Kidz XL Registration Forms
After School Program 2017 - 2018

Child Name: _____ Current Grade: _____

Parent Name: _____

APPLICATION CHECK LIST:

- ❒ Registration Fee - $25 per family (One time for the year)
- ❒ Tuition Fees - $30.00 per week for elementary age students
  ($25 per week for Middle School students)
- ❒ REGISTRATION PACKET COMPLETE
  - ☐ Financial Agreement
  - ☐ Registration Information
  - ☐ Permission for Contact form
  - ☐ Transportation Agreement
  - ☐ Health Information Form
  - ☐ Photography Permission
  - ☐ Policies and Agreements
  - ☐ Emergency Contact Information
- ❒ IMMUNIZATION FORM (blue form from school)
- ❒ BIRTH CERTIFICATE of child
- ❒ PARENT PICTURE ID
- ❒ *All* ATTACHED FORMS ARE COMPLETE

Kidz XL Sports
3801 SW 97th Ave
Miami, FL 33165
Office Phone: 305.221.1404
Prog. Director Phone: Zach Trudeau 786.257.6282
Ex. Director Phone: Abner Reyes 305.606.8316

Kidz XL accepts children of all abilities.

Kidz XL Xtreme League Sports

The Children's Trust

After School Kidz XL 2017/2018

Starting August 21 • 1:50 pm to 6:00 pm • $30 per week

Kidz XL will be in session when Miami-Dade Public Schools are in session. Kidz XL WILL BE open Teacher Planning Days and Spring Break, but NOT during Winter Break. Weekly Tuition will be decreased on weeks with Holidays.

Child's Name: _____

Student's Enrollment Date: _____

Parents: Please read, acknowledge, and sign your agreement to the enrollment of your child in view of the following rules, guidelines, and programmatic procedures of Kidz XL:

1. Kidz XL requires that enrolled students attend Kidz XL at least four (4) days every school week.
2. Students will read for 30 minutes every day during the hours of our program.
3. Students will be required to participate in physical fitness activities.
4. Students will be placed in an age-appropriate group with an instructor and will be taught the Bible at least once a week.
5. If a student receives a detention at their school, on that same day when they come to Kidz XL, we will require that they complete EXTRA homework and / or EXTRA special projects.
6. If a student refuses to cross the street from OHES, a Kidz XL staff member will leave that student at the OHES office, parents will be notified, and that student may be suspended from Kidz XL for one school day.
7. Kidz XL is a NO CURSING / NO FIGHTING program. If a student consistently breaks this policy, the student may be suspended from the program.
8. OHES Students enrolled at Kidz XL must meet at the OHES flagpole within 10 minutes after the OHES dismissal bell.
9. Parents must give the Kidz XL Director two (2) weeks notice if they are withdrawing their child from our program.

Parent Signature: _____ Date: _____

☐ **Check here to request an appointment if you require a SCHOLARSHIP INTERVIEW.**

CHILD INFORMATION FORM

Child's Last Name_____, **First** _____ **Middle** _____

Child's Date of Birth (mo/day/yr) ☐☐ ☐☐ ☐☐☐☐ **Child's Gender** ☐ Male ☐ Female

Last 4 Digits ONLY of Child's Social Security# ☐☐☐☐ ☐ No SSN

Miami-Dade County Public School ID# ☐☐☐☐☐☐☐

Child's Current School _____

Is your Child Proficient in English? ☐ Yes ☐ No

Other Language(s) Spoken in the Home ☐ Spanish ☐ Haitian-Creole ☐ Other_____ ☐ None

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

Child's Ethnicity ☐ Hispanic ☐ Haitian ☐ Other

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)

Child's Primary Caregiver (full name) _____

Primary Caregiver Email _____

Primary Phone ☐☐☐ ☐☐☐ ☐☐☐☐

(You may be contacted by The Children's Trust to ask about your satisfaction with these services)

MIAMI-DADE COUNTY PUBLIC SCHOOLS

CONSENT FORM FOR MUTUAL EXCHANGE OF INFORMATION

Date _____

Student's Name _____

Date of Birth _____ ID# _____

I hereby authorize the mutual exchange of records pertaining to my child or myself, _____ _____ , between the MIAMI-DADE COUNTY PUBLIC SCHOOLS and the following agencies (include all schools, physicians, psychologists, hospitals, clinics, etc., that have had significant contact with your child):

Name	**Address**
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

- The specific records to be disclosed pertain to: _____

_____

- The purpose for making these records available is: _____

_____

- **The receiving party will not disclose the information to any other party without signed consent.**

I certify that I am the parent or legal guardian of the child named above or that I am a student of majority age and have the authority to sign this release.

_____ _____
Name (print) Signature

_____
Address City, State Zip Code

Please return this form to: _____

_____

_____

_____

Miami-Dade County Public Schools

Permission for Release of Records and/or Information From Records

Student's Name: _____ DOB: _____

Records to be released: [Please check appropriate item(s)].

_____ Psychological Report _____ Test Scores _____ Attendance Information

_____ Grades _____ Health/Medical Records _____ Other (Specify)

_____

The record(s) indicated above is/are to be released to:

Agency _____ Contact Person _____

Address _____

The purpose for this release is: _____

I hereby grant permission for the release of the above record(s) and this release is to be in effect until _____ _____ (Date).

_____

Signature of Parent or Eligible Student (Date)

_____ _____

School/Agency Releasing/Requesting Records Signature of Authorized Personnel

_____

Title (Date)

Miami-Dade County Public Schools is subject to the Family Educational Rights and Privacy Act of 1974 Codified at 20 U.S.C. §1232 g. Therefore, all documents contained in a student's educational records, except those specifically waived, are accessible to the parents or eligible student.

Personally identifiable information may be transferred to a third party only on the condition that it will not be released to any other parties without obtaining the consent of the parent or eligible student.

A COPY OF THIS AUTHORIZATION SHALL BE AS VALID AS THE ORIGINAL

We want to get to know your child better so we can provide the best possible experience in our programs. Please tell us more about your child...

What are the main ways your child communicates? (Mark all that apply)

- ☐ Speaks and is easily understood
- ☐ Speaks but is difficult to understand
- ☐ Uses sign language
- ☐ Uses communication devices like pictures or a board
- ☐ Uses gestures like pointing, pulling or blinking
- ☐ Uses sounds that are not words like crying or grunting

What, if any, help does your child receive at this time? (Mark all that apply)

- ☐ Speech/language therapy
- ☐ Occupational therapy (OT)
- ☐ Physical therapy (PT)
- ☐ Daily medication (not including vitamins)
- ☐ Special education services in school
- ☐ Behavioral therapy or services
- ☐ Counseling for emotional concerns
- ☐ None

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

- ☐ Physical disability or impairment
- ☐ Medical condition or illness
- ☐ Hearing impairment or deaf
- ☐ Visual impairment or blind
- ☐ Speech or language condition
- ☐ Autism spectrum disorder
- ☐ Developmental delay (only if under age 5)
- ☐ Learning disability (school-age)
- ☐ Problems with attention or hyperactivity (ADHD/ADD)
- ☐ Problems with depression or anxiety
- ☐ Problems with aggression or temper
- ☐ Intellectual/developmental disability (over age 5)
- ☐ None of the above

If you marked "None of the above" on the question above, please skip the next two questions and sign below. If you marked any other answer 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

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**_____

FOR STAFF USE ONLY (*MUST BE COMPLETED*)

ORGANIZATION_____ SITE_____

POPULATION MEMBERSHIP (check all that apply): ☐Dep Syst ☐Delin Syst

Kidz XL Xtreme League Sports

The Children's Trust

Medical Health History /Authorization and Release Form

Child's Name:_____ Birthdate: _____ Date of Last Physical Examination: _____

Does your child have any ALLERGIES? ☐ Yes ☐ No *(If yes, please list)* _____

_____

Illnesses: *(please circle)*

Does your child have any problems with any of these?

Constipation	Convulsions
Diarrhea	Fainting Spells
Frequent Colds	Frequent Ear Infections
Lice	Frequent Sore Throats
Urinary Problem	Stomach Upsets

Has your child had any of these diseases?

