

CHAP REGISTRATION FORM 5780 (2019-20)		SITE: <input type="checkbox"/> AWK8 <input type="checkbox"/> VABHOE <input type="checkbox"/> CHABAD <input type="checkbox"/> _____	
STUDENT'S INFORMATION			
First & Last Name			
Hebrew Name		Gender	DOB Night or Day?
Grade Entering		School Entering	
Child's Cell		Child's E-Mail	
Any Previous Jewish Education? Where?			
PARENT'S INFORMATION			
Child lives with <input type="checkbox"/> Both Parents <input type="checkbox"/> Mother <input type="checkbox"/> Father <input type="checkbox"/> _____			
<u>MOTHER</u>		<u>FATHER</u>	
<input type="checkbox"/> Single <input type="checkbox"/> Married to father <input type="checkbox"/> Married to other		<input type="checkbox"/> Single <input type="checkbox"/> Married to mother <input type="checkbox"/> Married to other	
First & Last Name:		First & Last Name:	
Full Address:		Address: (if different than mother's address)	
Home ph #: () -		Home ph #: () -	
Cell ph #: () -		Cell ph #: () -	
Work ph #: () -		Work ph #: () -	
E-mail:		E-mail:	
Jewish? <input type="checkbox"/> By Birth <input type="checkbox"/> Converted <input type="checkbox"/> Not Jewish If converted, please provide documentation		Jewish? <input type="checkbox"/> By Birth <input type="checkbox"/> Converted <input type="checkbox"/> Not Jewish If converted, please provide documentation	
Occupation:		Occupation:	
Are there any ways you can be of assistance? Do you have access to any products that can help with the program or new building? Would you like to join a committee?			
Is your family a member of a Synagogue? If yes, please specify:			
COMMUNICATION			
Which way will you <u>commit</u> to respond to? <input type="checkbox"/> E-Mail <input type="checkbox"/> Facebook <input type="checkbox"/> Text Message <input type="checkbox"/> Phone Message <input type="checkbox"/> Snail Mail			
OTHER CHILDREN IN THE FAMILY			
	Child 1	Child 2	Child 3
Name			
Hebrew Name / DOB			
EMERGENCY CONTACT & HEALTH RECORD			
In case of emergency, if either parent cannot be reached, I give authorization to contact:			
Emergency Contact #1:		Emergency Contact #2:	
Relationship to Child:		Relationship to Child:	
Phone #		Phone #	
Primary Care Physician:		Phone #	
Physician's Address:			
Medical Conditions/ Allergies:			
Medications/ Treatments:			
Special Dietary or Other Health Needs:			
Does Child Have Health Insurance? <input type="checkbox"/> Yes <input type="checkbox"/> No Carrier: _____ Policy #: _____ (If not, the Children's Trust may be able to help you find affordable coverage-call 211 or visit www.thechildrenstrust.org)			

INFO FOR COUNTY

Is Child Proficient in English? Yes No | Other Languages Spoken: _____ | Country of Origin: _____

Miami-Dade County Public School ID | Last 4 Digits of Child's Social Security #

Child's Ethnicity: _____ | Child's Race: _____

Does child have a Psychoeducational Evaluation? Yes No | Date _____ | Please Attach a Copy

Number of Children Living in the Household (including child participant) _____

PICK UP DESIGNATION

The following person(s), other than carpool and parents are authorized to pick up my child. A note from you indicating who will pick up the child is still required even though you have indicated authorized persons. Your advanced notice will allow us to expect the alternate, and prepare your child without confusion. Thank you in advance for your prompt attention to this request and your continued cooperation.

Name # 1: _____ | Relationship to Child: _____ | Phone #: _____

Name # 2: _____ | Relationship to Child: _____ | Phone #: _____

Name # 3: _____ | Relationship to Child: _____ | Phone #: _____

My child has permission to walk home from the afterschool site between the hours of: _____ and _____

CERTIFIED INSTRUCTOR CONSENT

As per Department of Children & Families (DCF) standards, please be advised that we provide certified instructors licensed in the state of Florida and child enrichment service providers that are not a part of our regular child care program. These certified instructors are currently contracted with us to provide a higher quality of literacy and fitness instruction throughout the year. Your initial signifies that you are agreeing to your child's participation in the activities as instructed by our certified instructors throughout the year, including full days, teacher planning days, breaks and any holiday programming that we may conduct.

PERMISSION TO CROSS STREET

With the many activities that we have planned for this year's program, it is necessary to utilize both the classrooms in Aventura Waterways K-8 Center and our buildings at 2601 & 2611 N.E. 211th Terrace, & 2600 NE 212th Terrace, Miami Fl 33180, as well as other properties on the block. Therefore, we will require your permission to transport your child(ren) between locations.

