CHILD INFORMATION FORM

Child's Last Name______________________, **First** ____________________ **Middle** _______________

Child's Date of Birth (mo/day/yr) [ ][ ] [ ][ ] [ ][ ][ ][ ] **Child's Gender** ☐ Male ☐ Female

Last 4 Digits ONLY of Child's Social Security# [ ][ ][ ][ ] ☐ No SSN

Miami-Dade County Public School ID# [ ][ ][ ][ ][ ][ ][ ] ☐ No MDCPS ID

Child's Current School _______________________________________

Is your Child Proficient in English? ☐ Yes ☐ No

Other Language(s) Spoken in the Home ☐ Spanish ☐ Haitian-Creole ☐ Other__________ ☐ None

Street Address _________________________________ **City** _______________ **ZIP Code** _________

Child's Ethnicity ☐ Hispanic ☐ Haitian ☐ Other

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)

Parent/Guardian (full name) ____

Parent/Guardian Email ____

Parent/Guardian Phone [ ][ ][ ] [ ][ ][ ] [ ][ ][ ][ ]

(You may be contacted by The Children's Trust to ask about your satisfaction with these services)

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)

- ☐ Speaks and is easily understood
- ☐ Speaks but is difficult to understand
- ☐ Uses sign language
- ☐ Uses communication devices like pictures or a board
- ☐ Uses gestures like pointing, pulling or blinking
- ☐ 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)

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

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

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

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___________________________________ SITE_______________________________________

POPULATION MEMBERSHIP (check all that apply): ☐Dependency System ☐Delinquency System

EMERGENCY CONTACT INFORMATION

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

Emergency Contact Person#1

____

________________________________ ________________________________
Relationship to the Child Contact Phone Number

Emergency Contact Person#2

____

________________________________ ________________________________
Relationship to the Child Contact Phone Number

Please list the names of the person(s) who are authorized to pick up or transport your child in the event of an emergency:

________________________ ________________________ ________________________

________________________ ________________________ ________________________

TRANSPORTATION AUTHORIZATION FORM

I will make sure that the necessary transportation arrangements are made on a timely and daily

basis for my child_______________________________________.

It is my responsibility to make sure my child is picked up by either by a responsible adult or myself. Should any changes occur, I will notify ReCapturing the Vision, Int'l (Vision Smart Kids), IMMEDIATELY.

I give consent for my child to be transported to and from school by the names listed on the emergency/contact information.

Parent/Guardian Signature: ____

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 circumstances, 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 that one of the persons listed above be contracted to remove my child from the 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.

My child ____ has the following known allergies:

____

____

Signature:____Date____________________
Parent/Guardian

CONTRACT/MEDIA RELEASE FORM

I,______________________________, do agree to participate in the ReCapturing the Vision Program. In doing so, I am agreeing to try and become a more finished young lady/gentleman which is what I want to be.

I, ______________________________, support my daughter's/son's participation in the ReCapturing the Vision Program. As a parent, I will do my best to help her uphold her/his commitment to become a more finished and disciplined young lady/gentlemen. This letter fives my daughter/son who is a participant of the ReCapturing the Vision Program, my permission to appear in an media endorsements relating to the promotion of this program. I understand that my child's pre-and post-survey, results may be used in an ongoing research study to monitor the program's effectiveness and that (s)he will not be identified by name. I waive any liability to the school system, Recpaturing the Vision staff, or Dr. Jacqueline Del Rosario from possible suit due to promotion material.

____   __________________________
Parent/Guardian's Signature   Date

ReCapturing the Vision maintains that all articles, media appearances, and research studies will be in good taste.

LATE PICK UP POLICY

ReCapturing The Vision International, Inc. Vision Smart Kids Summer Program operates during the hours of Monday – Friday. Starting at 9am and ends at 5:00pm daily.

Parents should make every effort to ensure their child is picked-up before closing at 5:00pm. Parents arriving after 5:00pm will be required to sign a late pick up form confirming the pickup time and acknowledging that a late pick-up 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 pickup 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 late pickups will result in termination of your child's enrollment in the program.

Child's Name: ____

Parent/Guardian Signature:_______________________________

Date: ________________________ Time: ____________________

RECAPTURING™
THE VISION

VISION SMART KIDS SUMMER PROGRAM

The cost of the Vision Smart Kids
Summer Program
Is
$150 per child ($25 per week)
(for the 6 week session)

The FEE includes:

- **All meals and snacks,**
- **Activities and supplies,**
- **6 field trips (one every Friday)**

To be paid in three installments:

$50 deposit with Application
$50 on or before June 23
$50 on or before July 7
NO EXCEPTIONS!

Cash or Money Orders Only!

PARTICIPANT FEEDBACK/CLIENT SATISFACTION SURVEY

ReCapturing the Vision International along with The Children's Trust is committed to providing the highest quality of after school service. RTV will ensure that parents/students are given the opportunity to provide feedback by the following method:

- Each parent/student will receive a participant feedback form to complete and return to their RTV teacher.

Acknowledgement of Receipt of Parent Handbook

The Vision Smart Kids 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

By signing below I certify that I have received the Vision Smart Kids 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)

____