

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. 4<sup>th</sup> Ave.
- Bright Park - 750 E. 35<sup>th</sup> St.
- Cotson Park - 574 W. 23<sup>rd</sup> St.
- Goodlet Adult - 900 W. 44<sup>th</sup> Pl.
- Hoffman Gardens - 7650 W. 8<sup>th</sup> Ave.
- O'Quinn Park - 6051 W. 2<sup>nd</sup> Ave.
- Slade Park - 2501 W. 74<sup>th</sup> St.
- Veterans Park - 7900 W. 32<sup>nd</sup> Ave
- Walker Park - 800 W 29<sup>th</sup> St.
- Wilde Park - 1701 W. 53<sup>rd</sup> 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](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):*

- 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](http://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 \_\_\_\_\_

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**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



**During the 2009 legislative session, a new law was passed that requires child care facilities, family day care homes and large family child care homes provide parents with information detailing the causes, symptoms, and transmission of the influenza virus (the flu) every year during August and September.**

**My signature below verifies receipt of the brochure on *Influenza Virus, The Flu, A Guide to Parents*:**

**Name:** \_\_\_\_\_

**Child's Name:** \_\_\_\_\_

**Date Received:** \_\_\_\_\_

**Signature:** \_\_\_\_\_

**Please complete and return this portion of the brochure to your child care provider, in order for them to maintain it in their records.**



## What should I do if my child gets sick?

Consult your doctor and make sure your child gets plenty of rest and drinks a lot of fluids. Never give aspirin or medicine that has aspirin in it to children or teenagers who may have the flu.

### CALL OR TAKE YOUR CHILD TO A DOCTOR RIGHT AWAY IF YOUR CHILD:

- Has a high fever or fever that lasts a long time
- Has trouble breathing or breathes fast
- Has skin that looks blue
- Is not drinking enough
- Seems confused, will not wake up, does not want to be held, or has seizures (uncontrolled shaking)
- Gets better but then worse again
- Has other conditions (like heart or lung disease, diabetes) that get worse



## How can I protect my child from the flu?

A flu vaccine is the best way to protect against the flu. Because the flu virus changes year to year, annual vaccination against the flu is recommended. The CDC recommends that all children from the ages of 6 months up to their 19th birthday receive a flu vaccine every fall or winter (children receiving a vaccine for the first time require two doses). You also can protect your child by receiving a flu vaccine yourself.

## What can I do to prevent the spread of germs?

The main way that the flu spreads is in respiratory droplets from coughing and sneezing. This can happen when droplets from a cough or sneeze of an infected person are propelled through the air and infect someone nearby. Though much less frequent, the flu may also spread through indirect contact with contaminated hands and articles soiled with nose and throat secretions. To prevent the spread of germs:

- Wash hands often with soap and water.
- Cover mouth/nose during coughs and sneezes. If you don't have a tissue, cough or sneeze into your upper sleeve, not your hands.
- Limit contact with people who show signs of illness.
- Keep hands away from the face. Germs are often spread when a person touches something that is contaminated with germs and then touches his or her eyes, nose, or mouth.



## When should my child stay home from child care?

A person may be contagious and able to spread the virus from 1 day before showing symptoms to up to 5 days after getting sick. The time frame could be longer in children and in people who don't fight disease well (people with weakened immune systems). When sick, your child should stay at home to rest and to avoid giving the flu to other children and should not return to child care or other group setting until his or her temperature has been normal and has been sign and symptom free for a period of 24 hours.

**For additional helpful information about the dangers of the flu and how to protect your child, visit: <http://www.cdc.gov/flu/> or <http://www.immunizeflorida.org/>**

## What is the influenza (flu) virus?

Influenza (“the flu”) is caused by a virus which infects the nose, throat, and lungs. According to the US Center for Disease Control and Prevention (CDC), the flu is more dangerous than the common cold for children. Unlike the common cold, the flu can cause severe illness and life threatening complications in many people. Children under 5 who have the flu commonly need medical care. Severe flu complications are most common in children younger than 2 years old. Flu season can begin as early as October and last as late as May.



## How can I tell if my child has a cold, or the flu?

Most people with the flu feel tired and have fever, headache, dry cough, sore throat, runny or stuffy nose, and sore muscles. Some people, especially children, may also have stomach problems and diarrhea. Because the flu and colds have similar symptoms, it can be difficult to tell the difference between them based on symptoms alone. In general, the flu is worse than the common cold, and symptoms such as fever, body aches, extreme tiredness, and dry cough are more common and intense. People with colds are more likely to have a runny or stuffy nose. Colds generally do not result in serious health problems, such as pneumonia, bacterial infections, or hospitalizations.



For additional information, please visit [www.myflorida.com/childcare](http://www.myflorida.com/childcare) or contact your local licensing office below:

Palm Beach County Health Department  
Childcare Licensing Office  
P.O. Box 29  
800 Clematis St., 4th Floor  
West Palm Beach, FL 33402  
(561) 837-5900  
[www.pbchd.com](http://www.pbchd.com)

CF/PI 175-70, June 2009

*This brochure was created by the Department of Children and Families in consultation with the Department of Health.*



**INFLUENZA VIRUS**

**“The Flu”  
A Guide  
for Parents**