FIELD TRIP STATEMENT

I allow my child to participate in trips off Chabad Chayil grounds.
I understand these trips will include busing to another facility and location.

PHOTO RELEASE STATEMENT

I hereby grant permission for photography and videography, taken by the staff of Chabad Chayil, CHAP & The Children's Trust, of myself and my child's activities at school, camp or any activities related it for promotional or public relations purposes. I agree that I am to receive no compensation for my child's appearance and that this participation confers on me no ownership rights whatsoever.

MEDICAL EMERGENCY

I give permission for my child to receive Tylenol and/or other medications and receive first aid when deemed necessary. I give permission for my child to receive emergency medical treatment from physicians in a medical facility, should he/she become seriously injured or ill. **Please list** any special medical instructions under Emergency Contact & Health Record section on previous page.

PARENT POLICY AGREEMENT

I have read the following in its entirety. I understand its content and agree to abide by the policies and procedures.

PLEASE INITIAL ___ Certified Instructors Consent ___ Permission to Cross Street ___ Fieldtrip Statement

___ Photo/Video Release Statement ___ Medical Emergency Authorization ___ I have received a copy of Parent Handbook

Parent/Guardian Name: _____ | Signature: _____



The Youth Experiencing Success Program is funded by The Children's Trust. The Trust is a dedicated source of revenue established by voter referendum to improve the lives of children and families in Miami-Dade County.



INFLUENZA VIRUS

2018-2019

During the 2009 legislative session, a new law was passed that requires child care facilities, family day care homes and large family child care homes provide parents with information detailing the causes, symptoms, and transmission of the influenza virus (the flu) every year during August and September.

My signature below verifies receipt of the brochure on Influenza Virus, The Flu, A Guide to Parents:

Name: _____

Child's Name: _____

Date Received: _____

Signature: _____

Please complete and return this portion of the brochure to your child care provider, in order for them to maintain it in their records.

*****Brochure is in your copy of Student and Parent Handbook*****

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)

- | | |
|----------------------------------------------------------------|------------------------------------------------------------------------------|
| <input type="checkbox"/> Speaks and is easily understood | <input type="checkbox"/> Uses communication devices like pictures or a board |
| <input type="checkbox"/> Speaks but is difficult to understand | <input type="checkbox"/> Uses gestures like pointing, pulling or blinking |
| <input type="checkbox"/> Uses sign language | <input type="checkbox"/> Uses sounds that are not words like grunting |

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

- | | |
|--------------------------------------------------------------------|---------------------------------------------------------------|
| <input type="checkbox"/> Speech/language therapy | <input type="checkbox"/> Special education services in school |
| <input type="checkbox"/> Occupational therapy (OT) | <input type="checkbox"/> Behavioral therapy or services |
| <input type="checkbox"/> Physical therapy (PT) | <input type="checkbox"/> Counseling for emotional concerns |
| <input type="checkbox"/> Daily medication (not including vitamins) | <input type="checkbox"/> None |

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

- | | |
|------------------------------------------------------------|------------------------------------------------------------------------------|
| <input type="checkbox"/> Physical disability or impairment | <input type="checkbox"/> Developmental delay (only if under age 5) |
| <input type="checkbox"/> Medical condition or illness | <input type="checkbox"/> Problems with learning (if school-age) |
| <input type="checkbox"/> Hearing impairment or deaf | <input type="checkbox"/> Problems with attention or hyperactivity (ADHD/ADI) |
| <input type="checkbox"/> Visual impairment or blind | <input type="checkbox"/> Problems with depression or anxiety |
| <input type="checkbox"/> Speech or language condition | <input type="checkbox"/> Problems with aggression or temper |
| <input type="checkbox"/> Autism spectrum disorder | <input type="checkbox"/> 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 _____
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FOR STAFF USE ONLY (*MUST BE COMPLETED*)

ORGANIZATION _____ SITE _____

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

Permission for Food-related Activities & Special Occasion Food Consumption

Pursuant to 65C-22.005(1)(c)2., F.A.C., licensed child care facilities must obtain written permission from parents/guardians regarding a child's participation in food related activities. These activities include such things as: classroom cooking projects, gardening, school wide celebrations, and birthdays.

I _____ give/decline permission for my child _____
(Parent Guardian) (circle one) (Child's Name)

to participate in food related activities and special occasions wherein food is consumed.

Please provide the following information:

____My child **DOES NOT** have a food allergy or dietary restriction. He or she **may** participate in activities.

____My child **DOES NOT** have a food allergy or dietary restriction. He or she **may not** participate in activities.

____My child **DOES** have a food allergy or dietary restriction. He or she **may** participate in activities, 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

I understand that it is my responsibility to update this form in the event that my decision for permission changes. I agree that this form will remain in effect during the term of my child's enrollment.

