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**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***](http://www.thechildrenstrust.org)**.   
*For special needs resources for your child/youth, visit*** [***www.advocacynetwork.org***](http://www.advocacynetwork.org) ***or***[***www.thechildrenstrust.org/content/children-disabilities***](http://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: