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.)

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

Revised August 2018

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

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

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

- ☐ Autism spectrum disorder
- ☐ Developmental delay (only if under age 5)
- ☐ Intellectual/developmental disability (over age 5)
- ☐ Hearing impairment or deaf
- ☐ Learning disability (school age)
- ☐ Medical condition or illness
- ☐ Physical disability or impairment
- ☐ Problems with aggression or temper
- ☐ Problems with attention and hyperactivity (ADHD)
- ☐ Problems with depression or anxiety
- ☐ Speech or language condition
- ☐ Visual impairment or blind
- ☐ 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:

____

If you are interested in other services funded by The Children's Trust, please call 211 or visit www.thechildrenstrust.org. For special needs resources for your child, visit www.advocacynetwork.org or 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___________________	2___________________	3___________________
4___________________	5___________________	6___________________
7___________________	8___________________	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 Singature____ **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.

3150 SW 3rd Avenue, 8th Floor ● Miami, FL 33129
305.571.5700 ● Fax: 305.857.9592
www.thechildrenstrust.org

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.

____

Child's Name (print)

____

Parent/Guardian Name (print)

____

Parent/Guardian Signature **Signed by electronic signature on the form** Date

RECAPTURING THE VISION

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.

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: ______________________________

Signed by electronic signature on the form

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.

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: ______________________________

Signed by electronic signature on the form

Firma del Padre /Guardian: ______________________________ Fecha: ______________