(Parent or Guardian)

(Date)



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DISCIPLINE POLICY

Dear Parents,

Our program will insure that age-appropriate, constructive disciplinary practices are used for your child. This care will allow the child time to look over his or her behavior. We will encourage children to choose alternatives to improper behavior. To ensure a safe and successful program, discipline is a must. We welcome the ideas of parents, so feel free to share them with us.

The following disciplinary policy will be administered for behavior modification:

1st - Children will be corrected and asked to change their behavior.

2nd - Children will be re-directed from the situation.

3rd - Children will be placed in "quiet time."

4th - Verbal communication between parent and program director

5th - Written notification from program director to the parent outlining the problem and corrective measures taken

6th - Continued disruptive behavior may result in dismissal from program.

7th - **Children shall not be subjected to discipline which is sever, humiliating, or frightening.**

8th - **Discipline shall not be associated with food, rest, or toileting.**

9th - **Spanking or any other form of physical punishment is prohibited.**

10th - **Children may not be denied active play as a consequence of misbehavior.**

Child's Name: _____

Parent/Guardian Name: _____

Date: _____

Signature _____

CONNOR'S SCALE

This program is generously funded by

PARENTS QUESTIONNAIRE



OBSERVATION	DEGREE OF ACTIVITY			
	Not At All	Just A Little	Pretty Much	Very Much
CLASSROOM BEHAVIOR				
1. Constantly fidgeting.				
2. Hums and makes other odd noises.				
3. Demands must be met immediately - easily frustrated.				
4. Poor Coordination.				
5. Restless or Overactive.				
6. Excitable, impulsive.				
7. Inattentive, easily distracted.				
8. Fails to finish things he or she starts - short attention span.				
9. Overly sensitive.				
10. Overly serious or sad.				
11. Daydreams.				
12. Sullen or sulky.				
13. Cries often and easily.				
14. Disturbs other children.				
15. Quarrelsome.				
16. Mood changes quickly and drastically.				
17. Acts "smart".				
18. Destructive.				
19. Steals.				
20. Lies.				
21. Temper outbursts, explosive and unpredictable behavior.				
GROUP PARTICIPATION				
22. Isolates himself or herself from other children.				
23. Appears to be unaccepted by group.				
24. Appears to be easily led.				
25. No sense of fair play.				
26. Appears to lack leadership.				
27. Does not get along with opposite sex.				
28. Does not get along with same sex.				
29. Teases other children or interferes with their activities.				
ATTITUDE TOWARD AUTHORITY				
30. Submissive.				
31. Defiant.				
32. Impudent.				
33. Shy.				
34. Fearful.				
35. Excessive demands for teacher's attention.				
36. Stubborn.				
37. Overly anxious to please.				
38. Uncooperative.				
39. Attendance problem.				

Addendum to CHAP Registration Form

Student Name _____ Grade _____

SCHEDULE

Any Special Early Pickup Procedures:

Homework Help Schedule (if not standard):

Please remember that Friday dismissal is at 5:00 the latest! PLEASE be on time so that our staff can go home for Shabbat!

Notes:

PTA VOLUNTEER

It takes a village to raise a child! Are you able to help? Being a part of the PTA can be a full-time commitment or just a few hours per month, and we'd appreciate your participation with however much of yourself you can share!

- Class Mother
 Homework Help
 Monthly Birthday Party Committee
 Holiday Party Committee
 Fundraising
 Movie Night Committee
 End-of-Year Dinner Committee
 Yearbook Journal Committee
 Street Fair Committee

Any other way you can help out?

CHAP DONATION

Books & Supplies	A \$250+ Value Discounted at Time of Registration	\$125
Suggested Monthly Donation	It costs us \$17-\$25 per day, per child, to operate CHAP. Although we don't charge for the program, we ask parents to donate if they can, to help cover the costs. Children are accepted regardless of payment.	\$
Late Pickup	Begins 10 Minutes after dismissal - Billed at \$1 per minute	\$10
Transportation	Monthly (\$7 per day based on daily attendance averages out to \$130 per month)	\$130
Total Paid at Registration \$		Method
Terms		<input type="checkbox"/> Credit Card on File <input type="checkbox"/> Head Checks <input type="checkbox"/> Advance Full Payment
Credit Card #	Exp Date	CUV
Name _____	Date	For Internal Use Registered with _____ <input type="checkbox"/> Attendance <input type="checkbox"/> CRM <input type="checkbox"/> Complete Double checked & filed by _____
Signature _____		