Student Photo Here

AFTERSCHOOL 2024-2025 PARTICIPANT APPLICATION

Dates: August 15, 2024 – June 5, 2025
Time: Monday – Friday, 2:00pm-6:00pm (K-5th); 3:45pm-6:00pm (6-8th) ; 2:30pm-6:00pm (9th-12th)

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

How did you hear about our Organization / Program?

- ☐ Not Applicable
- ☐ Schools
- ☐ Childcare
- ☐ Other TCT Programs
- ☐ Internal Referral
- ☐ Helpline (211/Switchboard)
- ☐ Faith-Based Partners
- ☐ Community Based Organizations
- ☐ Walk-in
- ☐ Parent Club
- ☐ Self-referral
- ☐ DCF/ Our kids/ Child Welfare
- ☐ Police Department
- ☐ Health Care Provider
- ☐ DJJ/Juvenile Services
- ☐ Early Steps North & South
- ☐ Family and Neighborhood Supports Partnerships
- ☐ MDCPS Truancy Intervention
- ☐ Other_____

CHILD INFORMATION

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

Child's Date of Birth: (*MM/DD/YYYY*) _____ / _____ /_____ **Child/Youth Gender:** ☐ Male ☐ Female ☐ Other: _____
(Mandatory) **(Mandatory)**

Youth Phone Number (_____) _____ - _____ **Is this a cell/mobile phone?** ☐ **Yes** ☐ **No** ☐ **N/A**
(Optional) **(Optional)**

Youth Email address (Optional): _____

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.*

M-DCPS ID # ____ ____ ____ ____ ____ ____ ____ ☐ No M-DCPS ID# ☐ Not in School

ALL STUDENTS ATTENDING PUBLIC OR CHARTER SCHOOLS SHOULD HAVE A SCHOOL ID ENTERED. ALL STUDENTS WHO ATTEND A PRIVATE SCHOOL PLEASE SELECT NO M-DCPS ID#

Child/ Youth Current School Name: _____

What is the child/youth's current grade level? (For summer, select the last grade completed - Please select only one):

☐ Pre-K ☐ Kinder ☐ 1st Grade ☐ 2nd Grade ☐ 3rd Grade ☐ 4th Grade ☐ 5th Grade

☐ 6th Grade ☐ 7th Grade ☐ 8th Grade ☐ 9th Grade ☐ 10th Grade ☐ 11th Grade ☐ 12th Grade

What is the child/youth's preferred language for contact? (Please select only one) ☐ English ☐ Spanish ☐ Haitian-Creole

What language(s) does the child/youth feel comfortable communicating in? (Select all that apply)

☐ English ☐ Spanish ☐ Haitian-Creole ☐ Portuguese ☐ French ☐ Other: _____

Child/Youth Ethnicity: Is the child/youth Hispanic or Latina/o/x? ☐ Yes ☐ No **Is the child/youth Haitian?** ☐ Yes ☐ No

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

☐ White ☐ Biracial or Multiracial ☐ Other, Please Specify: _____

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

Child's Primary Caregiver (full name): _____

Primary Phone Number: (_____) _____ - _____ **Is this a cell/mobile phone?** ☐ Yes ☐ No
(Please write "not applicable" or "N/A", if no answer)

Primary Caregiver E-Mail:_____
(Please write "not applicable" or "N/A", if no answer)

Caregiver preferred language for contact (Please select only one): ☐ English ☐ Spanish ☐ Haitian-Creole ☐ Other: _____

Child's Secondary Caregiver (full name): _____
(Please write "not applicable" or "N/A", if no answer)

Primary Phone Number: (_____) _____ - _____ **Is this a cell/mobile phone?** ☐ Yes ☐ No
(Please write "not applicable" or "N/A", if no answer)

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.

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

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 sign language
- ☐ Uses gestures like pointing, pulling, smiling, frowning or blinking
- ☐ 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
- ☐ Developmental delay (only if **under age 5**)
- ☐ Intellectual/developmental disability (**over 5**)
- ☐ Hard-of-hearing or Deaf
- ☐ 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
- ☐ Other condition lasting one year or more (Please Specify):
  _____
- ☐ No condition lasting one year or more

If you marked "None of the above" on the previous two questions, please indicate N/A on the next two questions and sign below. If you marked any other answer on the question above, please answer the remaining questions and sign below.

