



### SUMMER 2025 PARTICIPANT APPLICATION

Dates: June 9, 2025 – July 25, 2025

Operating Hours: Monday to Friday: 8:00 AM - 6:00 PM for K-5th grade / 8:30 AM - 4:30 PM for 9th-12th grade

- Bel-Aire (K-5<sup>th</sup>): 10250 SW 194<sup>th</sup> St. Cutler Bay, FL 33157
- Estrella de Belen (K-5<sup>th</sup>): 510 East 41st Street Hialeah, FL 33013
- Pinelands (K-5<sup>th</sup>): 10201 Bahia Dr. Miami, FL 33189
- Pneuma (K-8<sup>th</sup>): 7205 SW 125<sup>th</sup> Ave. Miami, FL 33183
- Wayside (K-8<sup>th</sup>): 7701 SW 98<sup>th</sup> St. Kendall, FL 33156
- West Flagler Park (K-5<sup>th</sup>): 5911 W Flagler St. Miami, FL 33144
- John A. Ferguson (9<sup>th</sup> -12<sup>th</sup>): 15900 SW 56<sup>th</sup> St. Miami, FL 33185
- Miami Central (9<sup>th</sup>-12<sup>th</sup>): 1781 N.W. 95<sup>th</sup> St., Miami, FL 33147
- Felix Varela (9<sup>th</sup> -12<sup>th</sup>): 15255 SW 96<sup>th</sup> St. Miami, FL 33196

Has your child ever participated in our afterschool or summer camp programs?

YES or  NO

How did you hear about our Organization / Program?

- |   |  |  |
|---|--|--|
| <input type="checkbox"/> Not Applicable             | <input type="checkbox"/> Community Based Organizations | <input type="checkbox"/> DJJ/Juvenile Services                         |
| <input type="checkbox"/> Schools                    | <input type="checkbox"/> Walk-in                       | <input type="checkbox"/> Early Steps North & South                     |
| <input type="checkbox"/> Childcare                  | <input type="checkbox"/> Parent Club                   | <input type="checkbox"/> Family and Neighborhood Supports Partnerships |
| <input type="checkbox"/> Other TCT Programs         | <input type="checkbox"/> Self-referral                 | <input type="checkbox"/> MDCPS Truancy Intervention                    |
| <input type="checkbox"/> Internal Referral          | <input type="checkbox"/> DCF/ Our kids/ Child Welfare  | <input type="checkbox"/> Other _____                                   |
| <input type="checkbox"/> Helpline (211/Switchboard) | <input type="checkbox"/> Police Department             |  |
| <input type="checkbox"/> Faith-Based Partners       | <input type="checkbox"/> Health Care Provider          |  |

### CHILD INFORMATION

Child's Last Name: \_\_\_\_\_ First: \_\_\_\_\_ Middle Name: \_\_\_\_\_

Child's Date of Birth: (MM/DD/YYYY) \_\_\_\_ / \_\_\_\_ / \_\_\_\_ Child/Youth Gender:  Male  Female  Other: \_\_\_\_\_  
(Mandatory) (Mandatory)

Youth Phone Number ( \_\_\_\_\_ ) \_\_\_\_\_ - \_\_\_\_\_ Is this a cell/mobile phone?  Yes  No  N/A  
(Optional) (Optional)

Youth Email address (Optional): \_\_\_\_\_  
Please note that The Children's Trust may contact you via postal mail, email and/or text to ask about your satisfaction with services, and to make you aware of other

M-DCPS ID # \_\_\_\_\_  No M-DCPS ID#  Not in School  
ALL STUDENTS ATTENDING PUBLIC OR CHARTER SCHOOLS SHOULD HAVE A SCHOOL ID ENTERED. ALL STUDENTS WHO ATTEND A PRIVATE SCHOOL PLEASE SELECT NO M-DCPS ID#

Child/ Youth Current School Name: \_\_\_\_\_

Select the grade the child/youth completed during the most recent school year (2024-2025) (Please select only one):

- Pre-K  Kinder  1<sup>st</sup> Grade  2<sup>nd</sup> Grade  3<sup>rd</sup> Grade  4<sup>th</sup> Grade  5<sup>th</sup> Grade
- 6<sup>th</sup> Grade  7<sup>th</sup> Grade  8<sup>th</sup> Grade  9<sup>th</sup> Grade  10<sup>th</sup> Grade  11<sup>th</sup> Grade  12<sup>th</sup> Grade



**What is the child/youth's preferred language for contact?** (Please select only one)  English  Spanish  Haitian-Creole

**What language(s) does the child/youth feel comfortable communicating in?** (Select all that apply)

English  Spanish  Haitian-Creole  Portuguese  French  Other: \_\_\_\_\_

**Child/Youth Ethnicity:** Is the child/youth Hispanic or Latina/o/x?  Yes  No Is the child/youth Haitian?  Yes  No

**Child's Race** (Please select only one):  American Indian or Alaskan Native  Asian  Black or African American  Pacific Islander

White  Biracial or Multiracial  Other, Please Specify: \_\_\_\_\_

**Child's Home Address:** \_\_\_\_\_

**Apt/ Unit:** \_\_\_\_\_ **City:** \_\_\_\_\_ **ZIP Code:** \_\_\_\_\_

**Child's Primary Caregiver** (full name): \_\_\_\_\_

**Primary Phone Number:** ( \_\_\_\_\_ ) \_\_\_\_\_ - \_\_\_\_\_ **Is this a cell/mobile phone?**  Yes  No  
(Please write "not applicable" or "N/A", if no answer)

**Primary Caregiver E-Mail:** \_\_\_\_\_  
(Please write "not applicable" or "N/A", if no answer)

**Caregiver preferred language for contact** (Please select only one):  English  Spanish  Haitian-Creole  Other: \_\_\_\_\_

**Child's Secondary Caregiver** (full name): \_\_\_\_\_  
(Please write "not applicable" or "N/A", if no answer)

**Primary Phone Number:** ( \_\_\_\_\_ ) \_\_\_\_\_ - \_\_\_\_\_ **Is this a cell/mobile phone?**  Yes  No  
(Please write "not applicable" or "N/A", if no answer)

*The Children's Trust may contact you via postal mail, email and/or text to ask about your satisfaction with services, and to make you aware of other Trust-funded programs, initiatives and events that may interest you.*

## CHILD'S MEDICAL INFORMATION

**We want to get to know your child better so we can provide the best possible experience for your child. Please tell us more about your child. I give permission for this information to be submitted to the Trust for program quality/evaluation purposes**

**1) What are the main ways your child communicates?** (Mark all that apply)

- |  |  |
|--|--|
| <input type="checkbox"/> Speaks and is easily understood                     | <input type="checkbox"/> Uses sign language  |
| <input type="checkbox"/> Speaks but is difficult to understand               | <input type="checkbox"/> Uses gestures like pointing, pulling, smiling, frowning or blinking |
| <input type="checkbox"/> Uses communication devices like pictures or a board | <input type="checkbox"/> Uses sounds that are not words like laughing, crying or grunting    |

**2) 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                    |

**3) 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"/> Problems with aggression or temper                               |
| <input type="checkbox"/> Developmental delay (only if <u>under age 5</u> )       | <input type="checkbox"/> Problems with attention or hyperactivity (ADHD/ADD)              |
| <input type="checkbox"/> Intellectual/developmental disability ( <u>over 5</u> ) | <input type="checkbox"/> Problems with depression or anxiety                              |
| <input type="checkbox"/> Hard-of-hearing or Deaf                                 | <input type="checkbox"/> Speech or language condition                                     |
| <input type="checkbox"/> Learning Disability (school age)                        | <input type="checkbox"/> Visual impairment or blind                                       |
| <input type="checkbox"/> Medical Condition or illness                            | <input type="checkbox"/> Other condition lasting one year or more (Please Specify): _____ |
| <input type="checkbox"/> Physical disability or impairment                       | <input type="checkbox"/> No condition lasting one year or more                            |

If you marked "None of the above" on the previous two questions, please indicate N/A on 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.

4) 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

5) To support your child's successful participation in this program, in what areas might they need extra assistance?

- No specific help needed: N/A
  - Academic, learning or reading activities
  - Adapting activities to take into account a visual or hearing impairment
  - Holding a crayon/pencil, writing, using scissors or other fine motor tasks
  - Managing feelings and behavior
  - Personal services like help with feeding, toileting or changing clothes
  - Sports or physical activities like running or other gross motor tasks
  - Using assistive device(s) like a wheelchair, crutches, brace or walker
  - Other \_\_\_\_\_

6) Does Child have an IEP or a 504 Plan?  Yes (If yes, please attach)  No

7) Please circle or fill-in anything that applies to your child in the chart below:  N/A (Not Applicable)

Medication which affect: Learning, Physical Fitness Activities and Social Engagement	Food Allergies	Other Serious Allergies	Chronic Health Conditions	Physical Limitations which affect: Learning, Physical Fitness Activities and Social Engagement
<input type="checkbox"/> Antibiotics <input type="checkbox"/> Medication for chronic Health <input type="checkbox"/> Hyperactivity Medication <input type="checkbox"/> Other: _____ <input type="checkbox"/> _____	<input type="checkbox"/> _____ <input type="checkbox"/> _____ <input type="checkbox"/> _____ <input type="checkbox"/> _____	<input type="checkbox"/> Grass <input type="checkbox"/> Mosquitoes <input type="checkbox"/> Bee Stings <input type="checkbox"/> Penicillin <input type="checkbox"/> Other: _____ <input type="checkbox"/> _____	<input type="checkbox"/> Asthma <input type="checkbox"/> Diabetes <input type="checkbox"/> Sickle Cell Anemia <input type="checkbox"/> Seizures <input type="checkbox"/> Skin Condition <input type="checkbox"/> Seasonal Allergies <input type="checkbox"/> Reaction to Sunlight <input type="checkbox"/> Other: _____	<input type="checkbox"/> Other not listed above: _____ _____ _____ _____

**EXCEPT AS NOTED ABOVE**, my child is in good health, has no medical, food, other chronic allergies or serious health conditions. My child does not take medication routinely and his/her immunizations are current. **If there is anything else you consider we need to know about, to better understand and provide the necessary help your child deserves, please speak to your Site Supervisor.**

All information is kept confidential and stored in locked cabinets. By signing on the last page, I agree to the following.

**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).

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/content/children-disabilities](http://www.thechildrenstrust.org/content/children-disabilities).

**Child's Insurance Information:** (If child has no current insurance coverage, please write "not applicable" or "N/A")

**Carrier:** \_\_\_\_\_ **Doctor's Name:** \_\_\_\_\_ **Phone Number:** \_\_\_\_\_

## CHILD'S EMERGENCY 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 that any delay in reaching me might jeopardize my 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. **IN THE EVENT THAT NO ONE CAN BE CONTACTED, I GIVE PERMISSION FOR MY SON/DAUGHTER TO RECEIVE EMERGENCY MEDICAL TREATMENT.**

If you would like for us to follow a different emergency/medical procedure, please write it/explain below: (You can continue on the back of this page)

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## EMERGENCY / ALTERNATE PICK-UP CONTACT INFORMATION

Other phone numbers where I can be reached during the day: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

If I cannot be reached, please contact my designated alternate(s) named below:

1. \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_  
Name Relationship to child Cellular and/ or work number

2. \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_  
Name Relationship to child Cellular and/ or work number

**Please note:** Any family or friends authorized to pick up your child, must have a valid picture ID for verification purposes. A copy of the ID will be taken by site staff and placed in the student's file for future confirmation. In the event that I, the legal guardian, am not able to pick up my child on time, I will call the Site Supervisor and will authorize her/him to release my child to the persons listed above

## POLICY INFORMATION/CONSENT

**Non-Discrimination Policy:** Children who are 5 and have already attended or who are currently enrolled in kindergarten will be accepted into the Summer Camp and After-school program regardless of race, creed, immigration status, health, religion, disability, ethnicity or ability to pay for services. Children without documented legal status, or whose parents are without documented legal status will not be discriminated against for selection in these programs. As with the Miami-Dade County Public School system, all children are welcome. Children with severe physical, emotional or behavioral disabilities may find After-school/ Summer Camp programs specially designed to meet their needs through other programs, and every effort will be made to find the most suitable placement for each child.

### Parental Consent:

By signing this application on the next page, I agree and certify to the following Children's Trust Requirements:

- 1) I **acknowledge** that the application information and medical information I have provided above is true and complete to the best of my knowledge and ability.
- 2) As the legal guardian of \_\_\_\_\_,  I **authorize and give consent** or  I **DO NOT authorize or give consent** to Hope for Miami's staff (HFM), and The Children's Trust (TCT) or other affiliated program service providers to take/use still photographs, digital photographs, motion pictures, television transmission, and/or videotapes recordings (hereinafter "Recordings") of me, my children, or my wards for educational, research, documentary, and public relations purposes. Any such Recordings may reveal my identity through the image itself without any compensation to me, my children or my wards. With regard to the use of any Recordings taken of me, my children or my wards, I hereby waive any and all present and future claims I may have against TCT or HFM, their staff, service providers, employees, agents, affiliates and Board members.
- 3) I **understand** that participation by my children in the Program sponsored by Hope for Miami, The Children's Trust and its partners involves physical education, meals, and off-site field trips. As these activities may carry some degree of risk to my child's physical and emotional health, I hereby release, hold harmless and waive all claims associated with out-of-school/summer camp program activities from HFM, and the program site and all employees, officers, directors, agents, and volunteers associated with the out-of-school/summer camp program.

- 4) I understand that no medications or medical equipment will be administered by the After-school/ Summer Camp personnel to my child. Also, I agree to provide instructions on how and when essential medicines or medical equipment should be administered if my child were to need assistance with it. (Please, refer to the HFM Family Handbook for more details).
- 5) As my child attends an Out-of-school program funded by the Children's Trust (either Summer Camp, After-school, or all programs), I acknowledge and understand that my child must adhere to all behavioral and policy driven rules and regulations the program sites require. Failure to abide by these rules may lead to suspension and or removal of the program. I also acknowledge receipt of a written **Family Handbook** for this current program year, which details policies and procedures regarding my child and the program.
- 6) While the Out-of-school program (either Summer Camp or After-school) may take place on the premises of a religious organization, the primary purpose of the program is academic enrichment and a safe environment during Afterschool/Summer Camp time. However, your child may be invited to participate in other church activities on the premises or to **receive optional religious instruction**. No Children's Trust funds will be used for teacher stipends, books, curriculum or other expenses related to religious instruction. Such instruction will be given by church ministers or volunteers. **Please select the box concerning Religious instruction:**
- I **authorize** my child to participate. Initial here: \_\_\_\_\_  I **do not authorize** my child to participate. Initial here: \_\_\_\_\_
- 7) My child will be arriving and leaving from the site in the following manner:
- Arrival to the site:**  By bus/van.  Walking from school.  With authorized person/relative.  
 With Parent/Guardian
- Leaving from the site:**  By bus/van.  Walking from school.  With authorized person/relative.  
 With Parent/Guardian
- I **do not** give permission, under any circumstances, for my child to leave the program site with \_\_\_\_\_.  
 Relationship to child: \_\_\_\_\_. If possible, bring a picture to keep on file. **Child is allowed to go home with mother, father or legal guardian unless we have court documents stating otherwise due to custody battle or abuse. (Legal documentation must be provided).**
- 8) I agree to make every effort to ensure that my child participates in the program daily, unless he/she is too ill to attend. I also agree that I or my designated representative will **sign-out my child every day** he/she attends the program.
- 9) I understand that I am responsible to pick up my child at the end of the program day or arrange for an authorized person to pick up my child. Only those persons previously authorized in writing, may leave the premises with my child. I am aware of the **fees charged and or withdrawal policies** for parent tardiness on pick-up at the end of the day. For fee-based sites, the late fee is \$1 per minute. The program ends at **6:00 PM** each day. I also understand that my child will be suspended from transportation and the program if the fees are not current.
- 10) I understand that I need to call the Out-of-school/Summer Camp site supervisor if my child is not attending on a particular day so that Supervisor is aware that my child will not be showing up on that day. I'm also aware of the absenteeism policies and the risks associated with excessive absences.
- 11) I understand that I am releasing the After-school/Summer Camp Program of any liability once my child has been dismissed from the program site.

As part of my child's voluntary participation in this program, I give my permission for the information collected through this program to be submitted to The Children's Trust for program evaluation and quality purposes. The Children's Trust provides funding for the program to operate and follows strict data privacy protections for the information collected (for example, following the Family Educational Rights and Privacy Act/ FERPA guidelines).

I give my permission for the information in this application to be submitted to Miami-Dade County Public Schools for program quality and evaluation purposes. Miami-Dade County Public Schools provides academic supports for the program.

I am signing that I have reviewed and agreed to all terms and conditions described in this application, all the program standards, Policies and Procedures and Parent Handbooks:

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

\_\_\_\_\_  
 Date

**Accidental Injury Insurance (Fee based sites)**

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If your child is enrolled in a program managed by Hope for Miami, they are covered for supplemental medical expenses should they have an accident **while participating in program activities, during regularly scheduled program hours**. If your family has medical insurance, this supplemental policy will cover some deductibles and uncovered expenses. If your family is uninsured, the child's medical expenses may be covered, if an injury were to occur (accidents only).

- Cost is \$ 10.00 per student. Money Order must be payable to Hope for Miami.
- Medical expenses for accidents in and out patient for a maximum of \$25,000.00
- \$100.00 deductible on this policy
- Includes \$10,000 Accidental Death benefit and Accidental Dismemberment benefit (should there be a serious injury)
- Coverage through July 25, 2025

**N/A:** Not applicable for students attending a public school site M-DCPS

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

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**Sibling(s) names in our program:**

1. \_\_\_\_\_ 2. \_\_\_\_\_  
3. \_\_\_\_\_ 4. \_\_\_\_\_

**Sibling definition:** One or more children having one or both parents in common or legally adopted.

**Fees Collected:**

**Please Note:** Only Money Orders and Credit Card payments are accepted. No checks or cash.

**Accident Insurance fee: \$10 collected:**     Yes         No

**Registration Fee: \$90.00 collected:**     Yes         No

**Is child a part of the dependency system?**     Yes     No  
(Ex. DCF, Our Kids, Full Case Management Agencies, Family Courts, etc.)

**Family Handbook given:**     Yes     No  
(Please make sure parent signs the acknowledgment)

**Is child apart of the delinquency system?**     Yes     No  
(Ex. Department of Juvenile Justice, Civil Citation Programs, etc.)

**Application Verified by:** \_\_\_\_\_

**Date Verified:** \_\_\_\_\_

**Date of registration:** \_\_\_\_\_

**Tentative Start Date:** \_\_\_\_\_



## “Getting to Know Me”

Child’s Name: \_\_\_\_\_

Today’s Date: \_\_\_\_\_

Grade Level: \_\_\_\_\_

Age: \_\_\_\_\_

T-Shirt Size: \_\_\_\_\_

*Hope for Miami would like to learn more about your child so that we can provide them with the best possible learning experience while they are attending our program. No one knows your child better than you. Please tell us more about your child.*

### 1. What is your child’s favorite and/or calming and least favorite and/or upsetting; things, activities, rewards, and situations?

Favorite or Calming (Electronics, toys, sounds, etc.)

Least Favorite or Upsets (Loud noises, specific objects, etc.)

