CHILD/YOUTH PARTICIPANT INFORMATION FORM

Child/Youth Last Name _____ **First** _____**Middle Name**

Child/Youth's Date of Birth (MM/DD/YYYY) _____/_____/

Child/Youth Gender ☐ Female ☐ Male ☐ Non-binary/Gender non-conforming ☐ Transgender ☐ Other

Street Address _____ **City** _____ **ZIP Code**

Caregiver Last Name _____ **First** _____ **Caregiver Phone Number (_____) _____ -**

Is this a cell/mobile phone? ☐ Yes ☐ No **Caregiver Email address**

Caregiver preferred language for contact (Please select only one): ☐ English ☐ Spanish ☐ Haitian Creole

(Optional) Youth Phone Number (_____) _____ -_____ (if provided) Is this a cell/mobile phone? ☐ ☐ Yes ☐ No

(Optional) Youth Email address

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 Trust-funded programs, initiatives and events that may interest you.

What is the child/youth's current grade level? (For summer, select the last grade completed - Please select only one):

☐**Pre-K** ☐ **Kindergarten** ☐ **Grade 1st-12th (specify)**

☐**Attending College** ☐ ☐**Child under 5 not in school**☐☐☐ ☐**Not in school**

Miami-Dade County Public Schools ID # _____ _____ _____ _____ _____ _____ _____ ☐ No M-DCPS ID #
ALL STUDENTS ATTENDING PUBLIC OR CHARTER SCHOOLS MUST HAVE A SCHOOL ID # ENTERED.

Child/Youth's current school or college

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/Youth Race (Please select only one):
☐ American Indian or Alaskan ☐ Asian ☐ Black or African American ☐ Pacific Islander ☐ White

☐ Biracial or Multiracial ☐ Prefer to self-describe

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/youth 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/youth 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
☐ Other condition lasting one year or more (please specify):
☐ No condition lasting one year or more

If you marked "No condition lasting one year or more" 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 noted make it harder for your child/youth to do things that others of the same age can do?

☐ Yes ☐ No

To support your child/youth's successful participation in this program, in what areas might they 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 consider 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/youth:

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/youth, visit www.advocacynetwork.org or www.thechildrenstrust.org/content/children-disabilities.

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).

PARENT/GUARDIAN SIGNATURE _____ **DATE**

FOR STAFF USE ONLY (*MUST BE COMPLETED*)

ORGANIZATION _____ SITE

Referred From: _____