



STUDENT APPLICATION

SITE*: _____

2009-2010 After-school Program
2010 Summer Camp

CHILD INFORMATION:

LAST NAME*: _____ FIRST NAME * _____ Middle initial _____

STREET ADDRESS*: _____ APT. _____

CITY*: _____ STATE: FL ZIP*: _____

CONTACT PHONE NUMBER*: _____

GENDER*: Male Female BIRTHDAY *: ____/____/____ MM/DD/YYYY

CHILD'S RACE*: Asian Black/African-American White Pacific Islander Other. Please specify _____

CHILD'S ETHNICITY*: Haitian Hispanic Other Please specify _____

CHILDS'S COUNTRY OF ORIGIN (OPTIONAL): _____

IS CHILD PROFICIENT IN ENGLISH * Yes No

ADDITIONAL/OTHER LANGUAGE(S) SPOKEN IN THE HOME*: Spanish Haitian - Creole Other _____

CHILD'S SOCIAL SECURITY NO.*: _____ NO SSN; PREFER NOT TO GIVE SSN

MDCPS STUDENT ID NUMBER *: _____ NO MDCPS; PREFER NOT TO GIVE MDCPS

CURRENT GRADE LEVEL*: _____ CURRENT SCHOOL*: _____

DOES CHILD HAVE HEALTH INSURANCE (ex. Private insurance, KidCare, Medicaid)?* Yes No
(If not, The Children's trust may be able to help you find affordable coverage –call 211)

DOES THE CHILD HAVE ANY DOCUMENTED DISABILITIES*? YES NO

- If yes, do you have (check all that apply):
- an Individualized Family Service Plan
 - an Individualized Education Plan (IEP) from the school system
 - a Section 504 Plan
 - a medical diagnosis from a doctor
 - a diagnosis by a State certified/licensed professional (ex. Psychologist)
 - Information disclosed by the parent or guardian describing the child specific condition and/or need for accommodations

- If YES, how would you best classify the type(s)? (check all that apply):
- Autism Spectrum Disorders
 - Chronic Medical Condition
 - Developmental Delay (under 5 only)
 - Emotional and/or Behavioral Disorder
 - Hearing Impairment (or deaf)
 - Intellectual Disability (or mental retardation)
 - UNKNOWN DISABILITY _____
 - Learning Disability
 - Physical Disability
 - Speech/Learning Impairment
 - Visual Impairment (or blind)
 - Other Disability

***Required fields**

The Out of School Program is funded by The Children's Trust. The Trust is a dedicated source of revenue established by voter referendum to improve the lives of children and families in Miami-Dade County.

CHILD'S MEDICAL 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 the 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.

EXCEPT AS NOTED BELOW, this child is in good health, has no allergies and no chronic conditions which would affect treatment, and takes no medication routinely. His/her immunizations are current.

Child's Name	Food Allergies	Drug Allergies	Other Serious Allergies	Chronic Conditions

INSURANCE INFORMATION (if family has insurance coverage)

CARRIER: _____ **POLICY:** _____
Insurance Company Policy #

DOCTORS NAME: _____ **PHONE:** _____

FAMILY INFORMATION

FATHER'S NAME: _____
Last First

MOTHER'S NAME: _____
Last First

Does child live with a legal guardian other than mother or father? YES NO

If yes, GUARDIAN'S NAME: _____
Last First

PARENT/GUARDIAN ADDRESS: _____
Street City State Zip

HOME PHONE*: _____ **WORK PHONE*:** _____

CELL PHONE: _____ **E-MAIL:** _____

SOCIAL SECURITY NO. _____ (not required, but requested for record-keeping purposes)

EMERGENCY INFORMATION

Phone numbers where I can be reached during the day: _____

If I cannot be reached, please try to contact my designated alternate(s):

1. _____
Name Phone Number
2. _____
Name Phone Number

Optional:

NUMBER OF CHILDREN LIVING AT THIS ADDRESS: _____ **NUMBER OF ADULTS LIVING AT THIS ADDRESS:** _____

ESTIMATED YEARLY INCOME FOR FAMILY: \$ _____ (priority for enrollment will be given to low-income families)

FAMILY STATUS: Married Not Married Single Female Single Male Guardianship/Foster Care

If your child has a parent who is currently in prison or jail the child might be eligible for special opportunities this organization has to offer.

Please check this box if you are interested in hearing more information about the children of inmates' project which connects you to resources in your community.

Non-Discrimination Policy:

Children ages 5+ will be accepted into the Summer Camp and After-School programs 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 funded by the Children's Trust; every effort will be made to find the most suitable placement for each child.

Parental Consent:

By signing the application below, I agree and certify the following:

- 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) **I understand** that participation by my children in the Program sponsored by FCFC and its partners and funded by the Children's Trust involves physical education, organized sports, 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 program activities from FCFC, the Children's Trust, the program site and all employees, officers, directors, agents, and volunteers associated with the out-of-school program.
- 3) **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.
- 4) **I agree** to all the program standards. I am aware of the fees (\$10.00/1 hour, \$5.00/30 min) charged for parent tardiness on pick-up at the end of the day. The program ends at **6:00 PM** each day. A calendar with the schedule is attached to this application.
- 5) **I understand** that some of the program sites are being held on the premises of religious institutions for the primary purpose of providing academic enrichment and a safe environment during out-of-school time. In some cases, religious instruction may be offered as an option to the children on the premises, but only with written parental permission. Unless express written permission has been given for my child to participate in religious instruction, an optional non-religious activity will be conducted. No Children's Trust funds will be used for teacher stipends, books, curriculum or other expenses related to religious instruction.

I give my permission for this information to be submitted to The Children's Trust for program monitoring and evaluation purposes

Parent / Guardian Signature

Date

FOR STAFF USE ONLY (MUST BE COMPLETED):

TCT STUDENT ID Number: _____

REGISTRATION FEE: _____

REGISTRATION FEE WAIVER: _____

Parent must complete the Voluntary Consent for Photography and Communications, as responses will be entered in Data Tracker System

VOLUNTARY CONSENT RESPONSES: 1. Photography YES NO