|  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Participant Information** | | | | | | | | |
| **Last Name** | **First Name** | | | **Middle Name** | | **Student ID Last 4 Digits**  **of SS#** | | **Gender** |
|  |  | | |  | |  | | □ Male  □ Female |
| **Street Address** | | | | | **City** | **State** | **Zip Code** | |
|  | | | | |  |  |  | |
| **Birth Date** | | **Age** | **Grade** | | **Country of Birth** | | | |
| \_\_\_\_/\_\_\_\_/\_\_\_\_\_\_\_\_\_ | |  |  | | □ United States □ Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | |

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| **Parent/Legal Guardian Information** | | | | | | | |
| **Full Name of Mother/Legal Guardian** | | | | **Full name of Father/Legal Guardian** | | | |
|  | | | |  | | | |
| **Street Address (if different from participant)** | | | | **Street Address (if different from participant)** | | | |
|  | | | |  | | | |
| **City** | **State** | | **Zip** | **City** | **State** | | **Zip** |
|  |  | |  |  |  | |  |
| **Home Phone** | | **Mobile Phone** | | **Home Phone** | | **Mobile Phone** | |
|  | |  | |  | |  | |
| **Email Address:** | | | | | | | |
| **Are there any custody issues? □ Yes □ No** *If yes, please provide documentation to the 21st CCLC school site staff.* | | | | | | | |

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| **Emergency Contact / Pick-Up Authorization**  In the event that a parent/guardian cannot be reached in an emergency situation, the following individuals are provided consent for emergency contact and authorized participant pick up. | | | | |
| **Contact Name** | **Relation** | **Phone Number** | | **Phone Number** |
| **1.** |  |  | |  |
| **2.** |  |  | |  |
| **3.** |  |  | |  |
| **Individuals *NOT AUTHORIZED* for pick up/participant contact:** | | | | |
| **1.** | **2.** | | **3.** | |
| **Student Dismissal** | | | | |
| **Upon signing out from program, my son/daughter will:** | | | | |
| **□** Walk home □ Be picked up □ Ride the bus | | | | |

|  |  |  |  |
| --- | --- | --- | --- |
| **For Office Use Only** | **Date Received:** | **Entry Date:** | **Entered by:** |
|  |  |  |  |

|  |
| --- |
| **Community Resources**  Please indicate if you would like more information about: |
| **□** Food and Nutritional Assistance (EBT Program, WIC, Pantries)  □ Health Insurance (Medicaid, Florida Kid Care)  □ Employment (Workforce One, Job Fairs, Career Counseling)  □ Counseling Services  □ Financial Assistance/Financial Literacy  □ Child Care Resource and Referrals  Other\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

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| **Student Demographic Information**  The demographic information gathered herein is solely used for statistical purposes. Indicate N/A if you chose not to answer. Student information is kept confidential. | | |
| **Household arrangement** | **Household income** | **Free or Reduced Lunch** |
| □ Both parents  □ Single parent  □ Other arrangement  Number in Household: \_\_\_\_ | □ 0-9,9999 □ 40,000-49,999  □ 10,000-19,999 □ 50,000-69,9999  □ 20,000-29,999 □ 70,000-99,999  □ 30,000-39,999 □ 100,000-over | □ Yes  □ No |
| **Ethnicity** |
| □ Yes, Spanish/Hispanic/Latino  □ No, Not Spanish/Hispanic/Latino |
| **Language Spoken** | **Race** | **Cultural Influence** |
| □ Bilingual Creole/English  □ Bilingual Spanish/English  □ Creole  □ English  □ Spanish | □ African American/Black  □ Asian  □ American Indian or Alaska Native  □ Caucasian/White  □ Native Hawaiian or Pacific Islander  □ Multiracial | □ American  □ British  □ Central/South American-Hispanic  □ Cuban  □ German  □ Haitian  □ Italian  □ Puerto Rican  □ West Indian  □ Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

|  |  |  |
| --- | --- | --- |
| **Medical Information** | | |
| **Name of Insurance Carrier and Plan Name** | | **Family Physician** |
|  | |  |
| **Carrier Phone** | **Insurance ID number** | **Physician Contact Phone** |
|  |  |  |
| Description: wb00956_[1] **Please list ADA Accommodations needed** | | **Has the participant ever been diagnosed with or received treatment, attention, or advice from a physician for:** |
| \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | □ Allergies  □ Asthma  □ Diabetes  □ Epilepsy/Seizures  □ Serious headache/Migraine  □ Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| **Please explain any medical issues stated above with treatment, attention, or advice from a physician** | | |
| Signature\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | |