



Student
Photo Here

Grades K-5

AFTERSCHOOL 2021-2022 PARTICIPANT APPLICATION

Dates: August 23, 2021 - June 8, 2022 Time: Monday - Friday 2pm - 6pm

- | | |
|--|---|
| <input type="checkbox"/> Bel-Aire ES: 10250 SW 194th St., Cutler Bay, FL 33157 | <input type="checkbox"/> Pneuma Academy: 7205 SW 125th Ave, Miami FL 33183. |
| <input type="checkbox"/> El Buen Pastor Church: 310 E 5th St., Hialeah, FL 33010 | <input type="checkbox"/> Riverside United Methodist Church, 985 NW 1st St, Miami FL 33128. |
| <input type="checkbox"/> Great Heights Academy: 9280 Hammocks Blvd Miami FL, 33196 | <input type="checkbox"/> Wayside Baptist Church: 7701 SW 98th St, Kendall FL 33156 |
| <input type="checkbox"/> Pinelands Presbyterian Church: 10201 Bahia Dr., Miami, FL 3318 | |

Has your child ever participated in our WhizKidz afterschool or summer camp programs? ☐ YES or ☐ NO

How did you hear about our Organization/Program?

- | | | |
|--|---|--|
| <input type="checkbox"/> Not Applicable | <input type="checkbox"/> Walk-in | <input type="checkbox"/> Natural Helpers |
| <input type="checkbox"/> School / HClOS | <input type="checkbox"/> Other | <input type="checkbox"/> Early Steps North |
| <input type="checkbox"/> Childcare | <input type="checkbox"/> Schools | <input type="checkbox"/> Early Steps South |
| <input type="checkbox"/> Other TCT Programs | <input type="checkbox"/> Self-referral | <input type="checkbox"/> FDLRS |
| <input type="checkbox"/> Internal Referral | <input type="checkbox"/> DCF/ Our kids/ Child Welfare | <input type="checkbox"/> Family and Neighborhood Supports Partnerships |
| <input type="checkbox"/> Helpline (211/Switchboard) | <input type="checkbox"/> Police Department | <input type="checkbox"/> MDCPS Truancy Intervention |
| <input type="checkbox"/> Faith Based Partners | <input type="checkbox"/> Health Care Provider | <input type="checkbox"/> Parent Club |
| <input type="checkbox"/> Community Based Organizations | <input type="checkbox"/> DJJ/Juvenile Services | |

CHILD INFORMATION

Child's First Name: _____ Middle: _____ Last Name: _____

Child's Gender: ☐ Male ☐ Female

Child's Date of Birth: (mm/dd/yyyy)
(Mandatory)

M	M	D	D	Y	Y	Y	Y

Child's Current School Name: _____ Child's Current Grade

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(2021-2022 School Year)

Miami-Dade County Public Schools ID #
(Mandatory)

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☐ No MDCPS ID#

ALL STUDENTS ATTENDING PUBLIC OR CHARTER SCHOOLS SHOULD HAVE A SCHOOL ID ENTERED. ALL STUDENTS WHO ATTEND A PRIVATE SCHOOL PLEASE SELECT NO MDCPS ID#

Is your Child Proficient in English? ☐ Yes ☐ No

Other Language(s) Spoken in the Home: ☐ Spanish ☐ Haitian-Creole ☐ Sign Language ☐ Other _____ ☐ None

CHILD INFORMATION (Continued)

Child's Home Address: _____

Apt/ Unit: _____ City: _____ ZIP Code: _____

Child's Ethnicity: (select only one) ☐ Hispanic ☐ Haitian ☐ Other: _____Child's Race: (select only one) ☐ American Indian or Alaskan Native ☐ Asian ☐ Black or African American
☐ Pacific Islander ☐ White ☐ Multiracial ☐ Other _____Does child live with a legal guardian other than mother or father? ☐ Yes ☐ NoFamily Status: (select only one): ☐ Married ☐ Not Married ☐ Single Female ☐ Single Male
☐ Guardianship/Foster Care ☐ Other: _____Is child a part of the dependency system? ☐ Yes ☐ No
(Ex. DCF, Our Kids, Full Case Management Agencies, Family Courts etc.)Is child apart of the delinquency system? ☐ Yes ☐ No
(Ex. Department of Juvenile Justice, Civil Citation Programs, etc.)Does child receive free or reduced lunch? ☐ Yes ☐ NoDoes Child Have Health Insurance? (ex., private insurance, KidCare, Medicaid) ☐ Yes ☐ No(If not, we may be able to help you find affordable coverage-call 211 or visit www.thechildrenstrust.org). Please note that The Children's Trust may contact you via postal mail, email and/or text to ask about your satisfaction with these services, and to make you aware of other Trust-funded programs, initiatives and events you may be interested in.

Child's Insurance Information: (If child has no current insurance coverage, please write "not applicable" or "N/A")

Carrier: _____ Doctor's Name: _____ Phone Number: _____

PARENT/ GUARDIAN INFORMATION

(Please be aware that you may be contacted by the Children's Trust to ask about your satisfaction with these services)

Child's Primary Caregiver (full name): _____

Primary Phone Number: _____ Is this a cell/mobile phone? ☐ Yes ☐ No
(Please write "not applicable" or "N/A", if no answer)

Primary Caregiver E-Mail (Please write "not applicable" or "N/A", if no answer): _____

Child's Secondary Caregiver (full name): _____

Primary Phone Number: _____ Is this a cell/mobile phone? ☐ Yes ☐ No
(Please write "not applicable" or "N/A", if no answer)

CHILD'S MEDICAL INFORMATION

We want to get to know your child better so we can provide the best possible experience for your child. Please tell us more about your child. I give permission for this information to be submitted to the Trust for program quality/evaluation purposes.

1) What are the main ways your child communicates? (Mark all that apply)

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

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

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

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

- | | |
|---|--|
| <input type="checkbox"/> Autism Spectrum Disorder | <input type="checkbox"/> Problems with aggression or temper |
| <input type="checkbox"/> Developmental delay (only if under age 5) | <input type="checkbox"/> Problems with attention or hyperactivity (ADHD/ADD) |
| <input type="checkbox"/> Hard of hearing, deaf, or hearing impaired | <input type="checkbox"/> Problems with depression or anxiety |
| <input type="checkbox"/> Intellectual/developmental disability (over 5) | <input type="checkbox"/> Speech or language condition |
| <input type="checkbox"/> Learning Disability (school age) | <input type="checkbox"/> Visual impairment or blind |
| <input type="checkbox"/> Medical Condition or illness | <input type="checkbox"/> None of the above |
| <input type="checkbox"/> Physical disability or impairment | |

4) Does Child have an IEP or a 504 Plan? ☐ Yes (If yes, please attach) ☐ No

5) To support your child's successful participation in this program, in what areas might s/he need extra assistance?

- ☐ No specific help needed
- ☐ Academic, learning or reading activities
- ☐ Adapting activities to take into account a visual or hearing impairment
- ☐ Holding a crayon/pencil, writing, using scissors or other fine motor tasks
- ☐ Managing feelings and behavior
- ☐ Personal services like help with feeding, toileting or changing clothes
- ☐ Sports or physical activities like running or other gross motor tasks
- ☐ Using assistive device(s) like a wheelchair, crutches, brace or walker
- ☐ Other _____

6) 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

7) Please circle or fill-in anything that applies to your child in the chart below.

Medication which affect: Learning, Physical Fitness Activities and Social Engagement	Food Allergies	Other Serious Allergies	Chronic Health Conditions	Physical Limitations which affect: Learning, Physical Fitness Activities and Social Engagement
<input type="checkbox"/> Antibiotics <input type="checkbox"/> Medication for chronic Health <input type="checkbox"/> Hyper Activity Medication <input type="checkbox"/> Other: _____ <input type="checkbox"/> _____	<input type="checkbox"/> _____ <input type="checkbox"/> _____ <input type="checkbox"/> _____ <input type="checkbox"/> _____	<input type="checkbox"/> Grass <input type="checkbox"/> Mosquitoes <input type="checkbox"/> Bee Stings <input type="checkbox"/> Penicillin <input type="checkbox"/> Other: _____ <input type="checkbox"/> _____	<input type="checkbox"/> Asthma <input type="checkbox"/> Diabetes <input type="checkbox"/> Sickle Cell Anemia <input type="checkbox"/> Seizures <input type="checkbox"/> Skin Condition <input type="checkbox"/> Seasonal Allergies <input type="checkbox"/> Reaction to Sunlight <input type="checkbox"/> Other: _____	<input type="checkbox"/> Other not listed above: _____ _____ _____ _____

EXCEPT AS NOTED ABOVE, my child is in good health, has no medical, food, other chronic allergies or serious health conditions. My child does not take medication routinely and his/her immunizations are current. If there is anything else you consider we need to know about, to better understand and provide the necessary help your child deserves, please speak to your Site Supervisor. All information is kept confidential and stored in locked cabinets. By signing on the last page I agree to the following.

