



CHILD INFORMATION FORM

Child's Last Name _____, First _____ Middle _____

Child's Date of Birth (mo/day/yr)

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 Child's Gender Male Female

Last 4 Digits ONLY of Child's Social Security#

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 No SSN

Miami-Dade County Public School ID#

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 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

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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)

Child's Primary Caregiver (full name) _____

Primary Caregiver Email _____

Primary Phone

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

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

A member of the child's family is either: 1) an active duty member of the uniformed services; 2) a member of the National Guard or reserves; 3) a member or veteran who was severely injured and medically discharged or retired; or 4) a member killed in the line of duty.

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: ARTSOUTH, A NOT-FOR-PROFIT CORPORATION SITE: Miami-Dade College Homestead Campus - 500 College Terrace

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. ****Authorization for Emergency Medical-Surgical Treatment**—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

19, 2017

Nonrefundable Registration Fee: \$25. _____ Cash Check # _____ _____ Credit/Debit Card

Early Bird Tuition Fee: \$150. per 2-week session (\$75. per week) paid-in-full before May 19, 2017

Tuition: \$170 per 2-week session (\$85. per week), after May 19, 2017

PLEASE CHECK WHICH SESSIONS YOUR CHILD WILL ATTEND BELOW:

Session 1 June 19 – June 30 _____

Session 2 July 3 – July 14 _____

Session 3 July 17 – 28 _____

Session 4 July 31 – Aug. 11 _____

PAID AMOUNT: _____

RECEIPT #: _____