



# 21<sup>st</sup> Century Community Learning Centers



Broward County Public Schools  
2019-2020 Academic Year Registration

Participant Information				
Last Name	First Name	Middle Name	Student ID	Gender
				<input type="checkbox"/> Male <input type="checkbox"/> Female
Street Address		City	State	Zip Code
Birth Date	Age	Grade(2017-2018)	Country of Birth	
/ /			<input type="checkbox"/> United States <input type="checkbox"/> Other _____	

Parent/Legal Guardian Information					
Full Name of Mother/Legal Guardian			Full name of Father/Legal Guardian		
Street Address (if different from participant)			Street Address (if different from participant)		
City	State	Zip	City	State	Zip
Home Phone		Mobile Phone		Mobile Phone	
Email Address: _____					
Are there any custody issues? <input type="checkbox"/> Yes <input type="checkbox"/> No <i>If yes, please provide documentation to</i>					

Emergency Contact / Pick-Up Authorization			
In the event that a parent/guardian cannot be reached in an emergency situation, the following individuals are provided consent for emergency contact and authorized participant pick up.			
Contact Name	Relationship	Phone Number	Phone Number
1. _____			
2. _____			
3. _____			

Community Resources
Please indicate if you would like more information about:
<input type="checkbox"/> Food and Nutritional Assistance (EBT Program, WIC, Pantries)
<input type="checkbox"/> Health Insurance (Medicaid, Florida Kid Care)
<input type="checkbox"/> Employment (Workforce One, Job Fairs, Career Counseling)
<input type="checkbox"/> Counseling Services
<input type="checkbox"/> Financial Assistance/Financial Literacy
<input type="checkbox"/> Child Care Resource and Referrals



**Student Demographic Information**

The demographic information gathered herein is solely used for statistical purposes. Student information is kept confidential.

Household arrangement		Household income		Free or Reduced Lunch	
<input type="checkbox"/> Both parents <input type="checkbox"/> Single parent <input type="checkbox"/> Other arrangement  Number in Household: _____		<input type="checkbox"/> 0-9,999 <input type="checkbox"/> 40,000-49,999 <input type="checkbox"/> 10,000-19,999 <input type="checkbox"/> 50,000-69,999 <input type="checkbox"/> 20,000-29,999 <input type="checkbox"/> 70,000-99,999 <input type="checkbox"/> 30,000-39,999 <input type="checkbox"/> 100,000-over		<input type="checkbox"/> Yes <input type="checkbox"/> No	
Language Spoken		Race		Ethnicity	
<input type="checkbox"/> Bilingual Creole/English <input type="checkbox"/> Bilingual Spanish/English <input type="checkbox"/> Creole <input type="checkbox"/> English <input type="checkbox"/> Spanish		<input type="checkbox"/> African American/Black <input type="checkbox"/> Asian <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Caucasian/White <input type="checkbox"/> Native Hawaiian or Pacific Islander <input type="checkbox"/> Multiracial		<input type="checkbox"/> Yes, Spanish/Hispanic/Latino <input type="checkbox"/> No, Not Spanish/Hispanic/Latino	
Language Spoken		Race		Cultural Influence	
<input type="checkbox"/> Bilingual Creole/English <input type="checkbox"/> Bilingual Spanish/English <input type="checkbox"/> Creole <input type="checkbox"/> English <input type="checkbox"/> Spanish		<input type="checkbox"/> African American/Black <input type="checkbox"/> Asian <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Caucasian/White <input type="checkbox"/> Native Hawaiian or Pacific Islander <input type="checkbox"/> Multiracial		<input type="checkbox"/> American <input type="checkbox"/> British <input type="checkbox"/> Central/South American-Hispanic <input type="checkbox"/> Cuban <input type="checkbox"/> German <input type="checkbox"/> Haitian <input type="checkbox"/> Italian <input type="checkbox"/> Puerto Rican <input type="checkbox"/> West Indian <input type="checkbox"/> Other _____	

**Medical Information**

Name of Insurance Carrier and Plan Name		Family Physician	
Carrier Phone	Insurance ID number	Physician Contact Phone	
Please list ADA Accommodations needed		Has the participant ever been diagnosed with or received treatment, attention, or advice from a physician for:	
_____ _____ _____ _____ _____ _____		<input type="checkbox"/> Allergies <input type="checkbox"/> Asthma <input type="checkbox"/> Diabetes <input type="checkbox"/> Epilepsy/Seizures <input type="checkbox"/> Serious headache/Migraine <input type="checkbox"/> Other _____	
Please explain any medical issues stated above with treatment, attention, or advice from a physician			