Return to:

AKA AKADEMY
P.O. Box 16784
St. Petersburg, Fl 33733
www.zuochapter.org

AKA AKAdemy

AKA AKADEMY:_____

Participant Information (Child)

Date: _____ Participant Name: _____

Male☐ Female☐ T-Shirt Size (Adult)_____

Street Address: _____

Date of Birth: _____/_____/_____

City: _____ Zip Code:

SS#_____

Home Phone (____) _____ Cell Phone (_____) _____

Current School Status/Grade for 2023-2024 school year (check one)

☐6 ☐7 ☐8 ☐9 ☐10

Race: (mark with an X)

___ White
___ American Indian or Alaska Native
___ Asian Indian
___ Asian Unspecified
___ Black, African American
___ Chinese
___ Filipino
___ Guamanian or Chamorro
___ Japanese
___ Korean
___ Multiracial
___Native Hawaiian
___ Other Asian
___ Other Pacific Islander
___ Samoan
___ Vietnamese
___ Some other race

Ethnicity: ____ No, Not Spanish/Hispanic/Latino ____ Yes, Other Spanish/Hispanic/Latino
____ Yes, Puerto Rican ____ Yes, Mexican, Mexican American, Chicano
____ Yes, Cuban

Student ID # _____ **School Name:** _____

Consent _____
(Guardian Initials above)

.

Confidentiality Statement: The information provided in this form will be used only for the purpose of statistics and reporting to the Juvenile Welfare Board. This information will not be disseminated to the public and will be treated as confidential by AKA AKAdemy staff

revised 5/2 YDF/AKA

AKA AKADEMY: _____

Case/Household Application

Date: _____ Parent/Guardian_____ Male☐ Female☐

Street Address: _____ Birth Date: _____/_____/_____

City: _____ Zip Code:_____

Home Phone (____) _____ Parent Cell Phone (_____) _____

Student Cell Phone (____)_____

PARENT EMAIL ADDRESS:_____

STUDENT EMAIL ADDRESS:_____

GRADE (FY 23-24) _____ STUDENT ID _____

SCHOOL (FY 23-24)_____

Sisters/Brothers currently enrolled in AKAdemy:_____

_____

Emergency Contact: Name:_____ Phone: _____

Referred From: _____

Household Income: (circle one) /(check one)

$0-$9999 ☐ $10,000-$19,999 ☐ $20,000-$29,999 ☐ $30,000 -$39,999 ☐ $40,000 -$49,999 ☐ $50,000 & up ☐

Household Arrangement:

____Dual Parent-Married
____Other-Relative/Kinship Care – Married
____No Dependents – Married
____Single Parent – Female Head of Household
____Dual Parent – Non-Married Female Head of Household
____Other-Relative/Kinship Care – Female Head of Household
____No Dependents – Single Female
____Single Parent - Male Head of Household
____Dual Parent – Non-Married Male Head of Household
____Other-Relative/Kinship Care – Male Head of Household
____No Dependents – Single Male
____Other – Non Relative
____No Dependents – Couple, non-married

☐**Rent Home** ☐**Own Home** ☐**Other arrangement**

_____**# of Adults In Household**

_____ **# of Children In Household**

GUARDIAN/ADULT SIGNATURE _____ DATE: _____

Intake Date: _____ ***AKAdemy Staff Signature:***_____

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revised 5/2 YDF/AKA

Youth Development Foundation of Pinellas County, Inc.
AKA AKAdemy

PERMISSION TO PARTIPATE/RELEASE

I_____, the parent/legal guardian of _____, hereby authorize and given consent for my daughter/son to participate in activities related to the AKA AKADEMY PROGRAM for the 2023- 2024 program year. Furthermore, I agree to release and hold harmless the Youth Development Foundation of Pinellas County, Inc., Zeta Upsilon Omega Chapter of Alpha Kappa Alpha Sorority Inc., Eta Rho Services Inc., Eta Rho Chapter of Omega Psi Phi Fraternity and individual members, representatives and agents of the aforementioned organizations and any/ all agency funders. I, the undersigned have read this release and understand its terms.

_____ _____
Signature of Parent/ Legal Guardian Date

MEDICAL RELEASE

I _____, the parent/legal guardian of _____, authorize the members of the Youth Development Foundation of Pinellas County AKA AKADEMY staff and members of the Zeta Upsilon Omega Chapter of Alpha Kappa Alpha Sorority to take such actions as necessary for the medical care and treatment of my daughter in the event that I or my emergency contact cannot be reached for authorization. Additionally, I agree to accept responsibility for all costs and expenses incurred for any and all medical services that may be provided.

