**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 _____

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**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

**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.***

FORM 6

## What should I do if my child gets sick?

Consult your doctor and make sure your child gets plenty of rest and drinks a lot of fluids. Never give aspirin or medicine that has aspirin in it to children or teenagers who may have the flu.

**CALL OR TAKE YOUR CHILD TO A DOCTOR RIGHT AWAY IF YOUR CHILD:**

- Has a high fever or fever that lasts a long time
- Has trouble breathing or breathes fast
- Has skin that looks blue
- Is not drinking enough
- Seems confused, will not wake up, does not want to be held, or has seizures (uncontrolled shaking)
- Gets better but then worse again
- Has other conditions (like heart or lung disease, diabetes) that get worse

## How can I protect my child from the flu?

A flu vaccine is the best way to protect against the flu. Because the flu virus changes year to year, annual vaccination against the flu is recommended. The CDC recommends that all children from the ages of 6 months up to their 19th birthday receive a flu vaccine every fall or winter (children receiving a vaccine for the first time require two doses). You also can protect your child by receiving a flu vaccine yourself.

## What can I do to prevent the spread of germs?

The main way that the flu spreads is in respiratory droplets from coughing and sneezing. This can happen when droplets from a cough or sneeze of an infected person are propelled through the air and infect someone nearby. Though much less frequent, the flu may also spread through indirect contact with contaminated hands and articles soiled with nose and throat secretions. To prevent the spread of germs:

- Wash hands often with soap and water.
- Cover mouth/nose during coughs and sneezes. If you don't have a tissue, cough or sneeze into your upper sleeve, not your hands.
- Limit contact with people who show signs of illness.
- Keep hands away from the face. Germs are often spread when a person touches something that is contaminated with germs and then touches his or her eyes, nose, or mouth.

## When should my child stay home from child care?

A person may be contagious and able to spread the virus from 1 day before showing symptoms to up to 5 days after getting sick. The time frame could be longer in children and in people who don't fight disease well (people with weakened immune systems). When sick, your child should stay at home to rest and to avoid giving the flu to other children and should not return to child care or other group setting until his or her temperature has been normal and has been sign and symptom free for a period of 24 hours.

**For additional helpful information about the dangers of the flu and how to protect your child, visit:** http://www.cdc.gov/flu/

## What is the influenza (flu) virus?

Influenza ("the flu") is caused by a virus which infects the nose, throat, and lungs. According to the US Center for Disease Control and Prevention (CDC), the flu is more dangerous than the common cold for children. Unlike the common cold, the flu can cause severe illness and life threatening complications in many people. Children under 5 who have the flu commonly need medical care. Severe flu complications are most common in children younger than 2 years old. Flu season can begin as early as October and last as late as May.

## How can I tell if my child has a cold, or the flu?

Most people with the flu feel tired and have fever, headache, dry cough, sore throat, runny or stuffy nose, and sore muscles. Some people, especially children, may also have stomach problems and diarrhea. Because the flu and colds have similar symptoms, it can be difficult to tell the difference between them based on symptoms alone. In general, the flu is worse than the common cold, and symptoms such as fever, body aches, extreme tiredness, and dry cough are more common and intense. People with colds are more likely to have a runny or stuffy nose. Colds generally do not result in serious health problems, such as pneumonia, bacterial infections, or hospitalizations.

Florida Department of Children & Families

For additional information, please visit www.myflorida.com/childcare or contact your local licensing office below:

CF/PI 175-70, June 2009

*This brochure was created by the Department of Children and Families in consultation with the Department of Health.*

# INFLUENZA VIRUS

**"The Flu" A Guide for Parents**