4) **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**

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

☐ No specific help needed: **N/A**

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

6) **Does Child have an IEP or a 504 Plan?** ☐ Yes (If yes, please attach) ☐ No

7) **Please circle or fill-in anything that applies to your child in the chart below:** ☐ N/A (Not Applicable)

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 ○ Hyperactivity 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. **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 Site Supervisor**. All information is kept confidential and stored in locked cabinets. By signing on the last page, I agree to the following.

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/parents/health-connect/insurance.

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/content/children-disabilities.

Child's Insurance Information: (If child has no current insurance coverage, please write "not applicable" or "N/A")

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

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 that any 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)

_____

_____

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

Please note: Any family or friends authorized to pick up your child, must have a valid picture ID for verification purposes. A copy of the ID will be taken by site staff and placed in the 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 Site Supervisor and will authorize her/him to release my child to the persons listed above

POLICY INFORMATION/CONSENT

Non-Discrimination Policy: Children who are 5 and have already attended or who are currently enrolled in kindergarten will be accepted into the Summer Camp and 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/ Summer Camp programs specially designed to meet their needs through other programs, and every effort will be made to find the most suitable placement for each child.

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), and The Children's Trust (TCT) or other affiliated program 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 medications or medical equipment will be administered by the After-school/ Summer Camp personnel to my child. Also, I agree to provide instructions on how and when essential medicines or medical equipment should be administered if my child were to need assistance with it. (Please, refer to the HFM Family Handbook for more details).

5) As my child attends an Out-of-school program funded by the Children's Trust (either Summer Camp, After-school, or all programs), **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) While 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 Afterschool/Summer Camp time. However, your child may be invited to participate in other church activities on the premises or to ***receive optional religious instruction***. 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**. Initial here:** _____ ☐ I **do not authorize** my child to participate. **Initial here:** _____

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

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

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. **Child is allowed to go home with mother, father or legal guardian unless we have court documents stating otherwise due to custody battle or abuse. (Legal documentation must be provided).**

8) **I agree** to make every effort to ensure 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.

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 **fees charged and or withdrawal policies** for parent tardiness on pick-up at the end of the day. For fee based sites, the late fee is $1 per minute. The program ends at **6:00 PM** each day. I also understand that my child will be suspended from transportation and the program if the fees are not current.

10) **I understand** that I need to call the Out-of-school/Summer Camp site supervisor if my child is not attending on a particular day so that Supervisor is aware that my child will not be showing up on that day. I'm also aware of the absenteeism policies and the risks associated with excessive absences.

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.

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).

I give my permission for the information in this application to be submitted to Miami-Dade County Public Schools for program quality and evaluation purposes. Miami-Dade County Public Schools provides academic supports for the program.

I am signing that I have reviewed and agreed to all terms and conditions described in this application, all the program standards, Policies and Procedures and Parent Handbooks:

_____ _____

Parent / Legal Guardian Signature **Date**

Accidental Injury Insurance (*Fee based sites*)

If your child is enrolled in a program managed by Hope for Miami, they are covered for supplemental medical expenses should they have an accident **while participating in program activities, during regularly scheduled program hours.** If your family has medical insurance, this supplemental policy will cover some deductibles and uncovered expenses. If your family is uninsured, the child's medical expenses may be covered, if an injury were to occur (accidents only).

- Cost is $ 10.00 per student. Money Order must be payable to Hope for Miami.
- Medical expenses for accidents in and out patient for a maximum of $25,000.00
- $100.00 deductible on this policy
- Includes $10,000 Accidental Death benefit and Accidental Dismemberment benefit (should there be a serious injury).
- Coverage through July 25, 2025.

☐ **N/A:** Not applicable for students attending a public school site M-DCPS

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

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

Family Handbook given: ☐ Yes ☐ No
(Please make sure parent signs the acknowledgment)

Is child apart of the delinquency system? ☐ Yes ☐ No
(Ex. Department of Juvenile Justice, Civil Citation Programs, etc.)

Application Verified by: _____ **Date Verified:** _____

Date of registration: _____ **Tentative Start Date:** _____

"Getting to Know Me"

Child's Name: _____ **Today's Date:** _____

Grade Level: _____ **Age:** _____

T-Shirt Size: _____

Hope for Miami would like to learn more about your child so that we can provide them with the best possible learning experience while they are attending our program. No one knows your child better than you. Please tell us more about your child.

1. What is your child's favorite and/or calming and least favorite and/or upsetting; things, activities, rewards, and situations?

Favorite or Calming (Electronics, toys, sounds, etc.)	Least Favorite or Upsets (Loud noises, specific objects, etc.)
_____	_____
_____	_____
_____	_____

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

☐ Yes ☐ No If yes, please describe: _____

3. 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) _____

4. 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)

5. Do you suspect your child has a hearing or vision problem? ☐ Yes ☐ No

If yes, please describe _____

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

☐ Easily moves from one activity to the other ☐ Needs assistance to move from one activity to the other

Please explain _____

7. My child plays/interacts best (*check all that apply*):

☐ Independently ☐ With Adults ☐ Small group ☐ Large Group ☐ Outdoor ☐ Indoor
☐ With another child ☐ Additional comments

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8. Does your child follow simple instructions? ☐ Yes ☐ Needs help

Comment / Incentives: _____

9. What type of learning style works best for your child? (*check all that apply*)

☐ Verbal Instruction ☐ Charts/Graphs ☐ Written Instructions ☐ Reminders

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

☐ Noise ☐ Texture (i.e., sand, water) ☐ Lights ☐ Smells ☐ Animals ☐ Touch (*i.e., hugs*)
☐ 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?

Using the toilet	☐ Yes	☐ No	Walking or moving about	☐ Yes	☐ No
Eating	☐ Yes	☐ No	Washing 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: _____

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

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15. Please check all that apply: Which Descriptions best describe your child. (If the child is able, please allow them to answer below)

- ❑ I would rather read instructions than listen to the teacher explain them.
- ❑ I like having someone explain directions aloud.
- ❑ When I study, I have to take a lot of breaks to get up and walk around.
- ❑ I draw a lot of pictures during class.
- ❑ I remember things better if I write them down.
- ❑ I study by saying information aloud.
- ❑ Charts, pictures, and maps help me understand what I am reading.
- ❑ I can pay attention better if I have a snack while I study.
- ❑ I like to listen to music while I am studying.
- ❑ I am good at seeing pictures in my mind what I am studying.
- ❑ It is easy for me to remember jokes.

- ❑ I can think better if I tap my foot, play with a pencil or move a little.
- ❑ I prefer working by myself.
- ❑ I prefer working with a friend.
- ❑ I prefer working in a group of 3 or more.
- ❑ I find it easy to speak up in class and/or participate in discussions.
- ❑ I find it hard to speak up in class and/or participate in discussions.
- ❑ I find it easy to read aloud.
- ❑ I find it hard to read aloud.
- ❑ I find it easy to control my temper.
- ❑ I find it hard to control my temper.
- ❑ It is easier for me to control my temper if I try the following: _____

Hope for Miami After-School and Summer Camp COVID-19 Procedures (2024-2025):

First and foremost, thank you for trusting us with your children. We are deeply honored you have chosen us to keep your child safe. Hope for Miami continues to monitor the local conditions concerning COVID-19 and will continue implementing strategies to minimize the spread of communicable diseases while maintaining a safe learning and growing environment.

Hope for Miami is dedicated to:

1. *Continue to establish communication with local and state authorities to determine current mitigation levels in our community.*
2. *Protect and support staff, children, and their family members who are at higher risk for severe illness.*

Safety Actions: Based on the medical guidance received, Hope for Miami has outlined preventive measures that will be implemented by taking the following safety actions steps:

Promote healthy hygiene practices

1. We will continue to reinforce washing hands (upon arrival to site, after using the restroom, sneezing, coughing, and before eating meals) and covering coughs and sneezes among staff (part of our Universal Precautions training for staff).
2. Although masks are optional, we will encourage and teach all staff and children to wear a face mask if there are experiencing any related signs or symptoms. We will also remind children not to touch the face covering and to wash their hands often.
3. We will have adequate supplies to support healthy hygiene behaviors, including soap, hand sanitizer with at least 60 percent alcohol (for staff and older children who can safely use hand sanitizer) and tissues.

Intensify cleaning, disinfection, and ventilation

1. Clean, sanitize, and disinfect frequently touched surfaces (for example, door handles, sink handles, drinking fountains), and shared objects between use.
2. Ensure the safe and correct application of disinfectants and store cleaning products away from children.
3. Ensure that ventilation systems operate correctly and increase the circulation of air flow as much as possible.

Monitoring and Preparing Check for signs and symptoms

1. Maintain an adequate ratio of staff to children to ensure safety.
2. Encourage staff to stay home if they are sick and encourage parents to keep sick children at home.
3. Identify an area to separate anyone who exhibits COVID-like symptoms during hours of operation and ensure that children are not left without adult supervision.
4. Inform anyone exposed to a person diagnosed with COVID-19 to stay home and self-monitor for symptoms, and to follow CDC guidance if symptoms develop.
5. **Please Notify the site location immediately of any possible exposure or contact with someone with COVID-19.**