



STUDENT APPLICATION

SITE*: EKKLESIA

- 2008-2009 After-school Program
- 2009 Summer Camp

CHILD INFORMATION:

TCT STUDENT ID Number: _____

LAST NAME*: _____ FIRST NAME * _____ Middle initial _____

STREET ADDRESS*: _____ APT. _____

CITY*: _____ STATE: FL ZIP*: _____

CONTACT PHONE NUMBER*: _____

GENDER*: Male Female BIRTHDAY *: ____/____/____ MM/DD/YYYY

CHILD'S RACE*: Asian Black/African-American White Pacific Islander Other. Please specify _____

CHILD'S ETHNICITY*: Haitian Hispanic Other Please specify _____

CHILD'S COUNTRY OF ORIGIN (OPTIONAL): _____

IS CHILD PROFICIENT IN ENGLISH * Yes No

ADDITIONAL/OTHER LANGUAGE(S) SPOKEN IN THE HOME*: Spanish Haitian- Creole Other _____

CHILD'S SOCIAL SECURITY NO.*: _____ NO SSN; PREFER NOT TO GIVE SSN

MDCPS STUDENT ID NUMBER *: _____ NO MDCPS; PREFER NOT TO GIVE MDCPS

CURRENT GRADE LEVEL*: _____ CURRENT SCHOOL*: _____

DOES CHILD HAVE HEALTH INSURANCE (ex. Private insurance, KidCare, Medicaid)?* Yes No
(If not, The Children's trust may be able to help you find affordable coverage -call 211)

DOES THE CHILD HAVE ANY DOCUMENTED DISABILITIES*? YES NO

- If yes, do you have (check all that apply):
- an Individualized Family Service Plan (IFSP; if under 5 years old)
 - an Individualized Education Plan (IEP) from the school system
 - a Section 504 Plan
 - a medical diagnosis from a doctor
 - other documentation _____

If YES, how would you best classify the type(s)? (check all that apply):

- | | |
|--|---|
| <input type="checkbox"/> Autism Spectrum Disorders | <input type="checkbox"/> Learning Disability |
| <input type="checkbox"/> Chronic Medical Condition | <input type="checkbox"/> Physical Disability |
| <input type="checkbox"/> Developmental Delay (under 5 only) | <input type="checkbox"/> Speech/Learning Impairment |
| <input type="checkbox"/> Emotional and/or Behavioral Disorder | <input type="checkbox"/> Visual Impairment (or blind) |
| <input type="checkbox"/> Hearing Impairment (or deaf) | <input type="checkbox"/> Other Disability |
| <input type="checkbox"/> Intellectual Disability (or mental retardation) | |
| <input type="checkbox"/> UNKNOWN DISABILITY _____ | |

***Required fields**

The Out of School Program is funded by The Children's Trust. The Trust is a dedicated source of revenue established by voter referendum to improve the lives of children and families in Miami-Dade County.

CHILD'S MEDICAL INFORMATION

I understand that every effort will be made to reach me for instructions if my child should become ill or injured while on the site or on a field trip. If, in the judgment of the staff or a medical professional, delay in reaching me might jeopardize the child's well-being, I hereby authorize the staff or medical professional to secure whatever medical treatment is deemed necessary, including the administration of anesthetics and surgery.

EXCEPT AS NOTED BELOW, this child is in good health, has no allergies and no chronic conditions which would affect treatment, and takes no medication routinely. His/her immunizations are current.

Child's Name	Food Allergies	Drug Allergies	Other Serious Allergies	Chronic Conditions

IMMUNIZATION RECORDS: YES NO

INSURANCE INFORMATION (if family has insurance coverage)

CARRIER: _____ POLICY: _____
Insurance Company Policy #

DOCTORS NAME: _____ PHONE: _____

FAMILY INFORMATION

FATHER'S NAME: _____
Last First

MOTHER'S NAME: _____
Last First

Does child live with a legal guardian? YES NO

GUARDIAN'S NAME: _____
Last First

PARENT/GUARDIAN ADDRESS: _____
Street City State Zip

HOME PHONE*: _____ WORK PHONE*: _____

CELL PHONE: _____ E-MAIL: _____

SOCIAL SECURITY NO. _____ (not required, but requested for record-keeping purposes)

EMERGENCY INFORMATION

Phone numbers where I can be reached during the day: _____

If I cannot be reached, please try to contact my designated alternate(s):

1. _____
Name Phone Number
2. _____
Name Phone Number

Optional:

Does this child have a parent who is currently incarcerated? YES NO

