The Children's Trust

family central

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Intake Form

Adult Information

Are you a parent, guardian or primary caregiver? ☐ Yes ☐ No How many children are in your care? _____

How many of the children in your care have a disability or condition expected to last for a year or more that makes it harder for your child to do things that other children of the same age can do? _____

Participant's Last Name: _____ First: _____ MI: _____

Date of Birth: _____ Gender: ☐ Male ☐ Female Primary Phone Number: _____

Proficient in English: ☐ Yes ☐ No Other language(s) spoken in the home: _____

Address: _____ City: _____ Zip Code: _____

Ethnicity: _____ Race: _____

Highest grade completed? _____ Email: _____

Other family members enrolling in course: _____

1. Child's Last Name: _____ First: _____ MI: _____

Date of Birth: _____ Age: _____ Gender: ☐ Male ☐ Female

Last 4 Digits ONLY of Child's SSN: _____ ☐ No SSN ☐ Prefer not to give

Miami-Dade County Public School ID#: _____ ☐ No MDCPS ID ☐ Prefer not to give

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

Proficient in English: ☐ Yes ☐ No Other language(s) spoken in the home: _____

Does Child have Health Insurance? ☐ Yes ☐ No Ethnicity: _____ Race: _____

*Does your child have any Special Needs or health concerns? ☐ Yes ☐ No

2. Child's Last Name: _____ First: _____ MI: _____

Date of Birth: _____ Age: _____ Gender: ☐ Male ☐ Female

Last 4 Digits ONLY of Child's SSN: _____ ☐ No SSN ☐ Prefer not to give

Miami-Dade County Public School ID#: _____ ☐ No MDCPS ID ☐ Prefer not to give

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

Proficient in English: ☐ Yes ☐ No Other language(s) spoken in the home: _____

Does Child have Health Insurance? ☐ Yes ☐ No Ethnicity: _____ Race: _____

*Does your child have any Special Needs or health concerns? ☐ Yes ☐ No

Comments