

Has your child attended the program before? If yes, then what site did he/she attend? If no, what site would you like them to attend?

City of Hialeah Education & Community Services Department
Creative Learning & Play Program



ATTACH
CURRENT
PHOTO
of
CHILD

After-School Program 2020-2021

- Babcock Park - 651 E. 4th Ave.
- Bright Park - 750 E. 35th St.
- Cotson Park - 574 W. 23rd St.
- Goodlet Adult - 900 W. 44th Pl.
- Hoffman Gardens - 7650 W. 8th Ave.
- O'Quinn Park - 6051 W. 2nd Ave.
- Slade Park - 2501 W. 74th St.
- Veterans Park - 7900 W. 32nd Ave
- Walker Park - 800 W 29th St.
- Wilde Park - 1701 W. 53rd Ter.

CHILD'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

Primary Care Hours: 2:00 p.m. to 6:30 p.m. **Days of the Weeks in Care:** Monday - Friday
Meals typically Served While in Care: All Sites: P.M. Snack ; Babcock, Cotson, Hoffman, Wilde, Slade and Veterans: Supper

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 _____ None

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

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

Child's Current School: _____ **Child's Grade (as of 20-21):** _____

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

FAMILY INFORMATION

Custody (Primary Caregiver): Mother Father Both Other _____

Does the child 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 living in the household (including child 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.

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: _____

Please list allergies, special medical or dietary needs, or other areas of concern: _____

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

If you are interested in other services funded by The Children's Trust or need to find affordable coverage, please call 211 or visit www.thechildrenstrust.org

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

If yes, please explain _____

Does your child have a **documented medical condition** 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):

- Autism Spectrum Disorders
- Chronic Medical Condition (**diabetes, severe asthma, seizures, epilepsy**)
- Developmental Delay
- Emotional and/or Behavioral Disorder (ADHD / OCD / PTSD / ODD)
- Hearing Impairment (or deaf)
- Intellectual Disability (or MR)
- Learning Disability
- Physical Disability
- Speech/Language Impairment
- Visual Impairment (or blind)
- Other Disability _____

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

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

- Individualized Education Plan (IEP) from MDCPS
- Section 504 Plan
- a medical diagnosis (from a doctor)
- a diagnosis from a state certified / licensed professional (ex. psychologist)
- disclosure by parent/guardian describing the child's specific condition and/or need for accommodation(s)

Helpful Information About Child:

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 crying or 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"/> Learning disability (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 _____

Please tell us anything else you think it is important for us to know about your child

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

I give my permission for this information to be submitted to The Children's Trust for program quality and evaluation purposes. The Children's Trust provides funding for the program.

PARENT/GUARDIAN SIGNATURE _____ DATE _____

FOR STAFF USE ONLY (MUST BE COMPLETED)

Signature of staff entering into SAMIS

Date entered into SAMIS

TRANSPORTATION

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

DCF LICENSE NUMBERS

Walker # C11MD2739	Hoffman # C11MD2740	Wilde # C11MD2034
Slade # C11MD2032	Babcock # C11MD2033	Goodlet # C11MD2737

DCF REQUIREMENTS

- Section 65C-22.006(2), F.A.C., requires a current immunization record (Form 680 or 681) within 30 days of enrollment.
- Section 402.3125(5), F.S., requires that parents receive a copy of the Child Care Facility Brochure
- Section 65C-20.010(6)(c)2., F.A.C., requires that parents are notified in writing of the disciplinary practices used by the child care facility

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, "Creative Learning & Play" provided by the City of Hialeah**, from 8/31/20 to 6/11/21. The After-School 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, 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 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. I also give my permission for this information to be submitted to The Children's Trust for program monitoring and evaluation purposes. The Children's Trust provides funding for the program.

Parent/Legal Guardian Signature

Date

TO BE COMPLETED BY ECS STAFF:

Verified By: _____ Date: _____ Proof of Address: _____
Documentation Provided

Original to Site: _____ Enrollment Date: _____



The City of Hialeah's *Creative Learning & Play* out of school programs are 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.





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.

CITY OF HIALEAH EDUCATION & COMMUNITY SERVICES DEPARTMENT
Creative Learning & Play Program



CHILD'S CODE OF CONDUCT

I understand and agree to:

- Treat others with respect
- Conduct myself with self-respect
- Treat the property with respect

I understand examples of acceptable behavior:

- Participating
- Good manners
- Playing
- Studying
- Laughing
- Having fun
- Helping another person

I understand examples of unacceptable behavior:

- Bullying
- Whining
- Tattling
- Meanness
- Selfishness
- Fighting
- Horseplay
- Throwing things
- Tantrums
- Yelling at or insulting others
- Profanity
- Stealing
- Damaging property
- Disrespecting staff

Child's Signature

Date

Parent's Signature

Date

