



**CHILD INFORMATION FORM**

**Required as of 8/1/2018**

Child's Last Name \_\_\_\_\_ First \_\_\_\_\_ Middle Name \_\_\_\_\_

Child's Date of Birth (MM/DD/YYYY)  Child's Gender  Male  Female

Miami-Dade County Public Schools ID #   No M-DCPS ID #

Child's current school \_\_\_\_\_

Is your child proficient in English?  Yes  No

Other language(s) spoken in your home  Spanish  Haitian Creole  Other: \_\_\_\_\_  None

Street Address \_\_\_\_\_ City \_\_\_\_\_ Zip Code \_\_\_\_\_

Child's ethnicity  Hispanic  Haitian  Other, please specify: \_\_\_\_\_

Child's race (select only one)  American Indian or Alaskan  Asian  Black or African-American  
 Pacific Islander  White  Other  Multiracial

Child's current grade

Does child have health insurance? (ex., private insurance, KidCare, Medicaid)  Yes  No  
(If not, we may be able to help you find affordable coverage – call 211 or visit [www.thechildrenstrust.org/parents/health-connect/insurance](http://www.thechildrenstrust.org/parents/health-connect/insurance).)

Child's primary caregiver (full name) \_\_\_\_\_

Primary caregiver email address \_\_\_\_\_

Primary Phone Number  Is this a cell/mobile phone?  Yes  No

*(Please note that The Children's Trust may contact you via postal mail, email and/or text to ask about your satisfaction with these services, and to make you aware of other Trust-funded programs, initiatives and events you may be interested in.)*

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

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

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

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

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

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

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

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

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*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). For special needs resources for your child, visit [www.advocacynetwork.org](http://www.advocacynetwork.org) or [www.thechildrenstrust.org/cwd](http://www.thechildrenstrust.org/cwd)*

**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.**

Signed by electronic signature on the form

**PARENT/GUARDIAN SIGNATURE** \_\_\_\_\_ **DATE** \_\_\_\_\_

**FOR STAFF USE ONLY (MUST BE COMPLETED)**

ORGANIZATION \_\_\_\_\_ SITE \_\_\_\_\_

POPULATION MEMBERSHIP (check all that apply):  Dep Syst  Delin Syst

# DATA AND EMERGENCY CONTACT INFORMATION

INSTRUCTIONS: THIS FORM MUST BE COMPLETED BY PARENT/GUARDIAN

\_\_\_\_\_  
Student's Name

\_\_\_\_\_  
NAME of PARENT or GUARDIAN

\_\_\_\_\_  
Student **DOB** (MM/DD/YYYY)

\_\_\_\_\_  
CONTACT PHONE NUMBER

Please list **two additional emergency** contact persons in the event the parent or guardian cannot be contacted:

\_\_\_\_\_  
Emergency Contact #1

\_\_\_\_\_  
CONTACT PHONE NUMBER

\_\_\_\_\_  
Relationship to Student

\_\_\_\_\_  
Emergency Contact #2

\_\_\_\_\_  
CONTACT PHONE NUMBER

\_\_\_\_\_  
Relationship to Student

Please list the names of the person(s) who **ARE ALLOWED** to pick up or transport your child in the event of an **EMERGENCY**. **\*\*\*Please Print name as on ID / Driver's License.**

1 \_\_\_\_\_  
4 \_\_\_\_\_  
7 \_\_\_\_\_

2 \_\_\_\_\_  
5 \_\_\_\_\_  
8 \_\_\_\_\_

3 \_\_\_\_\_  
6 \_\_\_\_\_  
9 \_\_\_\_\_

## MEDICAL/EMERGENCY RELEASE

I hereby consent for my child to participate in the Vision Smart Kids Program and to receive emergency care during after school , if needed. Screening and evaluation for problems in areas of vision, hearing, growth and development, nutrition, dental, scoliosis, communicable diseases, blood pressure, speech and language, or other non-invasive health screenings may be done as part of the program.