_____ _____
Signature of Parent/Legal Guardian Date

_____ _____
Name of Emergency Contact/ Relationship Phone Number/Cell

List health issues/illnesses or allergies which we should be aware of: _____

_____

PHOTO/MEDIA/TELEVISION RELEASE

I_____, parent/legal guardian hereby release and consent that photographs that are taken during the course of AKA AKADEMY activities shall become the property of the Youth Development Foundation including without limitation the exclusive right to publish, display, reproduce and distribute the image in all forms or media now known or hereafter developed.

_____ _____
Signature of Parent/Legal Guardian Date

PARTICIPANT STATEMENT

I _____, understand that I must abide by all rules of the AKA AKAdemy and all agency funders (YDF, JWB, etc.)

_____ _____
Participant Signature Date

Juvenile Welfare Board
Investing in children. Strengthening our community.

Authorization and Consent for Disclosure,
Receipt, and Use of Confidential Information
by the Juvenile Welfare Board of Pinellas County

Participant Name: _____ Participant Phone: _____

Participant DOB: _____ Name of Program or Service _____

Participant Address: _____

I, _____ (*print participant name*) acknowledge that I am a participant of _____ (*name of program or service*). 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 JWB may review all information about me as it specifically relates to any program or service it pays for. I also acknowledge that because JWB provides funds for the program or service in which I am participating, it may review 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 confidentiality of any 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 participants, where no one is identified by name or any other personal characteristic.-

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, 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 authorize the release of any information concerning the performance of any tests, results of those tests, counseling and treatment records. I consent to my minor participating in online or paper surveys that

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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.

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. I understand and agree that if I withdraw my approval that it will not apply to any information already released to and used by JWB as a result of this Authorization.

_____

Specify Above the Date, Event or Condition for Termination of Authorization

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.

_____(*print participant name*)

_____ _____

Signature of Participant or Participant's Authorized Representative (check one): Effective Date

○ *Participant*

○ *Parent*

○ *Guardian*

○ *Personal Representative (Legal Documents Required)*

_____

Description of authority if signed by participant's authorized representative

_____ _____

Witness Signature Date

Juvenile Welfare Board of Pinellas County
14155 58th Street North, Suite 100
Clearwater, FL 33760
Phone: 727-453-5600
Fax: 727-453-5610
www.jwbpinellas.org

Written Statement of Purpose(s) for Collection of Social Security Number for Recipients of JWB-funded Programs and Services

The Juvenile Welfare Board (JWB) invests in partnerships, innovation and advocacy to strengthen Pinellas County children and families. The vision of the Juvenile Welfare Board is that children in Pinellas County will have a future of more successful and satisfying lives because of the efforts of JWB and its partners. JWB was established by Florida statute in 1945 (Special Act 2003-320: F.S. §189.429) and approved overwhelmingly by voters in a referendum in 1946. JWB was created with a mission to provide needed services to children throughout Pinellas County. JWB provides funds to agencies that provide services to children and families in Pinellas County.

The purpose of this document is to provide individuals with written information about how JWB uses the Social Security numbers it collects. JWB is required by Florida's Public Records law [Fla. Stat. §119.071(5)] to provide this information to you.

Florida law allows JWB to collect Social Security numbers in order to carry out its duties and responsibilities (Fla. Stat. §119.071(5) (a) 2a. (II); Special Act 2003-320: F.S. §189.429). Specifically, it is necessary for JWB to collect Social Security numbers to conduct research, fund services, and to ensure that all services delivered to participants are of the highest possible quality.

In addition, collecting Social Security information is necessary to:

• Identify and match individuals and data to research and improve how services are provided to children and families; and

• Receive reimbursement from Medicaid, if applicable, for providing services.

By law, JWB cannot release Social Security numbers (Fla. Stat. §119.071). JWB follows the highest security standards. All reports produced by JWB provide information about services in general. No individual person is ever identified in any way in any report.

_____
Print Participant Name

_____ _____
Participant Signature Date

_____
Print Parent/Guardian Name (if participant is under 18)

_____ _____
Parent/Guardian Signature (if participant is under 18) Date