



# UNITED COMMUNITY OPTIONS AFTERSCHOOL/SUMMER PROGRAM 2024 – 2025 REGISTRATION FORM

Parents,

Thank you for your interest in the United Community Options 24-25 Afterschool Program. We are so excited about this upcoming school year. Each family will be asked to complete a new after-school registration. After completion, we will contact you to schedule an intake appointment to evaluate the information provided, determine if your child is a good fit for our program, and finalize the registration. This meeting will give you an opportunity to discuss what qualities are important for a teacher to have when working with child(ren). Afterschool staff needs to know as much information as possible about your child in order to provide the best care. Take the time to list all questions and concerns you feel will be important to discuss.

**Please Note:** No student is allowed to begin before an official intake visit. **NO EXCEPTIONS**

Additional documents for registration Please email or bring documents to the main office

- **COPY OF IEP**
- **COPY OF BIRTH CERTIFICATE**
- **COPY OF GUARDIAN DRIVERS LICENSE**
- **THE LAST 4 DIGITS OF SOCIAL SECURITY NUMBER**
- **PROOF OF INCOME (W2 OR RECENT YEARS TAX RETURN)**
- **CURRENT PHYSICAL (YELLOW FORM)**
- **PROOF OF IMMUNIZATION (BLUE FORM)**
- **MEDICATION CONSENT (IF NEEDED)**
- **\$25 REGISTRATION FEE (INCLUDES 1 CAMP SHIRT)**
- **SIGNATURE PAGE FOR PARENT HANDBOOK**

## STUDENT INFORMATION

Full Name (First, Middle, Last)		Date of Enrollment	
Student I.D. #		Pick Up Password	
Student's Address			
	City		State
		Zip	
Primary Telephone #			
Child Lives with:			
Primary Hours of Care	From: _____ To: _____		
Days of the Week in Care	M T W TH F		
Meals Typically Served While in Care	Br AM Snack Lunch PM Snack Supper Eve Snack		
Last 4 Of Social	XXX-XX-____	Sex:	<input type="checkbox"/> Male <input type="checkbox"/> Female
Child's Primary Language		Date of Birth	Age
			Shirt Size (S,M,L)
Race (Select from):	<input type="checkbox"/> White	<input type="checkbox"/> Multiracial	<input type="checkbox"/> Asian
	<input type="checkbox"/> African American	<input type="checkbox"/> Native Hawaiian or Pacific Islander	<input type="checkbox"/> Declined
	<input type="checkbox"/> American Indian or Alaska Native		<input type="checkbox"/> Other _____
Cultural Influence (Identify your dominant cultural background)	<input type="checkbox"/> West Indian	<input type="checkbox"/> Irish	<input type="checkbox"/> Cuban
	<input type="checkbox"/> Italian	<input type="checkbox"/> Haitian	<input type="checkbox"/> Russian
	<input type="checkbox"/> German	<input type="checkbox"/> Polish	<input type="checkbox"/> Other _____
	<input type="checkbox"/> Central/S. American Hispanic	<input type="checkbox"/> Puerto Rican <input type="checkbox"/> Dominican	<input type="checkbox"/> Refused
Country of Birth	<input type="checkbox"/> Haiti	<input type="checkbox"/> Cuba	<input type="checkbox"/> United States
	<input type="checkbox"/> Jamaica	<input type="checkbox"/> Nicaragua	<input type="checkbox"/> Dominican Republic
	<input type="checkbox"/> Colombia	<input type="checkbox"/> Canada	<input type="checkbox"/> Declined
	<input type="checkbox"/> Peru	<input type="checkbox"/> Mexico	<input type="checkbox"/> Other _____
ETHNICITY	<input type="checkbox"/> No, Not Spanish/Hispanic/Latino	<input type="checkbox"/> Yes, other Spanish/Hispanic/Latino	<input type="checkbox"/> Yes, Puerto Rican
	<input type="checkbox"/> Unknown		<input type="checkbox"/> Yes, Cuban
LANGUAGE SPOKEN AT HOME	<input type="checkbox"/> English	<input type="checkbox"/> Creole	<input type="checkbox"/> Declined
	<input type="checkbox"/> Spanish	<input type="checkbox"/> French	<input type="checkbox"/> Other _____
		<input type="checkbox"/> Portuguese	
School Status	<input type="checkbox"/> Not Attending <input type="checkbox"/> Attending (School Name: _____)		Grade

● PLEASE BE SURE NOT TO LEAVE ANY SECTIONS BLANK OR INCOMPLETE

## PARENT INFORMATION

PARENT (1) FULL NAME Registering Parent			
Marital Status	<input type="checkbox"/> SINGLE	<input type="checkbox"/> MARRIED	<input type="checkbox"/> DIVORCED <input type="checkbox"/> WIDOWED
Address			
Home Phone		Cell Phone #	
Place of Employment		Work Phone #	
Email Address			
Parent (2) / Guardian			
Marital Status	<input type="checkbox"/> SINGLE	<input type="checkbox"/> MARRIED	<input type="checkbox"/> DIVORCED <input type="checkbox"/> WIDOWED
Address			
Home Phone			
Place of Employment			
Email Address			
Parent / Guardian			
Marital Status	<input type="checkbox"/> SINGLE	<input type="checkbox"/> MARRIED	<input type="checkbox"/> DIVORCED <input type="checkbox"/> WIDOWED

Custody:	Mother _____	Father _____	Both _____	Family Size _____
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## EMERGENCY CONTACT

Emergency Contact 1 (Not parent / guardian)					
Home Phone #		Cell Phone #		Work Phone #	
Emergency Contact 2 (Not parent / guardian)					
Home Phone #		Cell Phone #		Work Phone #	

## PICK UP INFORMATION

List anyone besides guardians and emergency contact person(s) who has your authorization to pick up your child.

	Name	Home Phone	Cell/work Phone	Relationship to child
#1				
#2				
#3				

## BEHAVIORAL INFORMATION

How does the student communicate?

If the student is non-verbal, in which other ways do they communicate?

Please describe any unusual habits.

Please describe any unusual fears.

Does the student have a current behavioral plan for home or school? If yes please describe AND provide copy (IEP).

## INDIVIDUALIZED SEIZURE PLAN FORM

Does the student have a history of seizures? If no please enter N/A for the following fields.

Please list the types of seizures the student experiences and the typical length of time for each.

Please describe each seizure physically as you have observed them.

What are the warning signs?

What typically happens after the seizures?

What is the student's typical recovery time?

When was the last seizure?

Are there special instructions for medication with the student's seizure activity?

Does the student have any restricted activities due to their seizure activity? If yes, what are these restrictions?

Please explain what to do if the student has a seizure.

## NUTRITIONAL INFORMATION

Is the student on a special diet?

If the student has food restrictions please list all foods to be restricted.

If the student has special feeding needs (Gagging reflex, Tongue Thrust, etc.) please describe

## GENERAL MEDICAL INFORMATION

Please define the student's disability including diagnosis and date of diagnosis.

Please list all of the student's allergies (Food, Environmental, Medication, etc.)

Please list all medications and dosages that your student is currently taking.

## INSURANCE INFORMATION

Hospital Preference

Insurance/Health Coverage (Company)

## ELIGIBILITY CRITERIA

\*Student must be between the ages of 3 and 21 years old with a documented special need

\*Student must reside in Broward County

\*Enrolled in a Broward County School Program

\*Student must not need less than a 1 to 5 staff ratio or a 1 to 3 staff ratio to meet their specific needs.

\*Student must not possess any behavioral problems which could endanger the safety of other students and staff members (i.e. Biting, fighting, or other forms of physical aggression).

- Section 65C 22.006(2), F.A.C, requires a current physical examination (Form 3040) and immunization record (Form 682 or 681) within 30 days of enrollment.
- Section 402.3125(5) F.S., requires that parents receive a copy of the Child Care Facility Brochure, "Know your Child Care Facility" (CF/PI 175-28) or (School year)  
Section 65C-20.11(2)(c)(1), F.A.C., requires that parents receive a copy of the family day care brochure. "Selecting A Family Day Care Home Provider" (CF/PI 175-28)
- Section 65C-22.010(6)(c), F.A.C., requires that a written copy of the family day care provider's discipline policy be available for review by the parent(s).

#### Smoking Policy

- I understand that there is no smoking on the premises of Main-Ft Lauderdale, Bright Horizons and UCO Administration Offices.

Your signature below indicates that you have read the above items and that the information on this enrollment form is complete and accurate.

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

Date \_\_\_\_\_



## CSC Sliding Fee Scale Assessment Form

This form is offered to assist providers, as needed, in gathering information in order to assess program participants using the CSC Sliding Fee Scale, as required. **Participation in program services shall not be denied based on inability to pay; waivers may be granted on a case by case basis with documentation.**

Student's Name: \_\_\_\_\_ Student ID# \_\_\_\_\_

Name of School: \_\_\_\_\_ Student Grade: \_\_\_\_\_

Student's Ethnicity (*Please check one*) African American ☐ White (Non-Hispanic) ☐ Hispanic ☐

Guardian's Name: \_\_\_\_\_

Relationship to Student: \_\_\_\_\_ Language Spoken in Home: \_\_\_\_\_

Guardian's Marital Status (*Please check one*): Single ☐ Married ☐ Divorced ☐ Widowed ☐

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Phone: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

Annual Gross Income: \$ \_\_\_\_\_ / Year Number of Family Members: \_\_\_\_\_

List any support documentation provided, i.e. Tax Return, Public Assistance, etc.: \_\_\_\_\_

***With my signature below, I verify that the above information is true and accurate to the best of my knowledge. I will notify my counselor if my income status changes.***

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

\_\_\_\_\_  
Date

### For Program Staff

Assessed Fee \$ \_\_\_\_\_ / Per Week

***If Waiver, document reasons for waiver***

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

\_\_\_\_\_  
Authorized Staff Signature

\_\_\_\_\_  
Date

## HANDBOOK ACCEPTANCE

I understand, agree and will adhere to all of the UCO Afterschool Parent Handbook policies and procedures especially the policies related to:

- Late Pickups
- Parent Fees
- Staff to student ratio of 1:5 and 1:3
- Providing necessary supplies for your child
- Maintaining student records- this includes medication and list of adults authorized to pick up your child
- Attendance (We expect 80%)
- Absences (Call Site Coordinator to report any absences)

**I understand the above eligibility criteria and agree that my child meets the eligibility requirements.**

**I attest that all information in this application is true to best of my knowledge.**

**I have received the HIPPA Notice of Health Information and Privacy Practices.**

**I give permission for my child to attend the UCO Summer Camp.**

**I give permission for photographic material to be taken during the session to be used for promotional purposes and I understand that there will be no compensation for this use.**

**If my child is unable to attend full sessions due to the omission of inaccurate information on this form, I understand that the fees paid will not be reimbursed.**

**I understand that I will provide a doctor's note and keep my child at home when he/she has a contagious or infectious illness.**

**I understand that I will provide accurate and updated contact information.**

**I understand and agree to the Afterschool Program pickup policy and late pick-up procedures.**

**I understand that there will be a two week trial basis during the school year and a one week trial basis for the summer camp to determine the appropriateness of the participant for the program.**

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Parent Signature

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Site Coordinator Signature