

Citizens Alliance for Progress, Inc.
YOUTH DEVELOPMENT APPLICATION

YOUTH PARTICIPANT INFORMATION

First Name _____ Middle _____ Last Name _____ DOB _____ Age _____

DEMOGRAPHIC

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

Race: *Please select one (1) option*

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

Spanish, Hispanic or Latino Ethnicity: *Please select one (1) option*

☐ Not Applicable ☐ Puerto Rican ☐ Cuban ☐ Mexican, Mexican American, Chicano ☐ Other _____

Any other language(s) spoken at home: ☐ No ☐ Yes, *please specify* _____

EDUCATION

Student Id # _____ School _____ Grade _____

Does student have or receive any of the following:

Special Education Services ☐ No ☐ Yes Bilingual or ESL Services ☐ No ☐ Yes

Attention Deficit Hyperactivity (ADHD) or ADD? ☐ No ☐ Yes IEP or 504 Plan ☐ No ☐ Yes

HOUSEHOLD INFORMATION

Parent / Guardian Name #1 (Head of Household)

☐ Male ☐ Female

First Name _____ M.I. _____ Last Name _____

Contact # _____

Relationship to Child

☐ Mother ☐ Father ☐ Other _____

Parent / Guardian Name #2 or Alternate Contact

☐ Male ☐ Female

First Name _____ M.I. _____ Last Name _____

Contact # _____

Relationship to Child

☐ Mother ☐ Father ☐ Other _____

Address _____

City _____ State _____ Zip Code _____

Family Email Address _____

Household Arrangement

☐ Dual Parent (☐ Married ☐ Non-Married) ☐ Single Parent ☐ Relative/Kinship Care (☐ Married ☐ Non-Married)

Current **Living** Situation: ☐ Own/Rent ☐ Temporary Housing Situation ☐ Homeless Shelter ☐ Other, please explain _____

Household Annual Income: \$ _____ **# of Adults** in Household _____ **# of Minor Children** in Household _____
(Before Taxes)

Other children in the program? ☐ No ☐ Yes If YES, please list: _____

Parent / Guardian Signature _____

Date _____

Office Use Only

☐ **New** Participant ☐ **Returning** Participant ☐ **Information Update** **REFERRED BY** _____
☐ Academic Enhancement ☐ Summer Enrichment Camp ☐ Summer Career Institute ☐ Youth Development / Drop In

Episode Start Date _____ Episode Close Date _____ Reason for Closure _____

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

I, _____, (Print Participant Name) acknowledge that I am a participant of **Citizens Alliance for Progress, Inc. (CAP)**. 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 provides no direct services to me, including, but not limited to, coordination of services, recommendation of services, or medical diagnoses. I further acknowledge that 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, 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, upon completion of the last research project. 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.

Participant Name

Effective Date

Signature of Participant - or -
Participant's **Authorized Representative** (check one):
☐ Participant ☐ Parent ☐ Guardian
☐ Personal Representative (Legal Documents Required)

Witness Signature

Date

INFORMED CONSENT

MEDIA RELEASE

I agree to allow my child _____ to be photographed and/or video/audio-taped by Citizens Alliance for Progress, Inc. (CAP) staff or their designee and for those photos and/or videos to be used for the advertising and promotion of Citizens Alliance for Progress, Inc. (CAP) programs. I hereby forever release and discharge Citizens Alliance for Progress, Inc. (CAP) from any and all claims, actions, demands arising out of or in connection with the use of said photographs or videos, including, without limitation, any and all claims for invasion of privacy and libel. This release shall inure to the benefit of the assignees, licensees and legal representatives of Citizens Alliance for Progress, Inc. (CAP).

FIELD TRIP RELEASE

I understand that my child's participation in CAP - Youth Development Program will include attending trips to various locations. I hereby give permission for my child to **attend all of the trips scheduled by Citizens Alliance for Progress, Inc. (CAP) program staff**. In exchange for permission for my child to participate in the program and attend the field trips, I knowingly agree to waive and release from any and all claims an causes of action that I may acquire against Citizens Alliance for Progress, Inc. (CAP), its trustees, officers, employees, or agents thereof for any and all injuries, loss or damage which my child may suffer or which are in any way connected with my child's participation in the program and field trips.

AUTHORIZATION TO PARTICIPATE:

I, _____ the parent/guardian of _____, hereby register him/her for participation in the CAP – Youth Development Program. I further agree that I am the legal parent or guardian of the above names child and the information provided on this registration is true and accurate.

Parent/Guardian Name-Please Print

Parent/Guardian Signature

Date

Citizens Alliance for Progress

EMERGENCY MEDICAL RELEASE

Please Print Information

Youth 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 _____

Parent/Guardian Name-Please Print

Parent/Guardian Signature

Date

