



CHILD INFORMATION FORM

Required as of 8/1/2018

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)

- | | |
|--|---|
| <input type="checkbox"/> Behavioral therapy or services | <input type="checkbox"/> Physical therapy (PT) |
| <input type="checkbox"/> Counseling for emotional concerns | <input type="checkbox"/> Special education services in school |
| <input type="checkbox"/> Daily medication (not including vitamins) | <input type="checkbox"/> Speech/language therapy |
| <input type="checkbox"/> Occupational therapy (OT) | <input type="checkbox"/> None of the above |

What conditions does your child have that are expected to last for a year or more? (Mark all that apply)

- | | |
|---|---|
| <input type="checkbox"/> Autism spectrum disorder | <input type="checkbox"/> Physical disability or impairment |
| <input type="checkbox"/> Developmental delay (only if under age 5) | <input type="checkbox"/> Problems with aggression or temper |
| <input type="checkbox"/> Intellectual/developmental disability (over age 5) | <input type="checkbox"/> Problems with attention and hyperactivity (ADHD) |
| <input type="checkbox"/> Hearing impairment or deaf | <input type="checkbox"/> Problems with depression or anxiety |
| <input type="checkbox"/> Learning disability (school age) | <input type="checkbox"/> Speech or language condition |
| <input type="checkbox"/> Medical condition or illness | <input type="checkbox"/> Visual impairment or blind |
| | <input type="checkbox"/> 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 _____
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FOR STAFF USE ONLY (MUST BE COMPLETED)

ORGANIZATION _____ SITE _____

POPULATION MEMBERSHIP (check all that apply):

Dep Syst

Delin Syst