



Citizens Alliance for Progress, Inc.

401 Martin Luther King Jr. Dr., Tarpon Springs, FL 34689 | Phone: (727) 934-5881 | www.citizensallianceforprogress.org

Summer Career Institute Application

STUDENT INFORMATION:

Student Social Security # \_\_\_\_\_ Student Identification # \_\_\_\_\_

First Name \_\_\_\_\_ Last Name \_\_\_\_\_ Date of Birth \_\_\_\_\_

Age \_\_\_\_\_ Gender:  Male  Female Pregnant  No  Yes Shirt Size \_\_\_\_\_  Youth  Adult

Address \_\_\_\_\_ City, St \_\_\_\_\_ Zip Code \_\_\_\_\_

School \_\_\_\_\_ Grade \_\_\_\_\_

Race

- Black (Non-Hispanic)  White (Non-Hispanic)  Hispanic  Asian Indian
 Asian (Non-Hispanic)  Pacific Islander  American Indian  Other

Primary Language:  English  Spanish  Other: \_\_\_\_\_

Ethnicity

- No, Not Spanish/Hispanic/Latino  Yes, Other Spanish/Hispanic/Latino  Yes, Cuban
 Yes, Puerto Rican  Yes, Mexican, Mexican American, Chicano

Household Annual Income: \$ \_\_\_\_\_ # of Adults in Household \_\_\_\_\_ # of Children in Household \_\_\_\_\_
(Before Taxes)

Household Arrangement

- Dual Parent-Married  No Dependents-Single Female
 Other-Relative/Kinship Care-Married  Single Parent-Male Head of Household
 No Dependents-Married  Dual Parent-Non Married Male Head of Household
 Single Parent-Female Head of Household  Dual Parent-Non Married Female Head of Household
 No Dependents-Single Male  Other-Relative/Kinship Care-Male Head of Household
 No Dependents-Couple, Non-married  Other-Relative/Kinship Care-Female Head of Household

PARENT INFORMATION:

Parent / Guardian #1 \_\_\_\_\_ Relationship to Child \_\_\_\_\_

Home/Cell # \_\_\_\_\_ Work # \_\_\_\_\_ Email Address \_\_\_\_\_

Parent / Guardian #2 \_\_\_\_\_ Relationship to Child \_\_\_\_\_

Home/Cell # \_\_\_\_\_ Work # \_\_\_\_\_ Email Address \_\_\_\_\_

Emergency Contact: \_\_\_\_\_ Phone # \_\_\_\_\_

Emergency Contact: \_\_\_\_\_ Phone # \_\_\_\_\_

Parent / Guardian Signature \_\_\_\_\_

Date \_\_\_\_\_

| OFFICE USE ONLY |

Episode Open Date: \_\_\_\_\_ Fam Id# \_\_\_\_\_ Mem Id# \_\_\_\_\_

## 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

\_\_\_\_\_  
Witness Signature

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

\_\_\_\_\_  
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 - Summer Career Institute 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 - Summer Career Institute. 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

