FORM 1

Grant Participant Information Form

(Office use only)
Participant ID # _____
Program Entry Date _____
Closing Date _____
Annual Review _____ ❒ _____ ❒

Thank you for applying for a scholarship to the City of St. Petersburg's Out of School Time (OST) Program funded in whole or in part by the Juvenile Welfare Board of Pinellas County ("JWB"). To maintain a scholarship, each participant must comply with the performance measures and minimum service levels.

Recreation Center: _____

Child's Name: _____ **Birth date:** _____ **Age:** _____

Sex: ☐ Male ☐ Female **Gender:** ☐ Male ☐ Female ☐ Trans Female ☐ Trans Male ☐ Gender Non-Conforming

Address _____ **City:** _____ **Zip Code:** _____

School Attending: _____ **Current Grade:** _____ **10-Digit Student ID #:** _____

Who has Legal Custody: _____ **Relationship to Child:** _____

Current Living Situation: (select one) ☐ Have Physical Address ☐ Legally Restricted ☐ Unsheltered ☐ Sheltered
☐ Safe Haven ☐ Institutional Setting ☐ Temporary Housing Situation ☐ Potentially Permanent Housing Situation

Parent/Legal Guardian's Name: _____

Address: _____ **City:** _____ **Zip Code:** _____

Home Phone: _____ **Cell Phone:** _____ **Email:** _____

Place of Employment: _____

Parent/Legal Guardian's Name: _____

Address: _____ **City:** _____ **Zip Code:** _____

Home Phone: _____ **Cell Phone:** _____ **Email:** _____

Place of Employment: _____

Total Number of Children in Household: _____ **Total Number of Adults in Household:** _____

Household Arrangement: (select one) ☐ Single Parent - Female head of household ☐ Single Parent - Male head of household
☐ Dual Parent – Married ☐ Dual Parent – Non-married Female head of household ☐ Other - Non-relative
☐ Dual Parent - Non-married Male head of household ☐ Other - Relative/Kinship Care - Male head of household
☐ Other - Relative/Kinship Care - Female head of household ☐ Other Relative/Kinship Care - Married

Gross yearly combined Household Income: $ _____

Participant's Lunch Status: ☐ Full ☐ Reduced ☐ Free **Is participant a Foster Child:** ☐ Yes ☐ No

Primary Language Spoken: (select one) ☐ English ☐ Spanish ☐ Chinese ☐ Vietnamese ☐ Korean ☐ Russian ☐ Arabic
☐ Tagalog ☐ Polish ☐ French ☐ Haitian Creole ☐ Portuguese ☐ Japanese ☐ Italian ☐ Haitian ☐ American Sign Language
☐ Other _____

Race: (select one) ☐ White ☐ Black, African American ☐ Asian ☐ American Indian or Alaska Native ☐ Haitian ☐ Native Hawaiian
☐ Other Asian (Hmong, Laotian, Thai, Pakistani, Cambodian, etc.) ☐ Other Pacific Islander (Fijian, Tongan, etc.) ☐ Some other Race
☐ Multiracial

Ethnicity: (select one) ☐ No, Not Hispanic, Latino or Spanish ☐ Yes, Mexican, Mexican American or Chicano ☐ Yes, Puerto Rican
☐ Yes, Cuban ☐ Yes, Another Hispanic/Latino or Spanish Origin

I certify that all information documented on this form regarding myself, and my child is true and complete to the best of my knowledge. I fully understand that any omissions, falsifications, or misrepresentations may disqualify my child from participating in the City of St. Petersburg and The Juvenile Welfare Board Matched Partnership Grant Program.

Signature of Custodial Parent/Legal Guardian (Affiant): _____

FORM 2

Authorization and Consent for Disclosure, Receipt, and Use of Confidential Information by the Juvenile Welfare Board of Pinellas County

Participant's Name:_____

I acknowledge that I am a participant of the City of St. Petersburg's TASCO Center-based Out of School Time Program. I acknowledge that the Juvenile Welfare Board of Pinellas County ("JWB") provides funds to make the program or service in which I am participating available. I also acknowledge that in order to make sure that all services delivered to participants are of the highest possible quality, JWB may need to review information about me and these services.

