Hallandale Beach
PROGRESS. INNOVATION. OPPORTUNITY.

Human Services Department

Beverly A. Sanders, M.ED
Director

750 N.W. 8th Avenue
Hallandale Beach, FL 33009
Ph (954) 457-1460
Fax (954) 457-1305

www.coHB.org

CITY OF HALLANDALE BEACH HUMAN SERVICES DEPARTMENT
PARENT'S STATEMENT AND WAIVER OF LIABILITY

Participant Name (please print): _____

Household Number: _____ Member Number: _____

In the event of an emergency when a parent or those persons listed on the Registration Form cannot be reached, the undersigned gives permission for his/her child or ward to receive any necessary medical treatment, and the undersigned will be responsible for payment of all related bills.

To the City of Hallandale Beach: In consideration of the opportunity afforded to my child or ward named in the Registration Form to participate in City of Hallandale Beach Human Services Department's Youth Development Programs, I, the undersigned parent or guardian, hereby acknowledge, freely and voluntarily RELEASE, WAIVE, DISCHARGE, AND COVENANT NOT TO SUE THE CITY OF HALLANDALE BEACH, its officers, agents, employees and volunteers from any and all liability or claims which may be sustained by the child directly or indirectly in connection with, or arising out of, the child's participation in the Program, whether caused in whole or in part by the negligence of the City of Hallandale Beach or otherwise.

The undersigned, on behalf of myself and my child or ward, shall save harmless the City of Hallandale Beach from and against all judgments, orders, decrees, attorney's fees, costs, expenses and liabilities arising from or out of such claim, investigation, or defense thereof which may be entered, incurred or assessed against the City of Hallandale Beach as a result of the foregoing.

The undersigned acknowledges that he/she has been provided with a copy of the policies and regulations set forth by the City of Hallandale Beach's Human Services Department for the Youth Development Programs and agrees to read and thoroughly understand them and explain them to the child or ward enrolled in the Program. Further, I understand it is my responsibility to notify the Parks and Recreation administrative offices immediately of any changes in information as listed on the Registration Form, including, but not limited to, home address and phone number, emergency contact phone numbers, password, etc.

I, THE UNDERSIGNED, HAVE READ THIS DOCUMENT, FULLY UNDERSTAND ITS TERMS, AND UNDERSTAND THAT I, ON BEHALF OF MYSELF AND THE CHILD DESCRIBED HEREIN, HAVE GIVEN UP SUBSTANTIAL RIGHTS BY SIGNING IT AND HAVE SIGNED IT FREELY AND WITHOUT ANY INDUCEMENT OR ASSURANCE OF ANY NATURE AND INTEND IT TO BE A COMPLETE AND UNCONDITIONAL RELEASE OF ANY AND ALL LIABILITY TO THE GREATEST EXTENT ALLOWED BY LAW AND AGREE THAT IF ANY PORTION OF THIS DOCUMENT IS HELD TO BE INVALID THE BALANCE NOTWITHSTANDING, SHALL CONTINUE IN FULL LEGAL FORCE AND EFFECT.

_____ _____
PARENT OR LEGAL GUARDIAN (PRINT) NAME OF CHILD OR WARD (PRINT)

_____ _____
PARENT OF LEGAL GUARDIAN (SIGNATURE) DATE

_____ _____
CITY EMPLOYEE DATE

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Mayor

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Vice Mayor

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MICHELE LAZAROW
Commissioner

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Commissioner

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CITY OF HALLANDALE BEACH
HUMAN SERVICES DEPARTMENT/HEPBURN CENTER
CONSENT TO PHOTOGRAPH
VIDEO/PHOTO RELEASE AUTHORIZATION

I, the undersigned, give permission to the City of Hallandale Beach, and/or parties designated by the City of Hallandale Beach to photograph the person named below and use such photographs in all forms of media, for any and all promotional purposes including advertising, display, audiovisual, exhibition or editorial use.

I further consent to the use of the name of the person named below in connection with the photographs if needed by the City of Hallandale Beach.

I understand that there will be no financial compensation for my time or expenses for this consent to photograph or use of the person's name and release the City of Hallandale Beach from any claims.

DATE: _____

PRINT NAME: _____

ADDRESS: _____

_____

PHONE: _____

When subject is a minor or legally incapable to give consent:

PARENT/REPRESENTATIVE NAME: _____

RELATIONSHIP: _____

WITNESS: _____

_____ _____ _____
SIGNATURE PARENT'S/REPRESENTATIVE'S SIGNATURE DATE

HSD-ADM-08 EFF. 03/05 (Revised 3/13)

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HUMAN SERVICES DEPARTMENT

HIPAA PRIVACY RULES

AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION

(Pursuant to 45 C.F.R. Parts 164.502 and 164.508)

1. Specific Description of Information Requested to be Disclosed (specify names and dates of actual medical records/reports to be disclosed, if know; otherwise, indicate records/reports by type:_____

_____

_____

2. Name(s) of the Person(s) {Covered Entity} Authorized to Make the Requested Disclosure (that is, the health plan, health care clearinghouse or health care provider required to obtain this authorization as a "covered entity"):_____

_____

_____

_____

3. Person(s) To Whom Covered Entity May Make the Requested Disclosure: The following named Staff Member(s) of the **City of Hallandale, Human Services Department**, a Florida municipality:_____

_____

_____

4. Expiration Date or Expiration Event that Relates to the Purpose or Use of the Requested Disclosure: unless previously revoked pursuant to paragraph 5 of this authorization, this authorization will expire upon the completion of the client services being handled by the City of Hallandale Beach, Human Services Department for the individual signing this authorization form (but not earlier than one year from the date of this authorization).

