures • Skin Condition • Seasonal Allergies • Reaction to Sunlight • Other:_____	• Other not listed above: _____ _____ _____ _____

EXCEPT AS NOTED ABOVE, my child is in good health, has no medical, food, other chronic allergies or serious health conditions. My child does not take medication routinely and his/her immunizations are current. By signing on the last page I agree to the following.
If there is anything else you consider we need to know about, to better understand and provide the necessary help your child deserves, please speak to your Lead Teacher. All information is kept confidential and stored in locked cabinets.

CHILD'S EMERGENCY INFORMATION:

I understand that every effort will be made to reach me for instructions if my child should become ill or injured while on the site or on a field trip. If in the judgment of the staff or a medical professional, delay in reaching me might jeopardize my child's well-being, I hereby authorize the staff or medical professional to secure whatever medical treatment is deemed necessary, including the administration of anesthetics and surgery. **IN THE EVENT THAT NO ONE CAN BE CONTACTED, I GIVE PERMISSION FOR MY SON/DAUGHTER TO RECEIVE EMERGENCY MEDICAL TREATMENT.**

If you would like for us to follow a different emergency/medical procedure, please write it/explain below: (You can continue on the back of this page)

_____

_____ (cont. back)

EMERGENCY / ALTERNATE PICK UP CONTACT INFORMATION

Other phone numbers where I can be reached during the day: _____/_____ /_____
If I cannot be reached, please contact my designated alternate(s) named below:

1. _____ _____ _____
Name | Relationship to child | Cellular and/ or work Number

2. _____ _____ _____
Name | Relationship to child | Cellular and/ or work Number

3. _____ _____ _____
Name | Relationship to child | Cellular and/ or work Number

Please note: Any family or friends authorized to pick up your child, must have a valid picture ID for verification purposes. A copy of ID will be taken by site staff and placed in student's file for future confirmation. In the event that I, the legal guardian am not able to pick up my child on time, I will call the Lead Teacher and will authorize her/him to release my child to the persons listed above.

POLICY INFORMATION/CONSENT

Non-Discrimination Policy: Children who are in grades 6-12 will be accepted into the After-school program regardless of race, creed, immigration status, health, religion, disability, ethnicity or ability to pay for services. Children without documented legal status, or whose parents are without documented legal status will not be discriminated against for selection in these programs. As with the Miami-Dade County Public School system, all children are welcome. Children with severe physical, emotional or behavioral disabilities may find After-school programs specially designed to meet their needs through other programs, every effort will be made to find the most suitable placement for each child.

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Parental Consent:

By signing this application on the next page, I agree and certify to the following Children's Trust Requirements:

1) **I acknowledge** that the application information and medical information I have provided above is true and complete to the best of my knowledge and ability.

2) As the legal guardian of ☐ **I authorize and give consent** or ☐ **I DO NOT authorize or give consent** to Hope for Miami's staff (HFM), nor The Children's Trust (TCT) or service providers to take/use still photographs, digital photographs, motion pictures, television transmission, and/or videotapes recordings (hereinafter "Recordings") of me, my children, or my wards for educational, research, documentary, and public relations purposes. Any such Recordings may reveal my identity through the image itself without any compensation to me, my children or my wards. With regard to the use of any Recordings taken of me, my children of my wards, I hereby waive any and all present and future claims I may have against TCT or HFM, their staff, service providers, employees, agents, affiliates and Board members.

3) **I understand** that participation by my children in the Program sponsored by Hope for Miami, The Children's Trust and its partners involves physical education, meals, and off-site field trips. As these activities may carry some degree of risk to my child's physical and emotional health, I hereby release, hold harmless and waive all claims associated with out-of-school/summer camp program activities from HFM, and the program site and all employees, officers, directors, agents, and volunteers associated with the out-of-school/summer camp program.

4) **I understand** that no medication/medical equipment will be administered by the After-school personnel to my child without the "Authorization For Prescription and Non-Prescription Medication/Medical Equipment Form" signed by me as the parent/legal guardian. Also, I agree to provide instructions on how and when the medicine/medical equipment should be administered if my child were to need assistance with it. (Please, refer to Family Handbook for more details).

5) As my child attends an Out-of-school program funded by the Children's Trust (either Summer Camp or After-school), **I acknowledge** and understand that my child must adhere to all behavioral and policy driven rules and regulations the program sites require. Failure to abide by these rules, may lead to suspension and or removal of the program. I also acknowledge receipt of a written **Family Handbook** for this current program year, which details policies and procedures regarding my child and the program.

6) As the Out-of-school program (either Summer Camp or After-school) may take place on the premises of a religious organization, the primary purpose of the program is academic enrichment and a safe environment during out-of-school/Summer Camp time. However, your child may be invited to participate in other church activities on the premises or to ***receive optional religious instruction***. Unless expressed written permission has been given by the parent or guardian to participate in the religious instruction, no child will be asked to participate, and no Children's Trust funds will be used for teacher stipends, books, curriculum or other expenses related to religious instruction. Such instruction will be given by church ministers or volunteers.

Please select the box concerning Religious instruction:

☐ I **authorize** my child to participate. ☐ I **do not authorize** my child to participate.

7) My child will be arriving and leaving from the site in the following manner:

Arrival to the site: ☐ By bus/van. ☐ Walking from school. ☐ With authorized person/relative.
☐ With Parent/Guardian. ☐ Driving on their own

Leaving from the site: ☐ By bus/van. ☐ Walking from school. ☐ With authorized person/relative.
☐ With Parent/Guardian. ☐ Driving on their own

I **do not** give permission, under any circumstances, for my child to leave the program site with _____.
Relationship to child: _____. If possible bring a picture to keep on file. **(Legal documentation is required)**
No child is allowed to go home with anyone not on their approved list.

8) **I agree** to make every effort to insure that my child participates in the program daily, unless he/she is too ill to attend. **I also agree** that I or my designated representative will **sign-out my child every day** he/she attends the program.

7/2019

9) **I understand** that I am responsible to pick up my child at the end of the program day or arrange for an authorized person to pick up my child. Only those persons previously authorized in writing, may leave the premises with my child. I am aware of the **penalties** for parent tardiness on pick-up at the end of the day. For Success sites, three late pick-ups will result in termination from the program. The program ends at **5:30 PM** each day.

10) **I understand** that I need to call the Out-of-school/Summer Camp Lead Teacher if my child is not attending on a particular day so that that Supervisor is aware that my child will not be showing up on that day.

11) **I understand** that I am releasing the After-school/Summer Camp Program of any liability once my child has been dismissed from the program site.

I give my permission for the information in this application to be submitted to The Children's Trust for program quality and evaluation purposes. The Children's Trust provides funding for the program. *If you are interested in other services funded by The Children's Trust, please call 211 or visit www.thechildrenstrust.org. For special needs resources for your child, visit www.advocacynetwork.org or www.thechildrenstrust.org/cwd*

I am signing that I have reviewed and agreed to all terms and conditions described in this application, all the program standards, and Family Handbook:

_____ _____

Parent / Legal Guardian Signature **Date**

LEAD TEACHER USE ONLY *(MUST BE COMPLETED)*

Sibling(s) names in our program: 1. _____ **2.**_____

3. _____ **4.**_____ **5.**_____

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

Family Handbook Given: ☐ Yes ☐ No

FOR STAFF USE ONLY (*MUST BE COMPLETED*)

Verified by: _____ **Date of registration:** _____ **Copy to HFM Office Personnel:** _____

Start Date: _____ **Withdrawn Date:** _____ (When Applicable) **Returned Date:** _____ (Participant will have to pay registration fee again)

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