

Youth Enrichment Program 2020-2021

SITE INFORMATION

Education and Community Services
7400 NW 24th Ave.
Hialeah, FL 33016



Afterschool:

Hours: 2:30 p.m. to 5:30 p.m.

Days of the Weeks in Care: Monday - Friday

Meals served while in care: Snack

Summer:

Hours: 8:00 a.m. to 2:00 p.m.

Days of the Weeks in Care: Monday - Thursday

Meals served while in care: Breakfast and Lunch

This handbook contains pertinent information about STEP Ahead Youth Enrichment program offered through Hialeah's Education & Community Services Department. Please use this checklist to ensure that you have received and have submitted all necessary documentation for registration.

Upon registering a student, the parent will receive a registration packet which includes:

- Registration Forms
- Program Handbook including
 - Program Information
 - Policies and Procedures, including Attendance & Discipline policies
 - Site Information

Parents must submit the following documents in order to complete a child's registration process.
(Check off items below.)

- ___ Registration Forms
- ___ Copy of Birth Certificate or Passport
- ___ Current Photo of child
- ___ Proof of Residency-Utility Bill
- ___ Current Report Card
- ___ Last four digits of Social
- ___ IEP - Individualized Education Plan

**For Staff Use Only
REGISTRATION FEE:**

After School Receipt #

Summer Receipt #

Please sign below to complete upon registration.

Child's Name: _____

I, _____, have received the STEP Ahead Program Handbook, STEP Ahead
Parent/Guardian

Procedures, including Attendance and Discipline policies, and I have submitted all required information.

Parent/Guardians' Signature: _____ Date: _____

Staff's Name: _____ Date: _____
(PRINT)



Youth Enrichment Program 2020-2021

ATTACH
CURRENT PHOTO
of
STUDENT

STUDENT'S INFORMATION

ECS STAFF: Registration date _____ **TCT #** _____

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

Student's Ethnicity: Hispanic Haitian Other, please specify _____

Student's Race: American Indian/Alaskan Asian Black/African-American
 Multiracial Pacific Islander White Other, please specify _____

Is student proficient in English? Yes No

Additional/Other Language(s) spoken at home: Spanish Haitian-Creole Other _____ None

Last 4 Digits ONLY of Student's Social Security # _____ (Required)

MDCPS Student ID # _____ No MDCPS ID (State Reason) _____

Student's Current School: _____ **Student's Grade** (as of 2020-21): _____

ECS STAFF: Verified Proof of Grade (Report card, Letter, other)

FAMILY INFORMATION

Custody (Primary Caregiver): Mother Father Both Other _____

Does the student live with a legal guardian other than the mother or father? Yes No

Mother / Legal Guardian email: _____
 Name: _____ Home Phone: _____
 Address: _____ Cell / Work Phone: _____

Father / Legal Guardian email: _____
 Name: _____ Home Phone: _____
 Address: _____ Cell / Work Phone: _____

(You may be contacted by The Children's Trust for quality improvement purposes)

Number of Children (ages 0-22) living in the household (including participant): _____

Is the participant a child of a Military family? Yes No
 (A member of the child's family is either: 1) an active duty member of the uniformed services; 2) a member of the National Guard or reserves; 3) a member or veteran who was severely injured and medically discharged or retired; or 4) a member killed in the line of duty.)

Migrant Farm Work: Yes No

Dependency System: Yes No

Delinquency System: Yes No

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.

Note: 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.

The City of Hialeah receives funding from the U. S. Department of Housing and Urban Development (HUD) for its Community Development Block Grant (CDBG). Funds received from this grant allows the City of Hialeah to provide enrichment programming that benefit very low, low and moderate-income persons. For reporting purposes please provide us with the following information:

1. How many people live in your household? _____

To determine your household size, include:

1.yourself (and your spouse);

2.the number of children who receive more than half of their support from you

3.the number of people (not your children or spouse) who live with you and receive more than half of their support from you

2. Annual Family Income? _____

MEDICAL INFORMATION

I hereby grant permission for the staff of this facility to contact the following medical personnel to obtain emergency medical care if warranted.

Doctor: _____ Address _____ Phone _____

Doctor: _____ Address _____ Phone _____

Hospital Preference: _____

We want to get to know your child better so we can provide the best possible experience in our programs. Please tell us more about your child...

