



**CHILD INFORMATION FORM**

Select Site:      Miami Christian School (June 8 - July 17)

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](http://www.thechildrenstrust.org/parents/health-connect/insurance).)

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

Primary guardian 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                       | *Please attach IEP or 504 to Registration |
|   | <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:**

\_\_\_\_\_

*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.

<b>PARENT/GUARDIAN SIGNATURE</b> _____	<b>DATE</b> _____
--	-------------------

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

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

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

## TUITION & FEES

1. A **\$50** Non-refundable Application Fee is due by **May 1, 2020** with this registration form

\*In order for your child to participate, you must be in good standing with GMYS

2. **Tuition must be paid in full by May 15, 2020** (see the chart below for possible Reduced Tuition Rates)

– if you believe that you qualify for a Reduced Tuition Rate, your most recent tax return MUST be attached to this form along with the \$50 non-refundable application fee)

Family Income (Adjusted Gross Income)	Tuition for Miami Christian School
Above \$53,000	\$525
Above \$48,000	\$445
Above \$43,000	\$315
Above \$38,000	\$185
Under \$38,000	Free

\*Most recent tax return MUST be attached to this form to be eligible for reduced tuition rates. Contact GMYS staff regarding special circumstances. Payment Plans are available upon request.

\*Scholarships only awarded for **complete** duration of the camp\*

3. OPTIONAL: **BEFORE/AFTER CARE - \$150 per student for the full 6 weeks**

*Can be paid in-full at the start of the camp*

*OR \$25 per week can be paid on the Monday of each week*

**Before Care begins at 7:30 AM. After Care ends at 6:00 PM**

My child(ren) \_\_\_\_\_ will require Before and/or After Care during the GMYS Summer Music Camp. I will sign my child(ren) in and out of before and/or After Care. I agree that GMYS is not responsible for my child(ren) if they are dropped off before 7:30am or picked up after 6:00pm. I acknowledge that the proper authorities will be notified if A) I or another emergency contact person does not arrive to retrieve the child(ren) by 6pm, or B) if no contact has been made with the camp staff notifying them of an emergency prohibiting the child(ren) from being picked up.

Please indicate below who will be dropping off or picking up the child(ren) for Before and/or After Care. This person MUST sign in and sign out the child(ren) with the Before/After Care supervisor.

**Child(ren) will ONLY be released to the individuals listed below:**

Name	Relationship to Child	Place of Employment	Work Number	Cell Number

## ATTENDANCE POLICY

Students absent more than six (6) days for the duration of the six-week summer camp will be dismissed from camp and not be allowed to participate in next year's summer camp. Attendance at all concerts is mandatory.

**By signing below, I agree to all statements and requirements above.**

\_\_\_\_\_  
Parent / Guardian Signature

\_\_\_\_\_  
Date

# Classes

## Grades K-2 of 2019-2020 School Year

Fun classes will include

- Music
- Art
- Movement
- Rhythm
- General Music

## Grades 3-5 of 2019-2020 School Year

String or Band Track

Classes will include

- Instrumental
- Ensemble
- Art
- Percussion

String Track (Violin, Viola, Cello, Bass)

Band Track (Flute, Clarinet, Trumpet, Trombone..)

**\*Instruments will be available for both tracks**

## Grades 6-12 of 2019-2020 School Year

Strings Instrument: \_\_\_\_\_

Band Instrument: \_\_\_\_\_

No experience Instrument: \_\_\_\_\_

\_\_\_\_\_  
Previous GMYS Ensemble

**Or**

\_\_\_\_\_  
School Ensemble

**Students will be placed in appropriate String or Band levels based on previous experience**

**Permission to Transport**

**Comprehensive Parental/Guardian Consent Form and Liability Waiver**

*(Students cannot attend off-site field trips unless this waiver is signed)*

I, (Parent/Guardian) \_\_\_\_\_ grant permission for my child \_\_\_\_\_ to be transported in a motor vehicle driven by or hired by GMYS, a MDCPS approved bus service, or a program van driven by a GMYS employee. I understand that my child is expected to follow all applicable laws regarding riding in a motor vehicle and is expected to follow the directions provided by the driver and/or other adult staff members or volunteers. I agree on behalf of myself, my child named herein, and our heirs, successors and assigns to hold harmless and defend GMYS, its officers, directors and agents, and any funding agencies, from any and all actions, claims, demands, damages, costs, expenses, and all consequential damage arising from or in connection with my child being transported by GMYS employees or a MDCPS approved bus service.

I have read this entire waiver and permission form, fully understand it, and agree to be legally bound by its terms.

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

**Emergency Contact Information and Authorization Pick-Up**

Children will ONLY be released to the individuals listed below in the table and in the Additional Authorization Pick-Up List below.

Name	Relationship to Child	Place of Employment	Work Number	Cell Number

**Additional Authorization Pick-Up List: Who else has permission to pick-up your child from camp?**

Please list their names here:

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**Walk-Home Authorization**

Days \_\_\_\_\_ Exact Times \_\_\_\_\_

I understand that GMYS is not responsible for the care of my child after the times listed above.

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

**Participant Medical Information**

Please state below any medical or behavioral conditions your child has or has had that should be considered. Include any medication which needs to be administered while attending the program (allergies, present medication, activities to avoid, behavioral characteristics/techniques, etc). Furthermore, indicate if there are any special needs and/or accommodations necessary that our staff needs to be aware of in order to provide the best possible care. **IF THERE ARE NONE, PLEASE WRITE N/A**

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**Medical Verification and Consent**

I hereby give permission to the physicians selected by GMYS to order X-rays, routine tests and treatment for the health of my child in the event I cannot be reached in an emergency. I give permission to the physician to hospitalize, secure proper treatment for and order injection and/or anesthesia and/or surgery for my child. I attest the participant is physically able to participate in all activities planned and hosted by GMYS and that the participant's physical condition has been verified by a licensed medical doctor, and I consent to any needed medical treatment for the participant in the event of an emergency. I understand as the participant's parent or legal guardian that the activities involve risk, and I do hereby voluntarily assume any and all risk such as injury caused by the negligence of GMYS and/or its volunteers, consultants and officers. My personal insurance bears primary responsibility in case of accident.

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



## AUTHORIZATION FOR PHOTOGRAPHY/VIDEO

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

I hereby:  consent and authorize or  do not consent and authorize

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

\_\_\_\_\_  
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.

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, their staff, service providers, employees, agents, affiliates and Board members.

3150 SW 3<sup>rd</sup> Avenue, 8<sup>th</sup> Floor • Miami, FL 33129  
(305) 571-5700 • Fax: (305) 860-2328  
[www.thechildrenstrust.org](http://www.thechildrenstrust.org)