By signing this Authorization, I am indicating that I understand and agree that my confidential information may be contained in a JWB data collection system, and that this data collection system is exempt from disclosure under the Florida Public Records Act. This means that by law, JWB cannot release individually identifiable information about me or the services I receive (Fla. Stat. §119.071). I acknowledge that as necessary to carry out the purposes listed herein, JWB may review all information about me, including my participant file and all other information pertaining to me held by the agency providing the program or service, regardless of whether that information is entered into a JWB data collection system. I further acknowledge that JWB is simply storing and reviewing records and information as the payor for these services, and that JWB generally provides no direct services to me, except in certain circumstances may facilitate service delivery I further acknowledge that JWB does not provide medical diagnoses to me and JWB is not a covered entity as that term is defined under HIPAA (the Health Insurance Portability and Accountability Act).

I authorize JWB to utilize my confidential information to verify eligibility for funded services or programs, to facilitate service delivery, make payment for services rendered to me by funded programs or services, quality control of funded services or programs, evidence-based research of JWB funded services or programs, including, but not limited to, tracking outcomes of funded programs and services, and determination of future services/programs funded by JWB. I understand that the confidential information disclosed, received or used by JWB related to my Authorization will not be further disclosed to any other party without my express written consent or as otherwise permitted or required by applicable law unless it is presented in a report that presents information on a group of individuals in de-identified format, which means that no information that identifies me as an individual is revealed.

I acknowledge that this Authorization covers all information about me including, but not limited to, personally identifiable information, Protected Health Information, general medical, general counseling, as well as psychiatric/ psychological/ substance abuse information from my medical health record, any information concerning the performance of any tests, results of those tests, and counseling and treatment records, as allowed by all state, federal and local laws, including, but not limited to the following: Florida Statutes 394.459, 381.004, and 395.3025; Florida Evidence Code 90.503, 90.5035, and 90.5036; HIPAA,

and the Code of Federal Regulations (CFR) Title 42. I consent to my minor participating in online or paper surveys that will be used for program improvements and enhancements. I understand that my records have a privileged and confidential status. I am waiving that status for the purposes contained by this Authorization.

I understand that the confidential information disclosed, received or used by JWB based on this Authorization will not be further disclosed to any other party without my express written consent or as otherwise permitted or required by applicable law. However, the individually identifiable confidential information received by JWB based on this Authorization may be used by JWB and its agents for research purposes, so long as the research results are reported as a whole in de-identified format, which means that no information that identifies me as an individual is revealed. Except, JWB will not provide any records covered by CFR Title 42 to any JWB agents.

I understand that I have the right to withdraw my approval in writing at any time. However, it is possible that JWB may have already relied on this Authorization before it receives notice of my withdrawal and that JWB may have already taken action based on the Authorization. If I do not withdraw my approval, it will automatically end one (1) year from the last day I received services from this program, or with respect to information used in research, or for compliance and quality review activities performed by JWB or its agents, upon completion of the last research project or compliance/ quality review, whatever occurs latest. By my signature below, I acknowledge that I have given my consent as indicated above freely, voluntarily, and without coercion, and that I have been given a copy of this authorization, signed by me on the date shown below.

_____ _____

Parent/Guardian Print Name Signature of Parent/Guardian

_____

Date

FORM 3

CHILD'S ENROLLMENT RECORD

DIRECTOR'S USE ONLY

Date enrolled_____

Child's Full Legal Name_____
First *Middle* *Last* *Nickname*

Date of Birth _____ **Sex**_____ **School**_____ **Grade**_____

Primary Hours of Care From_____ To_____ **Days of Week in Care**_____

Child's Physical Address_____
Street Address (number, apartment #, street) *City* *State* *Zip Code*

Family Information: **Child Lives with**_____

Parent's Name_____
First *Middle Initial* *Last*

Address:_____

_____
City *State* *Zip Code*

Home Phone:_____

Employer:_____

Address:_____

_____
City *State* *Zip Code*

Parent's Date of Birth_____

Work Phone_____ Other_____

Parent's Email _____

Parent's Name_____
First *Middle Initial* *Last*

Address:_____

_____
City *State* *Zip Code*

Home Phone:_____

Employer:_____

Address:_____

_____
City *State* *Zip Code*

Parent's Date of Birth_____

Work Phone_____ Other_____

Parent's Email _____

Custody: Mother_____ Father_____ Both_____ Other_____ Name_____

Emergency Contacts:
Child will be released only to the custodial parent or legal guardian and the persons listed below. The following people will also be contacted and are authorized to remove the child from the children's center in case of illness, accident or emergency, **if for some reason the custodial parent(s) or legal guardian(s) cannot be reached:**

