



STUDENT APPLICATION SUMMER 2021

Whiz Kidz Summer Camp Program 2021

Dates: June 14, 2021 - July 30, 2021 Time: Monday - Friday 8am - 6pm

Whiz Kidz Program

- Bel-Aire ES:** 10250 SW 194th St., Cutler Bay, FL 33157
- Angels Reach Academy:** 15165 NW 77th Ave Miami Lakes, FL 33014
- Blue Lakes K-8:** 9250 SW 52nd Terrace Miami, FL 33165
- Pinelands Presbyterian Church:** 10201 Bahia Dr., Miami, FL 33189
- El Buen Pastor Church:** 310 E 5th St., Hialeah, FL 33010
- Pneuma Academy:** 7205 SW 125th Ave Miami FL 33183
- GHA:** 9280 Hammocks Blvd Miami FL, 33196
- Riverside United Methodist Church,** 985 NW 1st St., Miami FL. 33128
- Gulfstream ES:** 20900 SW 97th Ave Cutler Bay, FL 33189
- Wayside Baptist Church:** 7701 SW 98th St., Kendall, FL 33156
- GHA South Campus:** 17200 SW 137 Avenue, Miami, FL 33177
- Other:** _____

CHILD INFORMATION

Child's First Name: _____ Middle: _____ Last Name: _____

Child's Gender: Male Female

Child's Date of Birth: (mm/dd/yyyy)

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(Mandatory)

Miami-Dade County Public School ID Number:

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 OR Private School

(Mandatory)

Child's Current School Name: _____ Child's Current Grade

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(2020-2021 School Year)

Is your Child Proficient in English? Yes No

Other Language(s) Spoken in the Home: Spanish Haitian-Creole Sign Language Other _____ None

Child's Home Address: _____

Apt/ Unit: _____ City: _____ ZIP Code: _____

Child's Ethnicity: (select only one) Hispanic Haitian Other: _____

Child's Race: (select only one) American Indian or Alaskan Native Asian Black or African American
 Pacific Islander White Multiracial Other _____



CHILD INFORMATION (Continued)

Does child live with a legal guardian other than mother or father? Yes No

Family Status: (select only one): Married Not Married Single Female Single Male
 Guardianship/Foster Care Other: _____

Is child a part of the dependency system? Yes No
 (Ex. DCF, Our Kids, Full Case Management Agencies, Family Courts etc.)

Is child apart of the delinquency system? Yes No
 (Ex. Department of Juvenile Justice, Civil Citation Programs, etc.)

Does child receive free or reduced lunch? Yes No

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). 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.

Child's Insurance Information: (If child has no current insurance coverage, please write "not applicable" or "N/A")

Carrier: _____ Doctor's Name: _____ Phone Number: _____

PARENT/ GUARDIAN INFORMATION

(Please be aware that you may be contacted by the Children's Trust to ask about your satisfaction with these services)

Child's Primary Caregiver (full name): _____

Primary Phone Number: _____ Is this a cell/mobile phone? Yes No
 (Please write "not applicable" or "N/A", if no answer)

Primary Caregiver E-Mail (Please write "not applicable" or "N/A", if no answer): _____

Child's Secondary Caregiver (full name): _____

Primary Phone Number: _____ Is this a cell/mobile phone? Yes No
 (Please write "not applicable" or "N/A", if no answer)

CHILD'S MEDICAL INFORMATION

We want to get to know your child better so we can provide the best possible experience for your child. Please tell us more about your child. I give permission for this information to be submitted to the Trust for program quality/evaluation purposes.

