# 21st Century Community Learning Centers

**Broward County Public Schools**
**2019-2020 Academic Year Registration**

| Participant Information | | | | |
|---|---|---|---|---|
| Last Name | First Name | Middle Name | **Student ID** | Gender |
| | | | | ☐ Male<br>☐ Female |

| Street Address | City | State | Zip Code |
|---|---|---|---|
| | | | |

| Birth Date | Age | Grade(2019-2020) | Country of Birth |
|---|---|---|---|
| ____/____/_____ | | | ☐ United States ☐ 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** | | **Home Phone** | **Mobile Phone** | |
| | | | | | |
| Email Address: | | | | | |
| Are there any custody issues? ☐ Yes ☐ No *If yes, please provide documentation to* | | | | | |

## 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:

- ☐ Food and Nutritional Assistance (EBT Program, WIC, Pantries)
- ☐ Health Insurance (Medicaid, Florida Kid Care)
- ☐ Employment (Workforce One, Job Fairs, Career Counseling)
- ☐ Counseling Services
- ☐ Financial Assistance/Financial Literacy
- ☐ Child Care Resource and Referrals

**Broward County Public Schools**

## 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 |
|---|---|---|
| ☐ Both parents<br>☐ Single parent<br>☐ Other arrangement<br><br>Number in Household: ____ | ☐ 0-9,9999 ☐ 40,000-49,999<br>☐ 10,000-19,999 ☐ 50,000-69,9999<br>☐ 20,000-29,999 ☐ 70,000-99,999<br>☐ 30,000-39,999 ☐ 100,000-over | ☐ Yes<br>☐ No<br>**Ethnicity**<br>☐ Yes, Spanish/Hispanic/Latino<br>☐ No, Not Spanish/Hispanic/Latino |
| **Language Spoken** | **Race** | **Cultural Influence** |
| ☐ Bilingual Creole/English<br>☐ Bilingual Spanish/English<br>☐ Creole<br>☐ English<br>☐ Spanish | ☐ African American/Black<br>☐ Asian<br>☐ American Indian or Alaska Native<br>☐ Caucasian/White<br>☐ Native Hawaiian or Pacific Islander<br>☐ Multiracial | ☐ American<br>☐ British<br>☐ Central/South American-Hispanic<br>☐ Cuban<br>☐ German<br>☐ Haitian<br>☐ Italian<br>☐ Puerto Rican<br>☐ West Indian<br>☐ 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: |
|---|---|
| _____<br>_____<br>_____<br>_____<br>_____<br>_____ | ☐ Allergies<br>☐ Asthma<br>☐ Diabetes<br>☐ Epilepsy/Seizures<br>☐ Serious headache/Migraine<br>☐ Other _____ |

**Please explain any medical issues stated above with treatment, attention, or advice from a physician**

_____

_____