Asthma	Bronchitis
Chicken Pox	Diabetes
Heart Disease	Hepatitis
Measles	Tuberculosis
Mumps	Polio
Skin Rash	Whooping Cough

Is your child currently taking any medications? ☐ Yes ☐ No *(If yes, please list)*

_____

Other ILLNESSES *(besides above)* _____

Has your child been HOSPITALIZED? *(explain)*_____

Has your child had INJURIES with fractures or loss of consciousness? *(explain)* _____

Any other members of your family with SERIOUS ILLNESS recently? _____

Any other members of your family with history of: ASTHEMA _____ DIABETES _____ EPILEPSY _____

INDICATE DESIRED ACTION IN THE EVENT OF ACCIDENT OR EMERGENCY:

In the event of accident or emergency, when a parent/guardian is unavailable, I hereby authorize a representative of *KIDZ XL SPORTS* to make such arrangements as he/she considers necessary for my child to receive medical/hospital care, including necessary transportation. Under such circumstances, I further authorize the physician named below to undertake such care and treatment of my child as he/she considers necessary. In the event that said physician is not available at any time, I authorize such care and treatment to be performed by licensed physician or surgeon. THE UNDERSIGNED PARENT/GUARDIAN FULLY UNDERSTANDS HE/SHE IS RESPONSIBLE TO PAY ALL COSTS INCURRED AS RESULT OF THE FOREGOING.

Physician's Name: _____ Telephone #:_____

Hospital of Choice: _____ Name of Medical Insurance:_____

Name of Insured: _____ Policy #:_____ Group #: _____

Insurance Contact Telephone #: _____

Parent Signature: _____ Date:_____

The Children's Trust

Kidz XL Extreme League Sports

Release Agreement

I hereby release, forever discharge and agree to hold harmless Kidz XL and the Kidz XL Sports Camp, After School Program, its directors, employees and volunteers, from any and all liability, claims or demands for personal injury, sickness or death, as well as property damage and expenses, of any nature whatsoever which may be incurred by the undersigned and the above named child that occur during any activities. Furthermore, I hereby assume all risk of personal injury, sickness, death, damage and expense as a result of participation in these activities. The undersigned further agrees to hold harmless and indemnify the above mentioned Kidz XL and the Kidz XL Summer Sports Camp, After School Program, its directors, employees, and volunteers, for any liability sustained by said organization(s) as the result of the negligent, willful or intentional acts of the below named child, including expenses incurred attendant thereto.

I, _____, parent or legal guardian of _____ *
(Guardian's Name) (Child's Name)

Herein authorize the adult sponsor of Kidz XL, Kidz XL Summer Camp Sports Camp and After School Program to consent to any X-ray, examination, anesthetic, medical or surgical diagnosis or treatment on the advice of any physician or surgeon licensed to practice in the state of treatment, when need for such treatment is immediate and when efforts to contact me are unsuccessful.

Signature of Parent of Guardian _____ Date _____ *

KIDZ XL SPORTS : Policies and Agreements

Please Initial Each Policy Statement

LATE POLICY

_____ IF YOU ARE GOING TO BE LATE PICKING UP YOUR CHILD/CHILDREN, PLEASE CALL KIDZ XL AT 786.257.6282 or 305.221.1404

_____ PLEASE BE ADVISED THAT KIDZ XL SPORTS MAY NOTIFY THE DEPARTMENT OF CHILDREN AND FAMILIES IF YOUR CHILD/CHILDREN ARE NOT PICKED UP BY 8:00 P.M.

Written Policy for recurring behavior problems
Written Policy for accident / injury reports

1. An incident report will be written for all: **1) student behavior problems; 2) accidents or injury; 3) parent concerns.** At the time of pick-up, the parent must sign the incident report signifying that they have read and understand the contents of the report.
2. After the third behavior incident report, the parents or guardians will meet with the KIDZ XL SPORTS staff worker to discuss and determine a plan of action.
3. If a fourth incident report is written concerning the same behavior problem, a second group meeting will be scheduled with the staff worker, Parent and a KIDZ XL SPORTS program leader.
4. Students may be suspended or expelled for behavior problems that have been noted on numerous incident reports and unresolved over two meetings with a staff worker.

_____ _____
Parent / Guardian Signature Date

Voluntary Concent for Kidz XL Photography: I consent to allow the taking of photos or videos of my child and/or me during program activities. Any photos/videos may reveal my child's and/or my identity without any compensation paid to my child, to me or to others. All photos and videos shall be the sole property of **Kidz XL Sports** and may be used for educational and/or promotional purposes.
Please circle one: ***YES*** ***NO***

Kidz XL Xtreme League Sports

The Children's Trust

EMERGENCY CONTACT INFORMATION

Child's Name: _____

Father's Name: _____

Mother's Name: _____

Guardian's Name: _____

Street Address: _____ Apt.# _____

City: _____ State: _____ Zip: _____

Father's

Work Phone: (____) _____ - _____ Cell Phone: (____) _____ - _____

Mother's

Work Phone: (____) _____ - _____ Cell Phone: (____) _____ - _____

Will both parents be allowed to pick up the child? _____

I/We hereby certify that I/we have legal responsibility for this child.

Signature of Parent/Guardian: _____

Emergency Contacts:

Your child will be released ONLY to the custodial parent or legal guardian and the persons listed below. Be sure to include the non-custodial parent if they are allowed to pick up your child. ***The following people are authorized to be contacted and to pick up the child in case of illness, accident, emergency, behavioral problems if the parent cannot be reached:***

Name	Address	Work#	Home#

FIELD TRIP RELEASE FORM

For and in consideration of being allowed to participate in the field trips this program year (2017-2018), I, in full recognition and appreciation of the dangers and hazards involved in such activities, do hereby agree to assume all risks and responsibilities surrounding my child's participation in this event and do hereby release and hold harmless La Vina del Senor Inc., DBA Kidz XL (Kidz XL), its Trustees, Board Members, Directors, and Employees, and participants from and against any and all liabilities to the undersigned, his/her dependents, assigns, personal representatives, heirs and next of kin for any and all damages, expenses (including attorney fees) claims, judgments, actions or causes of action as a result of any loss or injury to the person enrolled in Kidz XL during or arising out of activities of the above described event and during transportation to and from such event.

I understand that Kidz XL does not, in any manner, serve as principal, agent, or partner of any travel agent or commercial carrier which may provide services to the participants. I have read and understand this release and voluntarily sign this document and allow my child to participate in these series of trips.

I have read and understand this release and I voluntarily allow my son/daughter to participate in this event.

_____/_____/2017 Parent / Guardian Name _____

CONSENT TO ADMISSION AND TREATMENT

In the event of injury to the undersigned, born on_____/_____/_____, Social Security #_____ (Last 4 Digits), I hereby authorize Kidz XL or representatives thereof to admit my child to a facility for emergency medical treatment as may be deemed necessary to my health or welfare.

I hereby consent to whatever medical treatment is deemed necessary. I, on my behalf, and on behalf of my heirs, successors, assigns, and personal representatives, hereby release Kidz XL, its trustees, board members, and employees from any and all claims arising from my admission to such facility or from such treatment administered by such facility.

Persons to contact in the event of as emergency are listed below.

_____/_____/2017 _____
DATE PARENT GUARDIAN NAME

In the event of an emergency, please contact:

_____ _____ _____
NAME TELEPHONE

_____ _____ _____
ADDRESS

La Vina del Senor Inc., dba Kidz XL

Client Confidentiality Policy

Kidz XL has established this policy to guide its client record-keeping processes and, in so doing, protecting its client's information, as well as the integrity of Kidz XL as a trusted agency. The purpose of this policy is to ensure that Kidz XL follows all standards and laws in regards to the safekeeping of the client's confidential information.

The following list gives examples of a client's confidential information:

1. Medical Information
2. Driver's License
3. Social Security Card / Number
4. Passport
5. Birth Certificate

The above list is not exhaustive.

The following operational principles have been established so as to uphold the client's confidential information:

All of a client's confidential information will be filed in a filing cabinet that is kept locked, unless opened by the permitted people. If opened, the filing cabinets must be locked upon completion of use.

The only people permitted to have access to the filing cabinet are the executive director, the program director, and the administrative director.

If confidential documents are scanned and sent to the computer, those documents must be deleted after printing. There should be no confidential documents saved in the computer. All confidential client documentation must be kept in hard copy format, filed, and locked.

There may be legitimate requests for data from law enforcement officers. However, confidential information should not be given out without a valid warrant or without the approval of the Executive Director and/or Board of Directors.

Inappropriate use of privileges to access and use administrative data may result in disciplinary action, loss of access to the system, and possible sanctions up to and including dismissal.

Please sign and date below signifying that you have read and understand the above policy for the intention of safe-guarding your child's confidential information.

X _____

Date: _____