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

### 2. Does your child require assistive devices or medical equipment? (i.e. braces, walker, wheelchair, communication device, insulin, nebulizer, inhaler, EpiPen)

Yes  No If yes, please describe: \_\_\_\_\_

### 3. How does your child communicate?

- Verbally  Through gestures (i.e., pointing, pulling, blinking)  American Sign Language (ASL)
- With vocalizations  With communication devices (i.e., pictures)
- Other (please specify) \_\_\_\_\_

### 4. What services does your child receive?

- Speech/Language Therapy  Behavioral  Physical Therapy
  - Mental Health Counseling  Occupational Therapy  None
- May we contact your service provider to better support your child?  Yes  No (Signed authorization form required)

### 5. Do you suspect your child has a hearing or vision problem? Yes No

If yes, please describe \_\_\_\_\_

### 6. Which statement best describes your child’s ability to move from one activity to another?

- Easily moves from one activity to the other  Needs assistance to move from one activity to the other

Please explain \_\_\_\_\_

**7. My child plays/interacts best** (check all that apply):

- Independently       With Adults       Small group       Large Group       Outdoor       Indoor  
 With another child       Additional comments
- 

**8. Does your child follow simple instructions?**       Yes       Needs help

Comment / Incentives: \_\_\_\_\_

**9. What type of learning style works best for your child?** (check all that apply)

- Verbal Instruction       Charts/Graphs       Written Instructions       Reminders       N/A

**10. Do any of the following things bother your child?**

- Noise       Texture (i.e., sand, water)       Lights       Smells       Animals       Touch (i.e., hugs)  
 Other: \_\_\_\_\_       No

**11. Does your child wander, run away or bolt?**       Yes       No

If yes, what situations precede this behavior? \_\_\_\_\_

**12. Is your child able to do the following activities by him/herself?**

- |                  |                              |                             |                         |                              |                             |
|------------------|------------------------------|-----------------------------|-------------------------|------------------------------|-----------------------------|
| Using the toilet | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Walking or moving about | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Eating           | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Washing his/her hands   | <input type="checkbox"/> Yes | <input type="checkbox"/> No |

If no, please describe what assistance is needed: \_\_\_\_\_

**13. Does your child take medication?**       Yes       No

Medication side effects staff should be aware of: \_\_\_\_\_

**14. Is there anything else you would like for us to know about your child** (i.e., allergies, diet, seizures, nosebleeds)?       No

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**15. Please check all that apply: Which Descriptions best describe your child. (If the child is able, please allow them to answer below)**

- |  |  |
|--|--|
| <input type="checkbox"/> I would rather read instructions than listen to the teacher explain them. | <input type="checkbox"/> I can think better if I tap my foot, play with a pencil or move a little. |
| <input type="checkbox"/> I like having someone explain directions aloud.                           | <input type="checkbox"/> I prefer working by myself.   |
| <input type="checkbox"/> When I study, I have to take a lot of breaks to get up and walk around.   | <input type="checkbox"/> I prefer working with a friend.   |
| <input type="checkbox"/> I draw a lot of pictures during class.                                    | <input type="checkbox"/> I prefer working in a group of 3 or more.                                 |
| <input type="checkbox"/> I remember things better if I write them down.                            | <input type="checkbox"/> I find it easy to speak up in class and/or participate in discussions.    |
| <input type="checkbox"/> I study by saying information aloud.                                      | <input type="checkbox"/> I find it hard to speak up in class and/or participate in discussions.    |
| <input type="checkbox"/> Charts, pictures, and maps help me understand what I am reading.          | <input type="checkbox"/> I find it easy to read aloud.   |
| <input type="checkbox"/> I can pay attention better if I have a snack while I study.               | <input type="checkbox"/> I find it hard to read aloud.   |
| <input type="checkbox"/> I like to listen to music while I am studying.                            | <input type="checkbox"/> I find it easy to control my temper.                                      |
| <input type="checkbox"/> I am good at seeing pictures in my mind what I am studying.               | <input type="checkbox"/> I find it hard to control my temper.                                      |
| <input type="checkbox"/> It is easy for me to remember jokes.                                      | <input type="checkbox"/> It is easier for me to control my temper if I try the following: _____.   |

