CHILD INFORMATION FORM

School Year 2024-2025

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 primary caregiver (full name) _____

Primary caregiver 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

Revised August 2018

AUTHORIZATION FOR PHOTOGRAPHY/VIDEO

I, _____, the parent or guardian of _____, hereby authorize and give consent to the staff of The Children's Trust of Miami-Dade County and/or its funded service providers as follows:

I hereby:

☐ **consent and authorize** **OR** ☐ **do not consent and authorize**

the staff of The Children's Trust of Miami-Dade County and/or its funded service providers to take/use still photographs, digital photographs, motion pictures, television transmissions and/or videotaped recordings (hereinafter "Recordings") of me, my children or my wards for educational, research, documentary and public relations purposes.

_____ _____

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 The Children's Trust or its funded service providers.

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

3150 SW 3rd Avenue, 8th Floor ● Miami, FL 33129
305.571.5700 ● Fax: 305.860.2328
www.thechildrenstrust.org

6701 SW 80th Street ● Miami, FL 33143
786.220.0847 ● info@musicall.org
www.musicall.org