1) What are the main ways your child communicates? (Mark all that apply)

- | | |
|--|--|
| <input type="checkbox"/> Speaks and is easily understood | <input type="checkbox"/> Uses sign language |
| <input type="checkbox"/> Speaks but is difficult to understand | <input type="checkbox"/> Uses gestures like pointing, pulling, smiling, frowning or blinking |
| <input type="checkbox"/> Uses communication devices like pictures or a board | <input type="checkbox"/> Uses sounds that are not words like laughing, crying or grunting |

2) 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 |

3) 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"/> Problems with aggression or temper |
| <input type="checkbox"/> Developmental delay (only if under age 5) | <input type="checkbox"/> Problems with attention or hyperactivity (ADHD/ADD) |
| <input type="checkbox"/> Hard of hearing, deaf, or hearing impaired | <input type="checkbox"/> Problems with depression or anxiety |
| <input type="checkbox"/> Intellectual/developmental disability (over 5) | <input type="checkbox"/> Speech or language condition |
| <input type="checkbox"/> Learning Disability (school age) | <input type="checkbox"/> Visual impairment or blind |
| <input type="checkbox"/> Medical Condition or illness | <input type="checkbox"/> None of the above |
| <input type="checkbox"/> Physical disability or impairment | |

4) Does Child have an IEP? Yes (If yes, please attach) No

5) To support your child's successful participation in this program, in what areas might s/he need extra assistance?

- No specific help needed
- Academic, learning or reading activities
- Adapting activities to take into account a visual or hearing impairment
- Holding a crayon/pencil, writing, using scissors or other fine motor tasks
- Managing feelings and behavior
- Personal services like help with feeding, toileting or changing clothes
- Sports or physical activities like running or other gross motor tasks
- Using assistive device(s) like a wheelchair, crutches, brace or walker
- Other _____

6) 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

7) Please circle or fill-in anything that applies to your child in the chart below.

Medication which affect: Learning, Physical Fitness Activities and Social Engagement	Food Allergies	Other Serious Allergies	Chronic Health Conditions	Physical Limitations which affect: Learning, Physical Fitness Activities and Social Engagement
<input type="checkbox"/> Antibiotics <input type="checkbox"/> Medication for chronic Health <input type="checkbox"/> Hyper Activity Medication <input type="checkbox"/> Other: _____ <input type="checkbox"/> _____	<input type="checkbox"/> _____ <input type="checkbox"/> _____ <input type="checkbox"/> _____ <input type="checkbox"/> _____	<input type="checkbox"/> Grass <input type="checkbox"/> Mosquitoes <input type="checkbox"/> Bee Stings <input type="checkbox"/> Penicillin <input type="checkbox"/> Other: _____ <input type="checkbox"/> _____	<input type="checkbox"/> Asthma <input type="checkbox"/> Diabetes <input type="checkbox"/> Sickle Cell Anemia <input type="checkbox"/> Seizures <input type="checkbox"/> Skin Condition <input type="checkbox"/> Seasonal Allergies <input type="checkbox"/> Reaction to Sunlight <input type="checkbox"/> Other: _____	<input type="checkbox"/> Other not listed above: _____ _____ _____ _____

EXCEPT AS NOTED ABOVE, my child is in good health, has no medical, food, other chronic allergies or serious health conditions. My child does not take medication routinely and his/her immunizations are current. If there is anything else you consider we need to know about, to better understand and provide the necessary help your child deserves, please speak to your Site Supervisor. All information is kept confidential and stored in locked cabinets. By signing on the last page I agree to the following.

CHILD’S EMERGENCY INFORMATION

I understand that every effort will be made to reach me for instructions if my child should become ill or injured while on the site or on a field trip. If in the judgment of the staff or a medical professional, delay in reaching me might jeopardize my child’s well-being, I hereby authorize the staff or medical professional to secure whatever medical treatment is deemed necessary, including the administration of anesthetics and surgery. **IN THE EVENT THAT NO ONE CAN BE CONTACTED, I GIVE PERMISSION FOR MY SON/DAUGHTER TO RECEIVE EMERGENCY MEDICAL TREATMENT.**

If you would like for us to follow a different emergency/medical procedure, please write it/explain below: (You can continue on the back of this page)

 _____ (cont. back)

EMERGENCY / ALTERNATE PICK UP CONTACT INFORMATION

Other phone numbers where I can be reached during the day: _____ / _____ / _____

If I cannot be reached, please contact my designated alternate(s) named below:

1. _____ Name	_____ Relationship to child	_____ Cellular and/ or work Number
2. _____ Name	_____ Relationship to child	_____ Cellular and/ or work Number
3. _____ Name	_____ Relationship to child	_____ Cellular and/ or work Number

Please note: Any family or friends authorized to pick up your child, must have a valid picture ID for verification purposes. A copy of ID will be taken by site staff and placed in student’s file for future confirmation. In the event that I, the legal guardian am not able to pick up my child on time, I will call the Site Supervisor and will authorize her/him to release my child to the persons listed above.

POLICY INFORMATION/CONSENT

Non-Discrimination Policy: Children who are 5 and have already attended or who are currently enrolled in kindergarten will be accepted into the winter/ spring Camp and After-school program regardless of race, creed, immigration status, health, religion, disability, ethnicity or ability to pay for services. Children without documented legal status, or whose parents are without documented legal status will not be discriminated against for selection in these programs. As with the Miami-Dade County Public School system, all children are welcome. Children with severe physical, emotional or behavioral disabilities may find After-school programs specially designed to meet their needs through other programs, every effort will be made to find the most suitable placement for each child.



Parental Consent:

By signing this application on the next page, I agree and certify to the following Children's Trust Requirements:

- 1) **I acknowledge** that the application information and medical information I have provided above is true and complete to the best of my knowledge and ability.
- 2) As the legal guardian of _____, **I authorize and give consent** or **I DO NOT authorize or give consent** to Hope for Miami's staff (HFM), nor The Children's Trust (TCT) or service providers to take/use still photographs, digital photographs, motion pictures, television transmission, and/or videotapes recordings (hereinafter "Recordings") of me, my children, or my wards for educational, research, documentary, and public relations purposes. Any such Recordings may reveal my identity through the image itself without any compensation to me, my children or my wards. With regard to the use of any Recordings taken of me, my children or my wards, I hereby waive any and all present and future claims I may have against TCT or HFM, their staff, service providers, employees, agents, affiliates and Board members.
- 3) **I understand** that the email contact information provided to Hope For Miami is used for emergency contact and also being used to subscribe to our First to Know Parent Newsletter. Email campaigns which include planned events, prevention services, parent workshop opportunities, Summer Camp registration deadlines, and additional community resources that can help my family stay informed with the latest updates in my neighborhood. I also understand that I may opt out or unsubscribe from this platform at any time.
- 4) **I understand** that participation by my children in the Program sponsored by Hope for Miami, The Children's Trust and its partners involves physical education, meals, and off-site field trips. As these activities may carry some degree of risk to my child's physical and emotional health, I hereby release, hold harmless and waive all claims associated with out-of-school/summer camp program activities from HFM, and the program site and all employees, officers, directors, agents, and volunteers associated with the out-of-school/summer camp program.
- 5) **I understand** that no medication/medical equipment will be administered by the After-school personnel to my child without the "Authorization for Prescription and Non-Prescription Medication/Medical Equipment Form" signed by me as the parent/legal guardian. Also, I agree to provide instructions on how and when the medicine/medical equipment should be administered if my child were to need assistance with it. (Please, refer to parent handbook for more details).
- 6) As my child attends an Out-of-school program funded by the Children's Trust (either Summer Camp, After-school, Winter/Spring Camp or all programs), **I acknowledge** and understand that my child must adhere to all behavioral and policy driven rules and regulations the program sites require. Failure to abide by these rules, may lead to suspension and or removal of the program. I also acknowledge receipt of a written **Family Handbook** for this current program year, which details policies and procedures regarding my child and the program.
- 7) As the Out-of-school program (either Summer Camp, After-school, or Winter/Spring Camp) may take place on the premises of a religious organization, the primary purpose of the program is academic enrichment and a safe environment during out-of-school/Summer Camp time. However, your child may be invited to participate in other church activities on the premises or to **receive optional religious instruction**. Unless expressed written permission has been given by the parent or guardian to participate in the religious instruction, no child will be asked to participate, and no Children's Trust funds will be used for teacher stipends, books, curriculum or other expenses related to religious instruction. Such instruction will be given by church ministers or volunteers.
Please select the box concerning Religious instruction:

I authorize my child to participate. Initial: _____ **I do not authorize** my child to participate. Initial here: _____

- 8) My child will be arriving and leaving from the site in the following manner:

Arrival to the site: By bus/van. Walking from school. With authorized person/relative.
 With Parent/Guardian. Driving on their own

Leaving from the site: By bus/van. Walking from school. With authorized person/relative.
 With Parent/Guardian. Driving on their own

I **do not** give permission, under any circumstances, for my child to leave the program site with _____. Relationship to child: _____. If possible, bring a picture to keep on file. Child is allowed to go home with mother, father or legal guardian unless we have court documents stating otherwise due to custody battle or abuse. (Legal documentation must be provided).

- 9) I agree to make every effort to ensure that my child participates in the program daily, unless he/she is too ill to attend. I also agree that I or my designated representative will **sign-out my child every day** he/she attends the program.
- 10) I understand that I am responsible to pick up my child at the end of the program day or arrange for an authorized person to pick up my child. Only those persons previously authorized in writing, may leave the premises with my child. I am aware of the **fees charged** for parent tardiness on pick-up at the end of the day. For Whiz Kidz sites, the late fee is \$1 per minute. The program ends at **6:00 PM** each day.
- 11) I understand that I need to call the Out-of-school/Summer Camp site supervisor if my child is not attending on a particular day so that that Supervisor is aware that my child will not be showing up on that day.
- 12) I understand that I am releasing the After-school/Summer Camp Program of any liability once my child has been dismissed from the program site.

I give my permission for the information in this application to be submitted to The Children's Trust for program quality and evaluation purposes. The Children's Trust provides funding for the program. *If you are interested in other services funded by The Children's Trust please call 211 or visit www.thechildrenstrust.org.*

I am signing that I have reviewed and agreed to all terms and conditions described in this application, all the program standards, Policies and Procedures and Parent Handbook:

Parent / Legal Guardian Signature

Date

Accidental Injury Insurance

If your child is enrolled in a program managed by Hope for Miami, they are covered for supplemental medical expenses should they have an accident **while participating in program activities, during regularly scheduled program hours**. If your family has medical insurance, this supplemental policy will cover some deductibles and uncovered expenses. If your family is uninsured, the child's medical expenses may be covered, if an injury were to occur (accidents only).

- Cost is \$ 10.00 per student. Money Order must be payable to Hope for Miami.
- Medical expenses for accidents in and out patient for a maximum of \$25,000.00
- \$100.00 deductible on this policy
- Includes \$10,000 Accidental Death benefit and Accidental Dismemberment benefit (should there be a serious injury).
- Coverage through July 30, 2021

Site Supervisor USE ONLY (MUST BE COMPLETED)

Sibling(s) names in our program: 1. _____ 2. _____

3. _____ 4. _____ 5. _____

Sibling definition: One or more children having one or both parents in common or legally adopted.

Fees Collected : Please Note: Only Money Orders are accepted. No checks, no cash nor credit cards are accepted.

Accident Insurance fee: \$10 collected: Yes No

Registration Fee: \$90.00 collected: Yes No

Summer Camp Fee: \$345.00 collected: Yes No
(\$295.00 if paid in full by 4/15/2021)

Parent Handbook given: Yes No

(Please make sure parent signs the acknowledgement)

FOR STAFF USE ONLY (MUST BE COMPLETED)

Verified by: _____ Date of registration: _____ Copy to HFM Office Personnel: _____

Tentative Start Date: _____ Withdrawn Date: _____ Returned Date: _____ Paid Fees N/A
(When Applicable) (Participant will have to pay registration fee again)