CHILD'S EMERGENCY INFORMATION

I understand that every effort will be made to reach me for instructions if my child should become ill or injured while on the site or on a field trip. If in the judgment of the staff or a medical professional, delay in reaching me might jeopardize my child's well-being, I hereby authorize the staff or medical professional to secure whatever medical treatment is deemed necessary, including the administration of anesthetics and surgery. **IN THE EVENT THAT NO ONE CAN BE CONTACTED, I GIVE PERMISSION FOR MY SON/DAUGHTER TO RECEIVE EMERGENCY MEDICAL TREATMENT.**

If you would like for us to follow a different emergency/medical procedure, please write it/explain below: (You can continue on the back of this page)

(cont. back)

EMERGENCY / ALTERNATE PICK UP CONTACT INFORMATION

Other phone numbers where I can be reached during the day: _____ / _____ / _____

If I cannot be reached, please contact my designated alternate(s) named below:

1. _____	_____	_____
Name	Relationship to child	Cellular and/ or work Number
2. _____	_____	_____
Name	Relationship to child	Cellular and/ or work Number
3. _____	_____	_____
Name	Relationship to child	Cellular and/ or work Number

Please note: Any family or friends authorized to pick up your child, must have a valid picture ID for verification purposes. A copy of ID will be taken by site staff and placed in student's file for future confirmation. In the event that I, the legal guardian am not able to pick up my child on time, I will call the Site Supervisor and will authorize her/him to release my child to the persons listed above.

POLICY INFORMATION/CONSENT

Non-Discrimination Policy: Children who are 5 and have already attended or who are currently enrolled in kindergarten will be accepted into the Summer Camp and After-school program regardless of race, creed, immigration status, health, religion, disability, ethnicity or ability to pay for services. Children without documented legal status, or whose parents are without documented legal status will not be discriminated against for selection in these programs. As with the Miami-Dade County Public School system, all children are welcome. Children with severe physical, emotional or behavioral disabilities may find After-school programs specially designed to meet their needs through other programs, every effort will be made to find the most suitable placement for each child.

Parental Consent:

By signing this application on the next page, I agree and certify to the following Children's Trust Requirements:

- 1) **I acknowledge** that the application information and medical information I have provided above is true and complete to the best of my knowledge and ability.
- 2) As the legal guardian of _____, ☐ **I authorize and give consent** or ☐ **I DO NOT authorize or give consent** to Hope for Miami's staff (HFM), nor The Children's Trust (TCT) or service providers to take/use still photographs, digital photographs, motion pictures, television transmission, and/or videotapes recordings (hereinafter "Recordings") of me, my children, or my wards for educational, research, documentary, and public relations purposes. Any such Recordings may reveal my identity through the image itself without any compensation to me, my children or my wards. With regard to the use of any Recordings taken of me, my children or my wards, I hereby waive any and all present and future claims I may have against TCT or HFM, their staff, service providers, employees, agents, affiliates and Board members.
- 3) **I understand** that participation by my children in the Program sponsored by Hope for Miami, The Children's Trust and its partners involves physical education, meals, and off-site field trips. As these activities may carry some degree of risk to my child's physical and emotional health, I hereby release, hold harmless and waive all claims associated with out-of-school/summer camp program activities from HFM, and the program site and all employees, officers, directors, agents, and volunteers associated with the out-of-school/summer camp program.
- 4) **I understand** that no medication/medical equipment will be administered by the After-school personnel to my child without the "Authorization For Prescription and Non-Prescription Medication/Medical Equipment Form" signed by me as the parent/legal guardian. Also, I agree to provide instructions on how and when the medicine/medical equipment should be administered if my child were to need assistance with it. (Please, refer to parent handbook for more details).
- 5) As my child attends an Out-of-school program funded by the Children's Trust (either Summer Camp, After-school, Winter/Spring Camp or all programs), **I acknowledge** and understand that my child must adhere to all behavioral and policy driven rules and regulations the program sites require. Failure to abide by these rules, may lead to suspension and or removal of the program. I also acknowledge receipt of a written **Family Handbook** for this current program year, which details policies and procedures regarding my child and the program.
- 6) As the Out-of-school program (either Summer Camp, After-school, or Winter/Spring Camp) may take place on the premises of a religious organization, the primary purpose of the program is academic enrichment and a safe environment during out-of-school/Summer Camp time. However, your child may be invited to participate in other church activities on the premises or to **receive optional religious instruction**. Unless expressed written permission has been given by the parent or guardian to participate in the religious instruction, no child will be asked to participate, and no Children's Trust funds will be used for teacher stipends, books, curriculum or other expenses related to religious instruction. Such instruction will be given by church ministers or volunteers.