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**Acknowledgment of Health Procedures for After-School and Summer Camp Programs at Hope for Miami:**

**Hope for Miami is dedicated to:**

1. *Follow and comply with all updated CDC guidelines for preventive measures to stop the spread of infections.*
2. *Continue to engage with local and state authorities to evaluate current mitigation efforts in our community.*
3. *Protect and support staff, children, and family members at a higher risk for severe illness.*

**Safety Actions:** Following medical guidance, Hope for Miami has outlined preventive measures to be implemented through specific safety action steps.

**Promote healthy hygiene practices**

1. We will emphasize the importance of washing hands in the following situations: upon arrival at the site, after using the restroom, after sneezing or coughing, and before eating meals. This practice is part of our staff's Universal Precautions training.
2. Although masks are optional, we will encourage and instruct all staff and children to wear face masks if they are experiencing any related signs or symptoms. Additionally, we will remind children not to touch their face coverings and to wash their hands frequently.
3. We will ensure adequate supplies to promote healthy hygiene behaviors, including soap, hand sanitizer with at least 60 percent alcohol (for staff and older children who can use it safely), and tissues.
4. We will also post signs that educate us on how to prevent the spread of infections, properly wash hands, promote everyday protective measures, and correctly wear face covering.

**Intensify cleaning, disinfection, and ventilation**

1. Clean, sanitize, and disinfect frequently touched surfaces between each use, such as door handles, sink handles, drinking fountains, and shared objects.
2. Apply disinfectants safely and correctly, and store cleaning products out of reach of children.
3. Ensure ventilation systems function properly and increase airflow circulation whenever possible.

**Monitoring and Preparing Check for signs and symptoms**

1. Maintain an appropriate staff-to-child ratio to ensure safety.
2. Conduct health checks as needed (e.g., temperature and symptom screenings) in a safe and respectful manner, ensuring confidentiality and compliance with applicable privacy laws and regulations.
3. Encourage staff to stay home if unwell and advise parents to keep sick children at home.
4. Designate a separate area to isolate anyone displaying symptoms during operational hours, ensuring that children are not left without adult supervision.
5. Inform anyone exposed to a person diagnosed with an infection to stay home, self-monitor for symptoms, and follow CDC guidance if symptoms develop.
6. **Immediately notify the site location of any potential exposure to or contact with someone infected, such as with COVID-19 or the flu.**

By signing this form, I acknowledge the highly contagious nature of certain infections and the preventive measures that Hope for Miami, along with its community partners, employees, and representatives, has implemented to help reduce the spread of viruses. I understand there is a risk of exposure to or infection by these illnesses at any location where Hope for Miami conducts in-person after-school or summer camp programs. This risk includes potential infection due to my actions, omissions, or negligence, program employees, volunteers, other participants, and the independent site locations.

Furthermore, by signing this form, I agree and acknowledge that I—on behalf of myself and my child/participant—assume all risks associated with participation in these programs, including but not limited to infections such as COVID-19 or the flu. I provide this release and waiver for myself, my child/participant, heirs, successors, and representatives. I agree to release and hold harmless both Hope for Miami and the independent site locations (along with all related entities, employees, agents, and representatives) from any liability for loss, damage, costs, claims, lawsuits, or causes of action arising from any aspect of participating in the in-person after-school programs offered by Hope for Miami. I understand and agree that in the event of any personal or bodily injury to myself or any other person, I will not seek any form of recovery or bring any type of action against Hope for Miami and the independent site locations, their officers, directors, employees, or agents.

I acknowledge and agree that the promises and representations made above are essential, and I agree to them as a condition of my child(ren) participation in Hope for Miami programs.

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

\_\_\_\_\_  
Date

\_\_\_\_\_  
Print Name of Parent/Guardian

\_\_\_\_\_  
Print Name of Participant (s)