CHILD INFORMATION FORM

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

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

Last four (4) digits ONLY of child's social security # ☐☐☐☐ ☐ No SS #

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 Parent/Guardian (full name) _____

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.)

Is the Participant a Child of a Military Family? ☐ Yes ☐ No

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)

- ☐ 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.

PARENT/GUARDIAN SIGNATURE _____ **DATE**_____

FOR STAFF USE ONLY (*MUST BE COMPLETED*)

ORGANIZATION ArtSouth, A Not for Profit Corporation SITE _____

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

Please list 3 persons authorized to pick up your child from camp and for emergency contact

Name_____ **Phone** _____

Name_____ **Phone** _____

Name_____ **Phone** _____

1. **My child has permission to take field trips planned with the classes.**

2. **I understand that ArtSouth is not responsible for any personal items (i.e. clothing, games, ipods, cell phones or money) my child brings to camp.**

3. **I give permission to ArtSouth and all persons acting with its permission, the right and permission to obtain, use copyright, and/or publish photographic or video images of the above name registrant, in which the registrant is in whole or in part. It is my understanding that such pictures are for the purpose of art, advertising, trade, and any other lawful purpose whatsoever. I understand that I will not have any opportunity to approve nor review the finished product that may be used in connection therein or the use to which it may be applied.**

4. ****<u>Authorization for Emergency Medical-Surgical Treatment</u>—I understand that in the event I cannot be reached, I hereby grant permission to the physician or hospital selected by the camp administration to secure proper treatment for, order injection, anesthetic, or perform surgery on my child. I hereby give permission or arrange necessary transportation to a hospital. I understand that ARTSOUTH will not be held liable for injury or damage to my child(ren) while on campus or field trips.**

_____ _____

Parent/Guardian Signature **Date**

ArtSouth
5825 SW 68th Street Suite 2, office 202
South Miami, FL 33143-3611
Phone: (305) 662-1423 Fax: (305) 662-1451
www.artsouthmiami.org
info@artsouthmiami.org

Nonrefundable Registration Fee: $30 _____Cash Check #_____ _____ Credit/Debit Card

Early Bird Tuition Fee: $150 per 2-week session ($75 per week) paid-in-full <u>before</u> May 31, 2018

Tuition: $170 per 2-week session ($85. per week), <u>after May 31, 2018</u>

PLEASE CHECK WHICH SESSIONS YOUR CHILD WILL ATTEND BELOW:

Session 1/Wk 1 June 18 –22 _____
Session 1/Wk 2 June 25-29 _____
Session 1/Wk 3 July 2- 6 _____
Session 1/Wk 4 July 9 – 13 _____

Session 2/Wk 1 July 16 – July 20 _____
Session 2/Wk 2 July 23 - 27 _____
Session 2/Wk 3 July 30-Aug 3 _____
Session 2/Wk 4 August 6 -10 _____

PAID AMOUNT: _____ RECEIPT #: _____