Please select the box concerning Religious instruction:

☐ **I authorize** my child to participate. Initial here: ____ ☐ **I do not authorize** my child to participate. Initial here: ____

- 7) My child will be arriving and leaving from the site in the following manner:

Arrival to the site: ☐ By bus/van. ☐ Walking from school. ☐ With authorized person/relative.
☐ With Parent/Guardian. ☐ Driving on their own

Leaving from the site: ☐ By bus/van. ☐ Walking from school. ☐ With authorized person/relative.
☐ With Parent/Guardian. ☐ Driving on their own

I **do not** give permission, under any circumstances, for my child to leave the program site with _____.

Relationship to child: _____. If possible, bring a picture to keep on file. **Child is allowed to go home with mother, father or legal guardian unless we have court documents stating otherwise due to custody battle or abuse. (Legal documentation must be provided).**

- 8) **I agree** to make every effort to ensure that my child participates in the program daily, unless he/she is too ill to attend. **I also agree** that I or my designated representative will **sign-out my child every day** he/she attends the program.
- 9) **I understand** that I am responsible to pick up my child at the end of the program day or arrange for an authorized person to pick up my child. Only those persons previously authorized in writing, may leave the premises with my child. I am aware of the **fees charged** for parent tardiness on pick-up at the end of the day. For Whiz Kidz sites, the late fee is \$1 per minute. The program ends at **6:00 PM** each day.
- 10) **I understand** that I need to call the Out-of-school/Summer Camp site supervisor if my child is not attending on a particular day so that that Supervisor is aware that my child will not be showing up on that day.
- 11) **I understand** that I am releasing the After-school/Summer Camp Program of any liability once my child has been dismissed from the program site.

I give my permission for the information in this application to be submitted to The Children's Trust and to Miami-Dade County Public Schools for program quality and evaluation purposes. The Children's Trust provides funding for the program. Miami-Dade County Public Schools provides academic supports for the program. *If you are interested in other services funded by The Children's Trust please call 211 or visit www.thechildrenstrust.org. For special needs resources for your child, visit www.advocacynetwork.org or www.thechildrenstrust.org/content/children-disabilities.*

I am signing that I have reviewed and agreed to all terms and conditions described in this application, all the program standards, Policies and Procedures and Parent Handbook:

Parent / Legal Guardian Signature

Date

Accidental Injury Insurance

If your child is enrolled in a program managed by Hope for Miami, they are covered for supplemental medical expenses should they have an accident **while participating in program activities, during regularly scheduled program hours**. If your family has medical insurance, this supplemental policy will cover some deductibles and uncovered expenses. If your family is uninsured, the child's medical expenses may be covered, if an injury were to occur (accidents only).

- Cost is \$ 10.00 per student. Money Order must be payable to Hope for Miami.
- Medical expenses for accidents in and out patient for a maximum of \$25,000.00
- \$100.00 deductible on this policy
- Includes \$10,000 Accidental Death benefit and Accidental Dismemberment benefit (should there be a serious injury).
- Coverage through July 29, 2022.

Site Supervisor USE ONLY (MUST BE COMPLETED)

Sibling(s) names in our program: 1. _____ 2. _____

3. _____ 4. _____ 5. _____

Sibling definition: One or more children having one or both parents in common or legally adopted.

Fees Collected :

Please Note: Only Money Orders are accepted. No checks, no cash nor credit cards are accepted.

Accident Insurance fee: \$10 collected: ☐ Yes ☐ No

Registration Fee: \$90.00 collected: ☐ Yes ☐ No

Summer Camp Fee: \$420.00 collected: ☐ Yes ☐ No

(\$370.00 if paid in full by 4/1/2022)

Parent Handbook given: ☐ Yes ☐ No

(Please make sure parent signs the acknowledgement)

FOR STAFF USE ONLY (MUST BE COMPLETED)

Verified by: _____ Date of registration: _____ Copy to HFM Office Personnel: _____

Tentative Start Date: _____ Withdrawn Date: _____ Returned Date: _____ Paid ☐ Fees N/A ☐
(When Applicable) (Participant will have to pay registration fee again)



“Getting to Know Me”

Child's Name: _____

Today's Date: _____

Grade Level: _____

Age: _____

Hope for Miami would like to learn more about your child so that we can provide them with the best possible learning experience while they are attending our program. No one knows your child better than you. Please tell us more about your child.

1. What is your child's favorite and/or calming and least favorite and/or upsetting; things, activities, rewards, and situation?

Favorite or Calming

Least Favorite or Upsets

2. Does your child require devices or equipment? (i.e. braces, walker, wheelchair, communication device, insulin, nebulizer, inhaler, EpiPen)

☐ Yes ☐ No If yes, please describe: _____

3. My child plays/interacts best (check all that apply):

☐ Independently ☐ With Adults ☐ Small group ☐ Large Group ☐ Outdoor ☐ Indoor
☐ With another child ☐ Additional comments

4. Does your child follow simple instructions? ☐ Yes ☐ Needs help

Comment/Incentives: _____

5. What type of learning style works best for your child? (check all that apply)

☐ Verbal Instruction ☐ Charts/Graphs ☐ Written Instructions ☐ Reminders

6. Do any of the following things bother your child?

☐ Noise ☐ Texture (i.e., sand, water) ☐ Lights ☐ Smells ☐ Animals ☐ Touch (i.e., hugs)
☐ Other: _____

7. Does your child wander or run away? ☐ Yes ☐ No

8. Is there anything else you would like for us to know about your child (i.e., allergies, diet, seizures, nosebleeds)

Revised 7/9/2021

Hope for Miami

550 NW 42 Ave, Miami FL 33126

Fourth Floor

Tel: 786-388-3000





Participant Acknowledgement of Hope for Miami In-Person After-School and Summer Camp Preventive Measures and COVID-19 Procedures:

As we continue to navigate through the COVID-19 Pandemic, we first and foremost want to thank you for trusting us with your children. We are deeply honored you have chosen us to keep your child safe during these critical times. Hope for Miami is dedicated to maintain and adhere to any and all updated CDC guidelines on preventative measures to stop the spread of COVID-19. Therefore, it is important to inform you of some changes and highlighted steps that remain crucial in reducing the spread of COVID-19.

The novel coronavirus, COVID-19, continues to be declared a worldwide pandemic by the World Health Organization. COVID-19 is extremely contagious and continues to spread mainly from person-to-person contact. As a result, federal, state, and local governments and federal and state health agencies recommend social distancing and have, in many locations, prohibited the congregation of groups of people without preventative measures.

Hope for Miami is dedicated to:

1. *Continue to establish communication with local and state authorities to determine current mitigation levels in our community.*
2. *Protect and support staff, children, and their family members who are at higher risk for severe illness.*

Based on the medical guidance received, Hope for Miami has outlined preventive measures that will be implemented by taking the following safety actions steps:

Safety Actions.

Promote healthy hygiene practices

1. We will reinforce washing hands (upon arrival to site, after using the restroom, sneezing, coughing, and before eating meals) and covering coughs and sneezes among staff (part of our Universal Precautions training for staff).
2. Teach and reinforce the use of face coverings (masks have been purchased) among all staff. Children that are able to wear face mask will be asked to do so for as long as they can be tolerated. Face coverings are essential at times when social distancing is not possible. Staff and children should be frequently reminded not to touch the face covering and to wash their hands often.
3. Information and training will be provided to all staff on proper use, removal, and washing of cloth face coverings (covered in staff orientation).
4. We will have adequate supplies to support healthy hygiene behaviors, including soap, hand sanitizer with at least 60 percent alcohol (for staff and older children who can safely use hand sanitizer). and tissues. We have supplies purchased and ready to deliver to sites.
5. Post signs on how to stop the spread of COVID-19, properly wash hands, promote everyday protective measures, and properly wear a face covering.

