Be a Success in School (B.A.S.I.S)

Program and Child Information Form

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 Parent/Guardian (full name) _____

Parent/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)

- ☐ 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 _____ SITE _____

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

The following information is optional and ONLY used to assist CMB VISIONS in obtaining funding and various grants. This Information will be Held Confidential.

CHILD(REN) RESIDES WITH
(Check all that apply)

Mother ☐ Father ☐ Stepfather ☐ Stepmother ☐ Grandparent ☐

Aunt/Uncle ☐ Foster Parent ☐ Other (please identify): _____

Annual Family Income (Check One)

Under - $5000 ☐ $16000 - $20000 ☐
$6000 - $10000 ☐ $21000 - $30000 ☐
$11000 - $15000 ☐ above $30000 ☐

PICK UP AUTHORIZATION

(Mother, Father, and Emergency Contact listed are assumed unless otherwise notified.)
Please provide the name of persons who are authorized to pick up child/student

_____ Name

_____ Name

_____ Name

_____ Name

_____ Name

_____ Name

Code Word (optional):_____

Emergency Contact

Please consider someone outside of your household with alternative contact information if neither parent can be reached.

Name: _____ Name: _____

Cell Phone: _____ Cell Phone: _____

Work Phone: _____ Work Phone: _____

MEDICAL INFORMATION

Doctor: _____ Office Phone Number: _____

Dentist: _____ Office Phone Number: _____

Medical Ins. Co. Name: _____

Policy #: _____ Preferred Hospital: _____

Present Medical Problems and Chronic Conditions (epilepsy, asthma, etc.) _____

Allergies (drugs, insect bites, etc.): _____

Medicines taken regularly (medication cannot be distributed by CMB VISIONS staff without a signal medical form and the medication must be provided by the parents – including Tylenol, inhalers, etc.):

Special Precaution/Other: _____

Financial Need and Waiver

My child(ren) qualifies for FREE or REDUCED lunches at school (form required) ☐ YES/NO ☐

By **initialing below** I, as the parent or legal guardian, acknowledge the following information or policies. I understand that my initials are not required for the photo release.

_____ WAIVER AND MEDICAL RELEASE AGREEMENT: I, _____ (Parent or Legal Guardian) do hereby release CMB Visions Unlimited, Inc., their employees, successors, agents, attorneys, and all other persons, corporations, or insurance companies liable or who might be claimed to liable, from any claims, demands, injured, or damages, resulting from any accident which may occur as a result of _____ (Students name).

_____ In the event of a medical emergency, I _____ (Parent or Legal Guardian) hereby authorize CMB VISIONS to seek emergency medical treatment for _____ (Student's name).

_____ G-Rate and PG movies such as Incredibles, Parent Hotel Transylvania, & 101 Dalmatians are occasionally offered. If you authorize your child(ren) to view PG movies, please indicate by initialing.

_____ I have received, read, and understand all pages of the Program policies and procedures.

_____ I have read and understand the Discipline Policy.

_____ I have read and understand the Client Confidentiality policy.

_____ I have received a copy of the Child Care Facility Brochure, "Know Your Child Care Facility".

I have read and fully understand the contents of this application. I have completed the application to the best of my knowledge and ability. I understand that if any information listed in this application changes, I will notify CMB VISIONS immediately. The child/children listed above has/have my permission to participate in the activities, trips, and events sponsored by CMB VISIONS. In case of an emergency an alternate person will be called if the parent(s) cannot be reached by phone. The undersigned, individually and as parent or guardian of the participant, hereby authorize CMB VISIONS to carry out any measures deemed necessary should as emergency occur, including at the expense of the undersigned, appropriate medical treatment for the participant, and hereby releases CMB VISIONS, its employees and agents, from any liability or claims arising out of the participant's engagement in the above described events.

_____ _____

PRINT - Parent or Guardian SIGNATURE - Parent or Guardian

_____

Date

Client Confidentiality Policy

Staff will to the best of their ability, ensure confidentiality and privacy in regard to history, records and discussions about the people we serve. The very fact that an individual is served by CMB Visions Unlimited, Inc. must be kept private and confidential; disclosure can be made only under specified conditions, which are described below. This means that staff shall not disclose any information about a person, including the fact that the person is or is not served by our organization, to anyone outside of this organization unless authorized by the client or the client's
designee. The principle of confidentiality must be maintained in all programs, departments, functions and activities. The following policy directives are mandatory.

*No information requested by someone outside CMB Visions Unlimited, Inc. will be given over the telephone. Staff is instructed to respond with the statement: CMB Visions Unlimited, Inc. policy does not permit us to discuss confidential information." CMB Visions Unlimited, Inc. does not acknowledge any recognition of any individual identity.

*Release-of-information forms will be explained and completed in the presence of the person about whom any information may be released, before it is released. A record of this document will be kept in a client's chart or on file and secured.

*No information about individuals or records/data will be released to state, federal or other agencies that enable the identification of any person by name, address, Social Security number or other coding procedures.

*If records are inspected by an outside agency, the individual(s) who inspect the records must be specifically authorized to do so by the Executive Director. The taking of notes, copying of records or removal of records is specifically prohibited in all such authorized cases. All agency representatives and/or individuals who inspect records must sign a confidentiality statement.

*Staff will not discuss any individual's record with unauthorized individuals, whether on or off duty. All staff are required to sign a confidentiality acknowledgment stating their responsibility and commitment in regard to client information. These statements must be renewed by signature each calendar year.

*Client records must be stored in a secured room or locked file.

Name: _____
(Please Print)

_____ Date: _____
Client/Parent Signature

_____ Date: _____
Program Director Signature

AUTHORIZATION FOR PHOTOGRAPHY/VIDEO

I, _____, the parent or guardian of _____ hereby authorize and give consent to service providers and the staff of CMB Visions Unlimited, Inc. as follows:

I hereby:

❒ consent and authorize or ❒ do not consent and authorize

the staff of CMB Visions Unlimited, Inc. 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 including but not limited to the CMB Visions website, Facebook, etc. and other social media).

_____ _____

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 CMB Visions.

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 CMB Visions Unlimited, Inc., their staff, service providers, employees, agents, affiliates and Board members.