



Cool Kids Learn, Inc. Registration Form 2010-2011



Site Location: _____ Enrollment Date: _____

Child's*: Last Name _____, First Name _____ Middle Initial _____

Mother's: Last Name _____, First Name _____ Middle Initial _____

Father's: Last Name _____, First Name _____ Middle Initial _____

Does child live with a legal guardian other than mother or father? Yes No

If yes, Guardian's: Last Name _____, First Name _____ Middle Initial _____

Street Address* _____ City* _____ ZIP Code* _____

Parent/Guardian Phone _____ Work Phone _____ Email _____

Child's Gender* Male Female Child's Date of Birth (mo/day/yr)* _____

Child's Race*: American Indian or Alaskan Asian Black or African American
 Pacific Islander White Other, please specify _____

Child's Ethnicity*: Hispanic Haitian Other, please specify _____

Child's Country of Origin: _____ Is Child Proficient in English?* Yes No

Additional/Other language(s) spoken in the home*: Spanish Haitian-Creole Other _____

Child's Social Security number*: _____ (Required Miami Dade County) and or

Child's Student Identification* _____ (Required Miami Dade County)

Child's Grade Level for the 2010-2011 School Year *: _____

Child's 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 child have a documented disability?* Yes No (Must provide supporting documentation)

- If yes, do you have (check all that applies): an Individualized Family Service Plan (IFSP; if under 3 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/Language 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) | |

I give my permission for this information to be submitted to The Children's Trust for program monitoring and evaluation purposes.

PARENT/GUARDIAN SIGNATURE*: _____ DATE: _____

For Staff Use Only (MUST BE COMPLETED)

ORGANIZATION: _____ SITE LOCATION: _____

Parent must complete the Voluntary Consent for Photography and Communication. Enter responses in Data Tracker System.

- VOLUNTARY CONSENT RESPONSES:
- | | |
|---|---|
| 1. Photography <input type="checkbox"/> Yes <input type="checkbox"/> No | 2. Communication <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 3. Mailing List <input type="checkbox"/> Yes <input type="checkbox"/> No | 4. Release & Waiver <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 5. Permission to Transport <input type="checkbox"/> Yes <input type="checkbox"/> No | 6. Release of Academic Information <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 7. Permission to Walk <input type="checkbox"/> Yes <input type="checkbox"/> No | |

*Required fields.

List any Special Conditions and/or Medications (Must provide supporting documentation)

(i.e.: Allergies, Asthma, Diabetes, Epilepsy, Ear Infections, Convulsions, Penicillin, etc.)

(Staff will not be responsible for administering any medication, nor for ensuring that medication has been taken properly.)

Emergency Contact Persons [other than parent(s)/guardian(s)]

Name	Relationship	Phone 1#	Phone 2#

In the event of an emergency, if possible, I prefer the following physician and/or hospital:

Physician	Phone #
Hospital	

Permission to Pick Up

Please list all persons permitted by you to pick up your child. Person will be required to show picture ID. Child will not be released to anyone not on this list unless notified by registering parent(s)/guardian(s) in writing.

Name	Relationship	Phone 1#	Phone 2#

Consent to Medical and/or Surgical Treatment & Assumption of Risk and Release

In the event of injury to or illness of their son/daughter/ward, the undersigned hereby authorizes Cool Kids Learn or representative thereof, to admit the registrant named to a facility for emergency medical treatment as may be deemed necessary to his or her health welfare. The undersigned hereby consents to whatever medical treatment is deemed necessary. The undersigned on his or her behalf of the registrant, their heirs, assigns and personal representatives, hereby releases Cool Kids Learn, its commissioners, staff and employees from any and all claims arising out of the admission to, or treatment administered by, such facility.

The undersigned hereby acknowledges and agrees that participation in the academic program and related activities carry with it an inherent risk of physical injury. In consideration of the registrant's participation in the program, the undersigned, on behalf of the registrant, hereby assumes all such risks of physical injury and does hereby release and forever discharge Cool Kids Learn, its commissioners, staff, employees and agents from any and all liability, claim or loss arising from bodily injuries or damage to personal property resulting from the registrant's involvement and participation in the academic program.

***Parent/Guardian's Signature** _____ **Date** _____

Photographic Release

I hereby authorize Cool Kids Learn, and the members of its staff to take such photographs, television recordings and/or live television transmission of the registrant in whole, or in part, as they or members of the staff may wish, and to use and publish the same in such places and publications as the Children's Trust, Cool Kids Learn, or its staff in its sole discretion consider to be of benefit to said parties. I hereby waive any right that I may have to inspect and/or approve the finished product that may be used here under or the specific use to which it may be applied.

The undersigned hereby acknowledges that he/she is the legal guardian(s) of the program registrant and has read and agrees with the Consent to Medical and/or Surgical Treatment, Assumption of Risk and Release, Release of Student Academic information and Photographic Release stated above.

***Parent/Guardian's Signature** _____ **Date** _____

Permission to Transport

I hereby authorize Cool Kids Learn, Inc. to transport registrant on approved fieldtrips and outings. I understand that Cool Kids Learn will use insured transportation companies to transport my child

The undersigned hereby acknowledges and agrees that participation in the after school program and related activities carry with it an inherent risk of physical injury. In consideration of the registrant's participation in the program, the undersigned, on behalf of the registrant, hereby assumes all such risks of physical injury and does hereby release and forever discharge Cool Kids Learn, its commissioners, staff, employees and agents from any and all liability, claim or loss arising from bodily injuries or damage to personal property resulting from the registrant's involvement and participation in the academic program.

***Parent/Guardian's Signature** _____ **Date** _____

Permission to Walk to/From the Program Site

I hereby authorize my child to walk to and from the program site. I understand that my child must enter the building and immediately go the program area upon arrival. At dismissal, my child must exit and leave the grounds immediately, and not loiter in the building or in the bus loading area. The program reserves the right to revoke permission to walk at any time for any actions deemed inappropriate.

***Parent/Guardian's Signature** _____ **Date** _____

Release of Student Academic Information

I hereby authorize Cool Kids Learn to receive all information related to my child's academic information, i.e., I.E.P – if applicable, FCAT scores and school grades as authorized by myself or my child's principal and to use the same in determining an appropriate educational plan for my child. My child's academic information may NOT be shared outside of CKL for any reason unless such information is made anonymous.

***Parent/Guardian's Signature** _____ **Date** _____

Confidentiality of Student Information

This statement notifies parents that all student information given to Cool Kids Learn, Inc. will be secured (maintain in a locked/secure environment) at the end of each working day. It is also our responsibility to ensure that all computer records maintaining students information is held securely and appropriately protected. In addition, all information obtained will be kept confidential.

***Parent/Guardian's Signature** _____ **Date** _____



AUTHORIZATION FOR PHOTOGRAPHY/VIDEO

I, _____, the parent or guardian of _____ hereby authorize and give consent to service providers (Cool Kids Learn, Inc.) and the staff of The Children's Trust of Miami-Dade County as follows:

I hereby 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. Any such Recordings may reveal my identity through the image itself without any compensation to me, my children or my wards.

Any and all Recordings taken of me shall be the sole property of The Children's Trust.

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 The Children's Trust of Miami-Dade County, their staff, service providers, employees, agents, affiliates and Board members.

Signature of Parent or Guardian

Signature of Witness

Date

Date

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