Intensify cleaning, disinfection, and ventilation

1. Clean, sanitize, and disinfect frequently touched surfaces (for example, door handles, sink handles, drinking fountains) multiple times per day, and shared objects between use.
2. Avoid the use of items (for example, soft or plush toys) that are not easily cleaned, sanitized, or disinfected.
3. Ensure the safe and correct application of disinfectants and keep products away from children.
4. Ensure that ventilation systems operate correctly and increase the circulation of air flow as much as possible.

Ensure social distancing

1. Ensure that classes include the same group of children each day and that the same childcare providers remain with the same group each day.
2. Provide minimal exposure by limiting the mixing between groups.
3. Restrict nonessential visitors, volunteers, and activities involving other groups at the same time.
4. Keep all participants between 3ft and 6ft feet apart, as recommended by the Department of Children and Families who follow all CDC enhanced social distancing rules.
5. Maintain an adequate ratio of staff to children to ensure safety.

Revised 7/9/2021

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Monitoring and Preparing Check for signs and symptoms

1. Implement health checks (e.g., temperature checks and symptom screening) screenings safely and respectfully, and with measures in place to ensure confidentiality as well as following any applicable privacy laws or regulations. **Confidentiality should be maintained.**
2. Encourage staff to stay home if they are sick and encourage parents to keep sick children at home.
3. Identify an area to separate anyone who exhibits COVID-like symptoms during hours of operation and ensure that children are not left without adult supervision.
4. Notify local health officials, staff, and families immediately of any possible case of COVID-19 while maintaining confidentiality as required by the Americans with Disabilities Act (ADA).
5. Close off areas used by any sick person and do not use them until they have been cleaned. Wait 24 hours before you clean or disinfect to reduce risk to individuals cleaning. If it is not possible to wait 24 hours, wait as long as possible.
6. Ensure the safe and correct application of disinfectants and keep disinfectant products away from children.
7. Inform anyone exposed to a person diagnosed with COVID-19 to stay home and self-monitor for symptoms, and to follow CDC guidance if symptoms develop.
8. Advise sick staff members not to return until they have met CDC criteria to discontinue home isolation.

Additional updates and mitigation efforts

1. Avoid large gatherings where social distancing is not possible
2. Notify the site location immediately of any possible contact with COVID-19

By signing this form, I acknowledge the highly contagious nature of COVID-19, as well as the resulting preventive measures that Hope For Miami, its community partners, employees, and representatives have put in place to help mitigate the spread of the virus. I understand the risk of becoming exposed to, or infected by, COVID-19 at any of the locations at which Hope For Miami conducts its in-person after-school or summer camp programs. This includes the risk of becoming infected as a result of the actions, omissions, or negligence of myself, program employees, volunteers, and program participants and the independent site locations.

Further, by signing this form I hereby agree and acknowledge that I—on behalf of myself and my child/participant—assume all risks associated with such participation, including but not limited to those risks associated with COVID-19. I give this release and waiver for my child/participant, myself, my heirs, successors and representatives. I agree to release and hold-harmless both Hope for Miami and the independent site location (along with all related entities and all of their related employees, agents and representatives), of and from any liability for loss, damage, costs, claims, lawsuits and/or causes of action, arising out of any aspect of participation in the in-person afterschool programs offered by Hope for Miami. I understand and agree that in the event of any personal or bodily injury to the undersigned, I (on my own behalf or that of any other person) will not seek any type of recovery from, or bring any type of action whatsoever against, Hope for Miami and the independent site location, their officers, directors, employees, or agents. I hereby acknowledge and agree that the promises and representations made above are material and a necessary condition precedent to me being allowed to participate in Hope for Miami programs.

 Signature of Parent/Guardian

 Date

 Print Name of Parent/Guardian

 Name of Participant(s)