What are the main ways your child communicates? (Mark all that apply)

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

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

- | | |
|--|---|
| <input type="checkbox"/> Speech/language therapy | <input type="checkbox"/> Special education services in school |
| <input type="checkbox"/> Occupational therapy (OT) | <input type="checkbox"/> Behavioral therapy or services |
| <input type="checkbox"/> Physical therapy (PT) | <input type="checkbox"/> Counseling for emotional concerns |
| <input type="checkbox"/> Daily medication (not including vitamins) | <input type="checkbox"/> None |

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

- | | |
|--|--|
| <input type="checkbox"/> Physical disability or impairment | <input type="checkbox"/> Developmental delay (only if under age 5) |
| <input type="checkbox"/> Medical condition or illness | <input type="checkbox"/> Problems with learning (if school-age) |
| <input type="checkbox"/> Hearing impairment or deaf | <input type="checkbox"/> Problems with attention or hyperactivity (ADHD) |
| <input type="checkbox"/> Visual impairment or blind | <input type="checkbox"/> Problems with depression or anxiety |
| <input type="checkbox"/> Speech or language condition | <input type="checkbox"/> Problems with aggression or temper |
| <input type="checkbox"/> Autism spectrum disorder | <input type="checkbox"/> Intellectual/ Developmental Disability (over age 5) |
| <input type="checkbox"/> None of the above | |

If you marked "None of the above" on the question above, please skip the next two questions and sign below. If you marked any other answer above, please answer the remaining questions and sign below.

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

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 _____

***If you are interested in other services funded by The Children's Trust,
Please call 211 or visit www.thechildrenstrust.org***

Parent/Legal Guardian Signature _____ **Date:** _____

FOR STAFF USE ONLY (MUST BE COMPLETED)

Staff's Name: _____ **Date:** _____

(PRINT)

TRANSPORTATION

- I **authorize** the City of Hialeah to transport the participant to and from program/events/field trips sponsored and/or approved by the Youth Enrichment 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 Youth Enrichment Program.

TRANSPORTATION TO THE AFTER SCHOOL

Transportation to the after school program will be arranged by the following participating Miami Dade County Public Schools:

- Hialeah Senior High School
- Hialeah-Miami Lakes Senior High School
- Barbara Goleman Senior High School
- Hialeah Gardens Senior High School
- American Senior High School

Please complete the attached **REQUEST FOR ALTERNATE TRANSPORTATION STOP FOR SPECIAL EDUCATION STUDENTS** and submit to the student's school.

TRANSPORTATION HOME

Free transportation will be provided for students who live in Hialeah, Hialeah Gardens, Miami Lakes and Miami Gardens.

If you would like for the student to use the transportation home please indicate below:

- Yes
- No

Drop off address:

Please note- Someone must be present to receive the student when the bus drops them off.

If no, below please indicate how the student will be going home:

- Parent Pick-Up
- STS
- Other: _____



AUTHORIZATION FOR PHOTOGRAPHY/VIDEO

I, _____, the parent or guardian of _____ hereby authorize and give consent to service providers and the staff of The Children's Trust of Miami-Dade County as follows:

I hereby:

consent and authorize or **do not consent and authorize**

the staff of The Children's Trust of Miami-Dade County to take/use still photographs, digital photographs, motion pictures, television transmission, and/or videotaped recordings (hereinafter "Recordings") of me, my children, or my wards for educational, research, documentary, and public relations purposes.

Signature of Parent or Guardian

Date

Any such Recordings may reveal your identity through the image itself without any compensation to you, your children or wards.

Any and all Recordings taken of you, your children or wards shall be the sole property of The Children's Trust.

With regard to the use of any Recordings taken of you, your children or wards, you hereby waive any and all present and future claims you may have against The Children's Trust of Miami-Dade County, their staff, service providers, employees, agents, affiliates and Board members.

3150 SW 3rd Avenue, 8th Floor • Miami, FL 33129
(305) 571-5700 • Fax: (305) 860-2328
www.thechildrenstrust.org

**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 **Youth Transition Program, "STEP Ahead" provided by the City of Hialeah**, from 8/31/2020 to 6/11/2021. The Youth Enrichment Program includes, but not limited to, academic and job training activities, life skills, social skills, fitness, financial literacy, arts, fieldtrips, cooking 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, as well as with The Children's Trust. 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 child. I have read and fully understand the provisions of the above Request/Hold Harmless Agreement and have explained them to said child. I hereby agree that the said child 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 also my permission for this information to be submitted to The Children's Trust and the Community Development Block Grant for program monitoring and evaluation purposes.

Parent/Legal Guardian Signature

Date

TO BE COMPLETED BY ECS STAFF:

Verified By: _____ **Date:** _____

Proof of Address: _____ *Documentation Provided*

Enrollment Date: _____



The City of Hialeah's *STEP Ahead* Youth Enrichment program is funded in part 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.