

**Youth Enrichment Program 2022-2023**

**SITE INFORMATION**

Education and Community Services  
7400 W 24<sup>th</sup> 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 2022-2023

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 2021-22): \_\_\_\_\_

**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 programing 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: \_\_\_\_\_

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](http://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):*

- |  |   |
|--|---|
| <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 MR)   |   |

**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)

Please list special medical or dietary needs:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**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 answers above, please answer the remaining questions.

**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](http://www.thechildrenstrust.org)***

**No one knows your child better than you. Tell us more about your child.**

**When the child becomes agitated, is he/she likely to exhibit: (Mark all that apply)**

- No Behavior
- Attaches self to adults
- Wanders/runs away
- Physical Aggression
- Other: \_\_\_\_\_
- Verbal aggression
- Withdrawn/shy
- Self-injurious behavior
- Temper tantrum

**What might trigger the child's negative behavior? (Mark all that apply)**

- Over excitement
- Noises
- Textures
- Lights
- Other: \_\_\_\_\_
- Crowds
- Foods
- Temperature
- Touch

<b>Safety</b>	YES	NO	Needs Assistance	<b>Comments</b>
Will they stay with a group?				
Can they be responsible for their belongings?				
Do they know how to swim?				
<b>Personal Care Requirement</b>	YES	NO	Needs Assistance	<b>Comments</b>
Do they use the restroom independently?				
Do they eat independently?				
Can they dress independently?				
<b>Mobility</b>	YES	NO	Needs Assistance	<b>Comments</b>
Can they walk independently?				
If they use a wheelchair, is assistance needed in transferring?				
Do they use any adaptive equipment?				

## TRANSPORTATION

- I **authorize** the City of Hialeah to transport the participant to and from program/events/job exploration sites/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/job exploration sites/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

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

\*If your child attends American Senior High School you DO NOT need to submit the request for alternate transportation stop for special education students form, we will arrange transportation to the afterschool.

## 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 our transportation services to go home please indicate below:

- Yes  
 No

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

- Parent Pick-Up  
 STS  
 Other: \_\_\_\_\_

Drop-off address:

\_\_\_\_\_

\_\_\_\_\_

Drop-off Instructions:

- An adult will be present to receive the student when the bus drops them off.
- I authorize the student to independently walk inside the home. An adult will **not** be present to receive the student when the bus drops them off.

**Parent/Legal Guardian Signature** \_\_\_\_\_ **Date:** \_\_\_\_\_



## **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 your 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 3<sup>rd</sup> Avenue, 8<sup>th</sup> Floor • Miami, FL 33129  
(305) 571-5700 • Fax: (305) 860-2328  
[www.thechildrenstrust.org](http://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 \_\_\_\_\_ to \_\_\_\_\_. 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.