2024
Summer Theater Intensive
Application

Fill & email application to education@miaminewdrama.org or mail to 1040 Lincoln Rd, Miami Beach, FL 33139.

All students interested in participating must fill out this application.
All responses from this application will be kept confidential.
For questions, email us or call at 305-674-1040.

Session 1: Introduction to Commedia dell'Arte	**Session 2: A Musical Theater Journey**

• June 24 - July 3
• 9 days:
  ○ Week 1: 6/24, 6/25, 6/26, 6/27, 6/28, 6/29 (Mon - Sat)
  ○ Week 2: 7/01, 7/02, 7/03 (Mon - Wed)
• **Cost of Session #1**: $900 ($100 / day)
• **Location**: Miami Beach Botanical Garden
• **Hours**: 10:00a – 5:00p
  ○ Drop-off begins at 9:30a
	• July 8 - July 26
	• 15 days:
	  ○ Week 3: 7/08, 7/09, 7/10, 7/11, 7/12 (Mon - Fri)
	  ○ Week 4: 7/15, 7/16, 7/17, 7/18, 7/19 (Mon - Fri)
	  ○ Week 5: 7/22, 7/23, 7/24, 7/25, 7/26 (Mon - Fri)
	• **Cost of Session #2**: $1,500 ($100 / day)
	• **Location**: Miami Beach Regional Library
	• **Hours**: 10:00a – 5:00p
	  ○ Drop-off begins at 9:30a

SCHOLARSHIPS

Full Scholarship Requirements:

- Commit to **all 5 weeks** (**both** sessions).
- Attend all classes of both sessions.
  - Up to two (2) absences total will be excused in the case of emergency or illness.
- Participate in the final showcase of **both** sessions.
- Present need of financial assistance. When emailing this application, please include verifying documentation, such as:
  - Free Lunch Program
  - Reduced Lunch Program
  - S.N.A.P. (SUPPLEMENTAL NUTRITION ASSISTANCE PROGRAM)

Partial Scholarship Requirements

If you are not in need of financial assistance, you may still qualify for a partial scholarship, which will cover one or both sessions.

- Commit to attend at least one **full** session.
- Attend all classes of chosen session.
  - Up to one (1) absence total per session will be excused in the case of emergency or illness.
- Participate in the final showcase of chosen session.

Applications for full scholarships are due by 5:00pm EST on Thursday, June 6th, 2024. After this date, you may still apply for a partial scholarship until 5:00pm on Thursday, June 13th, 2024.

SCHOLARSHIP AGREEMENT:

By applying and accepting a scholarship, I am committed to the requirements above.
Due to the limited number of scholarships, I understand that if I have an unexcused absence, I will not qualify for full scholarships in future MiND Education programs for the next 12 months.
Only exceptions are in the case of an emergency or an "Act of God".

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STUDENT INFORMATION

First Name: _____ Last Name(s): _____

Age: _____ Date of Birth (mm/dd/yyyy): _____/_____/_____ Grade (2024-2025): _____

Primary Language: _____ Secondary Language (if applicable): S_____

Address (Street) _____ (City) _____ (State) _____ (Zip Code) _____

EMERGENCY CONTACT INFORMATION:	
Primary Emergency Contact a) Full name: _____ b) Relation to student: _____ c) Phone number: _____	Secondary Emergency Contact a) Full name: _____ b) Relation to student: _____ c) Phone number: _____

KEY
*** Required for ALL applicants**
^ Required for SCHOLARSHIP consideration

INTEREST / SCHOLARSHIP

* Which program are you applying for?

- ☐ Session #1: **Introduction to Commedia dell'Arte** (June 24 – July 3)
- ☐ Session #2: **A Musical Theater Journey** (July 8 – July 26)

^ Are you also applying for a scholarship? If so, which one? Please see requirements on page 1.

- ☐ Full Scholarship (covers 100% of both sessions)
- ☐ Partial Scholarship (varies in coverage, may cover one or both sessions)
- ☐ *Not applying for a scholarship*

^ If applying for a scholarship, can you commit to all the requirements and class dates?

☐ Yes ☐ No ☐ *Not applying for a scholarship*

^ Please share with us any additional information that might help us understand why your child should be considered for a scholarship. _____

_____

_____

_____

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GENERAL QUESTIONNAIRE

1. About the student:

a) List strong fears participants may have: _____

b) List activities participant particularly likes: _____

c) List activities participant particularly dislikes: _____

d) What are your expectations for this participant in this program: _____

2. Please tell us if the student has any diagnosed medical/behavioral conditions or allergies that require special attention:

_____

3. Check behaviors that are a concern:

☐ Withdrawn / shy ☐ Easily discouraged ☐ Frustration tolerance ☐ Physically harms others* ☐ Physically harms self*
☐ Hyperactive ☐ Short attention span ☐ Runs away* ☐ Opposition / defiant* ☐ Manipulative ☐ Steals
☐ Other _____ **Behavior management is required. Behaviors may require individualized behavior strategies / plan.*

Describe best ways to manage behaviors above (be specific): _____

MEDICAL / DIETARY INFORMATION

1. Does participant take medications? ☐ Yes ☐ No Is assistance needed? _____

*Medication side effects staff should be aware of: _____

2. Does the participant have seizures? ☐ Yes ☐ No

*If yes, describe type, frequency, duration, and warning signs: _____

*Desired seizure first aid procedures for this participant: _____

*First: Dial *911 / Call: _____

3. List **allergies**, **dietary preferences** / **restrictions**, other **medical conditions** that you want our team to be aware of

_____

ADDITIONAL INFORMATION OR SPECIAL PRECAUTIONS

Please include any additional information or special precautions that would be beneficial to our staff. Including, but not limited to, the following accommodations: environmental (changes to site to provide improved access), staffing (additional hands on assistance to participant), communication (to provide effective communication), activity (changes to increase participation with other children), transportation (request for lift equipped vehicle if needed), or others.

_____

_____

_____

Parent/Guardian Name

Parent/Guardian Signature

CHILD/YOUTH PARTICIPANT INFORMATION FORM (REV 6.2023)

Child/Youth Last Name _____ **First** _____ **Middle Name** _____

Child/Youth's Date of Birth (MM/DD/YYYY) _____/_____/_____

Child/Youth Gender ☐ Female ☐ Male ☐ Non-binary/Gender non-conforming ☐ Transgender ☐ Other

Street Address _____ **City** _____ **ZIP Code** _____

Caregiver Last Name _____ **First** _____ **Caregiver Phone Number (**_____**)** _____ **-**____

Is this a cell/mobile phone? ☐ Yes ☐ No **Caregiver Email address** _____

Caregiver preferred language for contact (Please select only one): ☐ English ☐ Spanish ☐ Haitian Creole

(Optional) Youth Phone Number (_____**)** _____ **-**_____ **(if provided) Is this a cell/mobile phone?** ☐ Yes ☐ No

(Optional) Youth Email address _____

Please note that The Children's Trust may contact you via postal mail, email and/or text to ask about your satisfaction with services, and to make you aware of other Trust-funded programs, initiatives and events that may interest you.

What is the child/youth's current grade level? (For summer, select the last grade completed - Please select only one):

☐**Pre-K** ☐ **Kindergarten** ☐ **Grade 1st-12th (specify)** _____

☐**Attending College** ☐**Child under 5 not in school** ☐**Not in school**

Miami-Dade County Public Schools ID # _____ _____ _____ _____ _____ _____ _____ ☐ No M-DCPS ID #

ALL STUDENTS ATTENDING PUBLIC OR CHARTER SCHOOLS MUST HAVE A SCHOOL ID # ENTERED.

Child/Youth's current school or college _____

What is the child/youth's preferred language for contact? (Please select only one)

☐ English ☐ Spanish ☐ Haitian Creole

What language(s) does the child/youth feel comfortable communicating in? (Select all that apply)

☐ English ☐ Spanish ☐ Haitian Creole ☐ Portuguese ☐ French ☐ Other:_____

Child/Youth Ethnicity

Is the child/youth Hispanic or Latina/o/x? ☐ Yes ☐ No Is the child/youth Haitian? ☐ Yes ☐ No

Child/Youth Race (Please select only one):

☐ American Indian or Alaskan ☐ Asian ☐ Black or African American ☐ Pacific Islander ☐ White

☐ Biracial or Multiracial ☐ Prefer to self-describe _____

We want to get to know your child better so that we can provide the best possible experience in our programs. Please tell us more about your child…

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

☐ Speaks and is easily understood

☐ Speaks but is difficult to understand

☐ Uses communication devices like pictures or a board

☐ Uses gestures or expressions like pointing, pulling, smiling, frowning, or blinking

☐ Uses sign language

☐ Uses sounds that are not words like laughing, crying, or grunting

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

- ☐ Behavioral therapy or services
- ☐ Counseling for emotional concerns
- ☐ Daily medication (not including vitamins)
- ☐ Occupational therapy (OT)
- ☐ Physical therapy (PT)
- ☐ Special education services in school
- ☐ Speech/language therapy
- ☐ None of the above

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

- ☐ Autism spectrum disorder
- ☐ Developmental delay (only if under age 5)
- ☐ Intellectual/developmental disability (over age 5)
- ☐ Hearing impairment or deaf
- ☐ Learning disability (school age)
- ☐ Medical condition or illness
- ☐ Physical disability or impairment
- ☐ Problems with aggression or temper
- ☐ Problems with attention and hyperactivity (ADHD)
- ☐ Problems with depression or anxiety
- ☐ Speech or language condition
- ☐ Visual impairment or blind
- ☐ Other condition lasting one year or more (please specify): _____
- ☐ No condition lasting one year or more

If you marked "No condition lasting one year or more" on the previous question, please skip the next two questions and sign below. If you marked any other answer on the question above, please answer the remaining questions and sign below.

Do any of the conditions noted make it harder for your child/youth to do things that others of the same age can do?

☐ Yes ☐ No

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

☐ No specific help needed

- ☐ Holding a crayon/pencil, writing, using scissors or other fine motor tasks
- ☐ Sports or physical activities like running or other gross motor tasks
- ☐ Managing feelings and behavior
- ☐ Academic, learning or reading activities
- ☐ Adapting activities to consider a visual or hearing impairment
- ☐ Using assistive device(s) like a wheelchair, crutches, brace, or walker
- ☐ Personal services like help with feeding, toileting, or changing clothes
- ☐ Other _____

Please tell us anything else you think it is important for us to know about your child/youth:

_____

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/youth, visit www.advocacynetwork.org or www.thechildrenstrust.org/content/children-disabilities.

As part of my child's voluntary participation in this program, I give my permission for the information collected through this program to be submitted to The Children's Trust for program evaluation and quality purposes. The Children's Trust provides funding for the program to operate and follows strict data privacy protections for the information collected (for example, following the Family Educational Rights and Privacy Act/FERPA guidelines).

PARENT/GUARDIAN SIGNATURE _____ **DATE**_____

FOR STAFF USE ONLY (*MUST BE COMPLETED*)

ORGANIZATION _____ SITE _____

Referred From: _____