In the event of serious accident or illness, I request that the school contact be reached, I request designated RTV personnel to take or send my child to the hospital specified above. In some circumstance, Emergency Services personnel may determine that another hospital should receive my child. I consent to be responsible for all expenses incurred. In case of an accident or illness where immediate medical treatment is not indicated, but where my child is unable to remain in the after school program, I request the teacher to contact me. If I cannot be reached, I request that one of the persons listed above be contacted to remove my child from the summer camp program and to be responsible for his/her care. These persons listed have transportation and are immediately available to come to school. I authorize my child's information to be released to any physician caring for my child.

Signed by electronic signature on the form

PARENT Signature \_\_\_\_\_

DATE: \_\_\_\_\_



## AUTHORIZATION FOR PHOTOGRAPHY/VIDEO

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

I hereby:

**consent and authorize**                      **OR**                       **do not consent and authorize**

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

**Signed by electronic signature on the form**

\_\_\_\_\_  
Signature of Parent or Guardian

\_\_\_\_\_  
Signature of Witness

\_\_\_\_\_  
Date

\_\_\_\_\_  
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 and its funded service providers.

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 and its staff, funded service providers, employees, agents, affiliates and board members.

**Vision Smart Kids Summer Camp Program:**

**Acknowledgement of Receipt of Parent Handbook**

The **Vision Smart Kids Summer Camp Program** Parent Handbook consists of the following policies and procedures:

- Confidentiality policy
- Discipline Policy
- Transportation Policy
- Late Pick-Up Policy
- Health Policy
- Know Your Childcare Brochure
- Influenza Virus Brochure
- Distracted Driver Brochure

By signing below I certify that I have received the **Vision Smart Kids Summer Camp Program** Parent Handbook and read it in its entirety and signed and returned the required forms to program staff.

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Child's Name (print)

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Parent/Guardian Name (print)

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Parent/Guardian Signature    Signed by electronic signature on the form

Date



## LATE PICK UP POLICY

ReCapturing the Vision International, Inc. Vision Smart Kids **Summer Camp Program** operates during the hours of Monday-Friday. Starting as early as 9:30 a.m. and ends at 4:00 p.m. Monday – Thursday, Friday 9:30 a.m. – 3 p.m.

Parents should make every effort to ensure their child is picked up before closing at 4:00 p.m. Parents arriving after 4:00 p.m. will be required to sign a late pick up form confirming the pickup time and acknowledging that a late pick-fee of \$1.00 per minute will be assessed per child and must be paid.

In addition the following actions will be enforced:

- **FIRST ACTION:** Written and signed agreement to adhere to the pick up policy of the program.
- **SECOND ACTION:** Fee assessed and final warning of late pick up action.
- **THIRD ACTION:** Contact The Department of Children and Families and /or The Local Police Department.

More than three (3) late pick-ups will result in termination of your child's enrollment in the program.

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

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

## POLÍTICA DE RECOGIDA TARDE

ReCapturing de Vision International, Inc. El programa Vision Smart Kids campamento de verano opera durante las horas de lunes a viernes. Comenzando a las 9:30 a.m. y terminando a las 4:00 p.m. lunes a jueves, 9:30 a.m. – 3 p.m. de viernes.

Los padres deben esforzarse mucho para que su hijo sea recogido antes de cerrar a las 4:00 p.m. Los padres que lleguen después de las 4:00 p.m. se le pedirá que firme un formulario de recogida tarde confirmando la hora de recogida y reconociendo que se cobrará un cargo por recogida tardía de \$ 1.00 por minuto por niño y debe pagarse.

Además, se aplicarán las siguientes acciones:

- **PRIMERA ACCIÓN:** Acuerdo escrito y firmado para cumplir con la política de retiro del programa.
- **SEGUNDA ACCIÓN:** Tarifa evaluada y advertencia final de la acción de retiro tardío.
- **TERCERA ACCIÓN:** Se contactara a El Departamento de Niños y Familias y / o el Departamento de Policía Local.

Más de tres (3) recogidas tardías resultarán en la terminación de la inscripción de su hijo en el programa.

El nombre del niño: \_\_\_\_\_

Firma del Padre /Guardian: \_\_\_\_\_ Fecha: \_\_\_\_\_