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| **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 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

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| **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 |

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

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| **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 ReferralsOther\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

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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 arrangementNumber 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 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

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| **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:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |