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**CHILD/YOUTH INFORMATION FORM**

**Child’s Last Name First Middle Name**

**Child’s Date of Birth** (MM/DD/YYYY)  **/ / Child/Youth** **Gender**  **Female**  **Male**

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

**Child’s Primary Caregiver** (full name)

**Primary Phone Number ( )**  **-**  **Is this a cell/mobile phone?**  Yes  No

**Primary Caregiver 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.*

**Miami-Dade County Public Schools ID #**  No M-DCPS ID #

***ALL STUDENTS ATTENDING PUBLIC OR CHARTER SCHOOLS MUST HAVE A SCHOOL ID # ENTERED.***

**Child's Current School:**  **Child’s Current Grade (Pre-K – 12th)**

**Is your child proficient in English?**  Yes  No

**Other language(s) spoken in your home**  Spanish  Haitian Creole  Other:  None

**Child's Ethnicity**  Hispanic  Haitian  Other, please specify:

**Child's Race** **(select one):**

American Indian or Alaskan  Asian   Black or African American  Pacific Islander  White  Multiracial  Other

**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)**

|  |  |
| --- | --- |
| 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 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  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 noted 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?**

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

No specific help needed

**Please tell us anything else you think it is important for us to know about your child**:

**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](http://www.thechildrenstrust.org/parents/health-connect/insurance).

***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, visit*** [***www.advocacynetwork.org***](http://www.advocacynetwork.org) ***or*** [***www.thechildrenstrust.org/content/children-disabilities***](http://www.thechildrenstrust.org/content/children-disabilities)***.***

**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 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

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