Name_____ Date of Birth_____

Home Phone_____ Cell Phone_____

Address_____
Street Address (number, apartment #, street) *City* *State* *Zip Code*

Name_____ Date of Birth_____

Home Phone_____ Cell Phone_____

Address_____
Street Address (number, apartment #, street) *City* *State* *Zip Code*

Please use additional sheet of paper to list name, address and phone number of any other people authorized to pick the child up.

CONTINUED ON BACK

CHILD'S ENROLLMENT RECORD
(Back Page)

Medical Information:

Child's Physician/Health Resource_____

Telephone Number _____

Address_____
Street Address (number, apartment #, street) *City* *State* *Zip Code*

Hospital Preference_____

Name of Dentist_____ Telephone_____

Address_____
Street Address (number, apartment #, street) *City* *State* *Zip Code*

Meals typically served while in care: ☐ Breakfast ☐ AM Snack ☐ Lunch ☐ PM Snack ☐ Supper

Emergency Care Plan Instructions (if applicable)_____

MISCELLANEOUS INFORMATION

List all known allergies_____

List all identifying scars, birthmarks, skin discolorations_____

Special medical or dietary needs of child_____

List any areas of concern_____

My signature below verifies that:

I give permission to consult the child's physician/health resource listed above in case of emergency if parent/guardian cannot be reached.

I have received a copy of the "Know Your Child's Children's Center" brochure.

I was notified in writing of the disciplinary and expulsion policies used by the children's center.

I was provided the food and nutrition policies used by the children's center.

Your signature below indicates that you have received the above items and that the information on this enrollment form is complete and accurate. I hereby grant permission for the staff of this facility to have access to my child's records.

_____

Signature of Custodial Parent or Legal Guardian **Date**

FORM 4

EMERGENCY MEDICAL RELEASE

This form must contain only one child's name, and be the original notarized form.

A new notarized form is required when there is a change in legal guardianship.

Please Print Information

Child's Full Name:_____ Birthdate:_____

Allergies:_____

Medicines Routinely Taken:_____

Name of Custodial Parent(s)/Legal Guardian(s):_____

Address:_____ _____ _____ _____
Street Address (number, apartment #, street) *City* *State* *Zip Code*

Home Telephone _____ Cell Telephone_____ Work Telephone _____

Family Physician's Name/Health Care Resource:_____

Address:_____ _____ _____ _____
Street Address (number, apartment #, street) *City* *State* *Zip Code*

Telephone (___)_____

Hospital Preference:_____
Name *City*

Medical Insurance Company:_____

Policy #:_____ Expiration Date:_____

Emergency Contact (if custodial parent/guardian cannot be reached**):**_____

Address:_____ _____ _____ _____
Street Address (number, apartment #, street) *City,* *State,* *Zip Code*

Home Telephone _____ Cell Telephone _____ Work Telephone _____

Sign in the presence of the Notary.

I hereby give my consent to any emergency facility and physician to administer necessary treatment to my child _____, in the event of an emergency at which time
(Child's Full Name)
I cannot be reached. I give consent to transport by ambulance if situation warrants it.

_____
Signature of Custodial Parent/Legal Guardian (Affiant)

STATE OF FLORIDA COUNTY OF _____

The foregoing instrument was acknowledged before me this _____ _____ 20_____
(Month) *(Day)* *(Year)*

by means of ☐ physical presence or ☐ online notarization by _____ who is personally known
(Name of Affiant)

to me or has produced _____as identification.
(Type of identification)

SEAL OF NOTARY

Signed:_____(*Signature of Notary)*

FORM 5

Food Experience Permission Form

I give permission for my child _____ to participate in food related activities.

Please check one of the following:

_____☐_____ My child DOES NOT have a food allergy or dietary restriction.

_____☐_____ My child DOES have a food allergy or dietary restriction. He or she may participate, but may not eat or handle the following items (please list below)

_____

_____

_____☐_____ My child DOES have a food allergy or dietary restriction. He or she may not participate in activities.

_____ _____

Parent Signature Date

C- 1050 Sample Form PCLB 12/13