City of Hialeah Education & Community Services Department

Step Ahead

Youth Enrichment Program 2018-2019

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
❒ 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 2018-19): _____

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

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 (ADD / ADHD / OCD / PTSD)
- ❒ 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 student:

_____

_____

_____

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)

- ☐ Speaks and is easily understood
- ☐ Speaks but is difficult to understand
- ☐ Uses sign language
- ☐ Uses communication devices like pictures or a board
- ☐ Uses gestures like pointing, pulling or blinking
- ☐ Uses sounds that are not words like grunting

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

- ☐ Speech/language therapy
- ☐ Occupational therapy (OT)
- ☐ Physical therapy (PT)
- ☐ Daily medication (not including vitamins)
- ☐ Special education services in school
- ☐ Behavioral therapy or services
- ☐ Counseling for emotional concerns
- ☐ None

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

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

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) likea 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

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)

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

COMMUNITY DEVELOPMENT BLOCK GRANT (CDBG)

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 are 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. Which of these describes your household income?

_____ $0
_____ $1 to $9 999
_____ $10 000 to $24 999
_____ $25 000 to 49 999
_____ $50 000 to 74 999
_____ $75 000 to 99 999
_____ $100 000 to 149 999
_____ $150 000 and greater

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.

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 and financial literacy, arts, fieldtrips, cooking, gardening 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 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 *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.

City of Hialeah Education & Community Services Department

Youth Enrichment Program 2018-2019

This handbook contains pertinent information about STEP Ahead 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.

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

Step Ahead

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

Upon registering a child, 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
- Disciplinary Policy

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

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)