5800 Palm Ave, Hialeah Fl 33012

Client Application

YOUTH'S LAST NAME: _____ FIRST NAME: _____ Middle initial: _____

STREET ADDRESS: _____ APT._____

CITY*: _____ STATE: Florida ZIP: _____

CONTACT PHONE NUMBER: _____EMAIL:_____

GENDER: □ Male □ Female BIRTHDAY *: _____/_____/_____ MM/DD/YYYY

YOUTH'S RACE: □ American Indian/Alaska Native □ Asian □ Black/African-American □ White □ Pacific Islander
□Other Please specify _____

YOUTH'S ETHNICITY: □ Haitian □ Hispanic □ Other Please specify _____

YOUTH'S COUNTRY OF ORIGIN _____

IS YOUTH PROFICIENT IN ENGLISH □ Yes □ No

ADDITIONAL/OTHER LANGUAGE(S) SPOKEN IN THE HOME: □ English □ Spanish □ Haitian Creole □ Sign Language

MDCPS STUDENT ID NUMBER: _____ □ NO MDCPS; □ PREFER NOT TO GIVE MDCPS #

YOUTH'S SOCIAL SECURITY NO. _____ □ NO SSN; □ PREFER NOT TO GIVE SSN

CURRENT GRADE LEVEL: _____ CURRENT SCHOOL: _____

DOES YOUTH 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 THE YOUTH HAVE ANY *DOCUMENTED* DISABILITY? ¶YES* ¶NO
(*A hard copy of the selected documentation must be kept within the participant's file)

Please check all that apply:
- □ an Individualized Education Plan (IEP) from the school system
- □ a Section 504 Plan
- □ a medical diagnosis from a doctor
- □ a diagnosis by a State certified/licensed professional (ex. Psychologist)
- □ Information disclosed by the parent or guardian describing the child specific condition and/or need for accommodations

How would you best classify the type(s)? (check all that apply):
- □ Autism Spectrum Disorders
- □ Chronic Medical Condition
- □ Developmental Delay (under 5 only)
- □ Emotional and/or Behavioral Disorder
- □ Hearing Impairment (or deaf)
- □ Intellectual Disability (or mental retardation)
- □ UNKNOWN DISABILITY
- □ Learning Disability
- □ Physical Disability
- □ Speech/Language Impairment
- □ Visual Impairment (or blind)
- □ Other Disability
- □ Asthma

MEDICAL 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, delay in reaching me might jeopardize the 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.

EXCEPT AS NOTED BELOW, this child is in good health, has no allergies and no chronic conditions which would affect treatment, and takes no medication routinely. His/her immunizations are current.

CLIENT'S Name	Food Allergies	Drug Allergies	Other Serious Allergies	Chronic Conditions

INSURANCE INFORMATION (if family has insurance coverage)

CARRIER: _____ POLICY: _____
Insurance Company Policy #

DOCTORS NAME: _____ PHONE: _____

FAMILY INFORMATION

FATHER'S NAME: _____
Last First

MOTHER'S NAME: _____
Last First

Does youth live with a legal guardian other than mother or father? ☐ YES ☐ NO

If yes, GUARDIAN'S NAME:

_____
Last First

PARENT/GUARDIAN ADDRESS: _____
Street City State Zip

HOME PHONE*: _____WORK PHONE*: _____CELL PHONE: _____

E-MAIL: _____

EMERGENCY INFORMATION

Phone numbers where I can be reached during the day: _____
If I cannot be reached, please try to contact my designated alternate(s):

1. _____ _____
Name Phone Number

2. _____ _____
Name Phone Number

Non-Discrimination Policy:
Youth ages 22 and older will be accepted into our Success@work program regardless of race, creed, immigration status, health, religion, disability, ethnicity or ability to pay for services. Clients 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 clients are welcome. Clients with severe physical, emotional or behavioral disabilities may be referred to other programs specially designed to meet their needs. We are not able to provide one on one service on this program.
Parental Consent:
By signing the application below, I agree and certify the following:

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) I understand that participation in this program involves physical education, organized sports, meals, and off-site field trips and volunteer employment. 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 SUCCESS@Work program activities from NHBC, the program site and all employees, officers, directors, agents, and volunteers associated with the program.
3) I agree to make every effort to insure that my son/daughter participates in the program daily, unless he/she is too ill to attend. I also agree that I or my designated representative will contact and set up transportation every day he/she attends the program.
4) I agree to all the program standards. I am aware of the fees ($10.00/1 hour, $5.00/30 min) charged for parent tardiness on pick-up at the end of the day. The program ends at 3:00 PM each day.
5) I understand that this program site is being held on the premises of a religious institution for the primary purpose of providing academic enrichment and a safe environment during out-of-school time. In some cases, religious instruction may be offered as an option to the children on the premises, but only with written parental permission.

_____ _____
Parent / Guardian Signature Date