

City of Hialeah Education & Community Services Department  
Young Leaders with Character



Afterschool Program 2020-2021

ATTACH  
CURRENT  
PHOTO  
of  
CHILD

Child's Current School: \_\_\_\_\_

**CHILD'S INFORMATION**

**ECS STAFF: Registration Date** \_\_\_\_\_

First Name: \_\_\_\_\_ Last Name: \_\_\_\_\_ Middle Initial: \_\_\_\_\_  
Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_  
Home Phone: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_ Gender: M / F

**Child's Race:**  American Indian/Alaskan  Asian  Black/African-American  
 Pacific Islander  White  Other, please specify \_\_\_\_\_

**Child's Ethnicity:**  Hispanic  Haitian  Other, please specify \_\_\_\_\_

**Is Child Proficient in English?**  Yes  No

**Additional/Other Language(s) Spoken at home:**  Spanish  Haitian-Creole  Other \_\_\_\_\_

**Child's Social Security #** \_\_\_\_\_  No SSN  Prefer not to give SSN

**MDCPS Student ID #** \_\_\_\_\_  No MDCPS ID **Child's Grade** (as of 2020-21): \_\_\_\_\_

**ECS STAFF**  Verified Proof of Grade and School (Report Card, Letter from School, Other)

**FAMILY INFORMATION**

**Mother / Legal Guardian** Email: \_\_\_\_\_

Name: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

Address: \_\_\_\_\_ Work Phone: \_\_\_\_\_

**Father / Legal Guardian Contact** Email: \_\_\_\_\_

Name: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

Address: \_\_\_\_\_ Work Phone: \_\_\_\_\_

**Emergency Contact Person** (If Parents / Guardian cannot be reached, please list emergency contacts.)

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_ Phone: \_\_\_\_\_

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_ Phone: \_\_\_\_\_

**PERSON (S) AUTHORIZED TO PICK-UP CHILD FROM THE PROGRAM** (Other than Parent / Guardian)

1. \_\_\_\_\_ 2. \_\_\_\_\_ 3. \_\_\_\_\_

Phone: \_\_\_\_\_ Phone: \_\_\_\_\_ Phone: \_\_\_\_\_

**YOUR CHILD WILL NOT BE RELEASED TO ANY PERSON NOT LISTED HEREIN.**

In case of an emergency, at least one parent, guardian or designated emergency contact person needs to be available to respond to the site within 15 minutes. Responding party should be authorized to make an emergency medical decision on behalf of the child.

## MEDICAL INFORMATION

Does your child have health insurance (ex., private insurance, KidCare, Medicaid)?  Yes  No

Does your child have any **allergies** (ex., food, medicine)?  Yes  No

If yes, please explain \_\_\_\_\_

Does your child have any **medical conditions** or a **disability**?  Yes  No

If yes, please explain and check the appropriated boxes \_\_\_\_\_

If yes, how would you best classify the type(s)? (check all that apply):

- |  |   |
|--|---|
| <input type="checkbox"/> Autism Spectrum Disorders   | <input type="checkbox"/> Learning Disability          |
| <input type="checkbox"/> Chronic Medical Condition<br>( <b>diabetes, severe asthma, seizures, epilepsy</b> ) | <input type="checkbox"/> Physical Disability          |
| <input type="checkbox"/> Developmental Delay   | <input type="checkbox"/> Speech/Language Impairment   |
| <input type="checkbox"/> Emotional and/or Behavioral Disorder<br>(ADD / ADHD / OCD / PTSD)                   | <input type="checkbox"/> Visual Impairment (or blind) |
| <input type="checkbox"/> Hearing Impairment (or deaf)  | <input type="checkbox"/> Other Disability _____       |
| <input type="checkbox"/> Intellectual Disability (or mental retardation)                                     |   |

**Note: If "asthma" is circled under Chronic Medical Condition, please check:  Acute or  Seasonal Allergies**

Does your child have a **documented disability**?  Yes  No

If yes, do you have (check all that apply):

- an Individualized Education Plan (IEP) from school system  a medical diagnosis from a doctor  
 disclosure by parent/guardian describing the child's specific condition and/or need for accommodation(s)  
 a diagnosis from a state certified / licensed professional (ex. Psychologist)  
 a Section 504 Plan  other documentation \_\_\_\_\_

## TRANSPORTATION

- I **authorize** the City of Hialeah to transport the participant to and from program/events/field trips sponsored and/or approved by the After-School Program.
- I **do not authorize** the City of Hialeah to transport the participant to and from program/events/field trips sponsored and/or approved by the After-School Program.

### REQUEST FOR A MINOR TO PARTICIPATE IN PROGRAMS/EVENTS SPONSORED/APPROVED BY THE CITY OF HIALEAH AND HOLD HARMLESS AGREEMENT

**PARTICIPATION:** I hereby give permission for the participant named on this form to participate in the **After-School Program, "Young Leaders with Character" provided by the City of Hialeah**, from \_\_\_\_\_ to \_\_\_\_\_. The Afterschool Program includes, but not limited to, literacy programs, fitness, cultural arts, social development, indoor/outdoor games, crafts, fieldtrips and special events. My permission shall be effective upon signing this Request/Hold Harmless Agreement. I have instructed the participant to obey, at all times, all instructions, orders and commands given by the authorized representatives of the City of Hialeah or its designees. I further give permission for the participant to be filmed and/or photographed in such program/event for use in publicizing the program/event.

**RELEASE OF ALL CLAIMS:** The undersigned, individually and on behalf of the participant, releases, covenants not to sue and forever discharges the City of Hialeah, its Officers, Agents, Employees, Counselors, Volunteers and their successors and assigns (all of whom constitute the released parties) of all liabilities, claims, actions, damages, costs or expenses, that the participant may have against the released parties arising out of, or in any way connected with participation in the program/event sponsored/approved by the City of Hialeah, including travel to and from such program/event, and including injury or damage to person or property, or resulting in death of the participant, whether caused by the **NEGLIGENCE** of the released parties or otherwise.

**CONSENT TO TREATMENT:** I authorize such physician or medical staff as the City of Hialeah may designate, to carry out any minor medical treatment deemed necessary, or to take my child to the emergency room of the nearest hospital for treatment, if necessary. I understand that, in order to provide necessary medical treatment to my child, there may be an exchange or disclosure of confidential/protected health information between the City of Hialeah and medical providers. I authorize the City of Hialeah to exchange or disclose my child's confidential/protected health information with such medical providers. I further understand that the City of Hialeah shall protect my child's confidential/protected health information and comply with all applicable federal and state laws by not disclosing such information to any third party who does not have a need to know such information.

I, the undersigned, am the parent/guardian of the above-specified minor child. I have read and fully understand the provisions of the above Request/Hold Harmless Agreement and have explained them to said minor. I hereby agree that the said minor and I will be bound thereby.

Under penalties of perjury, I declare that I have read the foregoing Request/Hold Harmless Agreement and that the facts stated in it are true.

**I have fully completed the registration form and I have been provided the Program Handbook and a written program disciplinary policy by the ECS Department**

\_\_\_\_\_  
Parent/Legal Guardian Signature

\_\_\_\_\_  
Date

**TO BE COMPLETED BY ECS STAFF**

Verified By: \_\_\_\_\_ Date: \_\_\_\_\_ Proof of Address: \_\_\_\_\_ Start Date: \_\_\_\_\_  
PRINT NAME DOCUMENTATION PROVIDED