5. Right to Revoke this Authorization. The individual signing this authorization shall have the right to revoke this authorization at any time by delivering a written statement to the person(s) named in paragraphs 2 and 3 above (with a photocopy of this authorization attached), specifically stating that such individual revokes this authorization. Such revocation shall be effective upon the delivery of such written statement to such person(s). However, no such revocation shall affect the validity or effectiveness of this authorization (or any action taken pursuant hereto) prior to the effectiveness of such revocation, and the person(s) named in paragraphs 2 and 3 above shall be fully protected in acting upon the authority contained in this authorization prior to their actual receipt of a copy of a revocation statement complying with the terms of this paragraph 5.

6. Re-disclosure of Disclosed Protected Health Information. By his or her signature hereto, the individual signing this authorization form understands that the person(s) named in paragraph 3 above have the right to re-disclose the protected health information received by such person(s) pursuant to this authorization, and hereby consents to such re-disclosure. Such individual also understands and acknowledges that any of the protected health information so disclosed will lose the privacy protection afforded such information by the Health Insurance Portability and Accountability Act of 1996 (HIPPA) and in particular 42 U.S.C. 1320d-2, and the regulations promulgated by the Secretary of Health and Human Services under said section (45 C.F.R. part 164).

Dated: _____, 20_____.

_____
Signature of Patient/Client

_____
Print Name of Patient/Client

_____
Witness

_____ /____XXX-XX-_____
Date of Birth / Social Security Number

HSD-ADM-10 EFF. 08/04 (Revised 3/13)

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HUMAN SERVICES DEPARTMENT

AUTHORIZATION TO RELEASE INFORMATION
(FOR MINOR CHILD)

I, the undersigned Kristin Baltazar do hereby authorize the
(Print - Parent's/Guardian's Name)
release of all appropriate information regarding my child's medical or employment history, income status, educational records and/or any applicable information necessary to provide services on my behalf.
I, further authorize you to furnish to the City of Hallandale Beach, Human Services Department, information they are requesting from your agency. I understand that the information is confidential and will only be used for the purpose of determining and/or assessing appropriate services.
By my signature below I, release and hold harmless the City of Hallandale Beach, Human Services Department, its employees and the respondent from any liability that may result from furnishing this information.

CHILD'S INFORMATION

_____ DOB _____
First Middle Last

Last 4 Social Security # _____XXX-XX-_____

PARENT'S/GUARDIAN'S INFORMATION

_____ DOB _____
First Middle Last

Last 4 Social Security # _____D L# _____
Parent's/Guardian's Signature _____ Date _____

"The City of Hallandale Beach (COHB) collects and uses partial social security numbers (last four digits) of participants of COHB-funded programs and the parents/guardians of such participants so that COHB may collect and use data from other agencies for comparison purposes in order for COHB to track and measure the impact of COHB-funded programs and services.
All individual information will be safeguarded and will not be disclosed. COHB's collection of the partial social security numbers from its participants and the parents/guardians of such participants is imperative for the performance of COHB's duties and responsibilities as prescribed by law. The partial social security numbers collected by COHB shall not be used by COHB for any purpose other than the purpose provided in this written statement."

Purposes	Applicable Statute
For use in student application, enrollment and as an identifier for portions of a student's educational record, including as required for financial aid application, administration/reporting.	The Family Educational Rights and Privacy Act (FERPA) (20 U.S.C. § 1232g; 34 CFR Part 99)
For use in administering federal and state programs including verifying program eligibility.	Florida Social and Economic Assistance, FS 409.2576(3); Florida Maternal and Infant Health Care, FS 383.011

********* Do not write below this line *********

Agency Representative Kadene Shaw Title Social Worker I
PRINT NAME

Please fax information to (954) 457-1305. For additional information call (954) 457-1460.

HSD-ADM –25.1– EFF – 04/04 Revised: 1/15/15

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HUMAN SERVICES DEPARTMENT
AUSTIN HEPBURN CENTER
AFTER SCHOOL TUTORIAL ENRICHMENT PROGRAM

PARENT ACKNOWLEDGEMENT
Parent Handbook
2016/2017

I, the Parent/Guardian of:

Child's Name _____ _____ _____

Acknowledge that I have received a Parent Handbook for the After School Program as part of my child's participation in the Program. I agree to adhere to the policies and guidelines set forth to support the Program. I further acknowledged that failure to adhere to the rules and guidelines set forth may result in the dismissal of my child/children from the Program.

_____ _____
PRINT NAME DATE

_____
SIGNATURE