SCAMP
(School + Camp!)
@ THE DOANE STUART SCHOOL

Dear SCAMP Parents:

As we do each year, to ensure a safe and secure environment for everyone at SCAMP, we are asking that you complete and submit the enclosed SCAMPER Information Form, Health Form and Sunscreen Permission Form for your child(ren) no later than **Friday, June 8, 2018**. (*A PDF of these required forms can also be found at* DOANESTUART.ORG/SCAMP). Please mail your completed forms to:

The Doane Stuart School
ATTN: SCAMP
199 Washington Avenue
Rensselaer, NY 12144

You may also email pdfs of your completed forms to SCAMP@doanestuart.org.

Please contact us (your SCAMP Co-Directors!) with any questions or concerns, or with any information you would like us to know about your SCAMPER. Also, if you have any questions about billing, please contact Connie Correa at (518) 465-5222 ext. 204 or at ccorrea@doanestuart.org.

Thank you for your cooperation. We are excited for a summer of fun and learning at SCAMP!

Cordially,

James Cernik
SCAMP Co-Director
(518) 465-5222 ext. 412
SCAMP@Doanestuart.org

Erin Baillargeon
SCAMP Co-Director
(518) 465-5222 ext. 430
SCAMP@doanestuart.org

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SCAMPER INFORMATION FORM 2018

Rev. 5/8/17

SCAMPER INFO

Last Name	*First* *Middle*	*Grade 2018*	*Date of Birth*
Last Name	*First* *Middle*	*Grade 2018*	*Date of Birth*
Last Name	*First* *Middle*	*Grade 2018*	*Date of Birth*

Student(s) Address:	School District:

PARENT / GUARDIAN INFO

Parent/Guardian 1 Name *(Please indicate Ms., Mr., Mrs., Dr., etc.)*	**Parent/Guardian 2** Name *(Please indicate Ms., Mr., Mrs., Dr., etc.)*
Relationship to Scamper(s):	Relationship to Scamper(s):
Address: Address is same as Scamper	Address : Address is same as Scamper
Primary phone number: Home Cell	Primary phone number *(if different):* Home Cell
Secondary phone number: Home Cell	Secondary phone number: Home Cell
E-mail:	E-mail:
Employer	Employer
Occupation	Occupation
Work phone(s)	Work phone(s)
Receives SCAMP Emails/Mailings YES NO	Receives SCAMP Emails/Mailings YES NO

Please complete both sides of the form.

EMERGENCY INFORMATION

In the case of emergency resulting from sudden illness or accident, I authorize Doane Stuart SCAMP to take my child immediately to the hospital or physicians used by the camp, and to contact me as soon as possible.
In case I cannot be reached, you have my permission to contact the following:

Family Doctor	*Phone number*	*Preferred Emergency Hospital*

Family friend or relative	*Relationship*	*Phone*	*Address*

Family friend or relative	*Relationship*	*Phone*	*Address*

To give emergency treatment, if for any reason none of the above can be reached, please list any **important health information** about your child and/or children:

Please list any **allergies or reaction to medications**:

Medical Insurance Company	**Policy #**

Please list the names of people who have your permission to pick up your child(ren):

Name:	*Relationship*:
Name:	*Relationship:*
Name:	*Relationship:*

Signature: Date:

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Child's Name: _____ **Date of Birth:** _____ **Grade:** _____ **School:** _____

__ Immunizations given since last Health Appraisal: __ None given today __ Immunization record attached

	1st	2nd	3rd	4th	5th
DTaP	*	*	*		
Tdap	*				
OPV/IPV/EIPV	*	*	*	**	
HIB	*	*	*		
Hep B	*	*	*		
Varicella	*		__ Disease/Date:		
MMR	*	*			
Other					

SICKLE CELL SCREEN		Date
Positive	Negative	
PPD		Date
Positive	Negative	
LEAD SCREEN		Date
Results:		

Vision - without glasses/contact lenses	R	L
Vision - with glasses/contact lenses	R	L
Vision - near point	R	L
Hearing	R	L

PLEASE PROVIDE MO/D/YR FOR ALL IMMUNIZATIONS

* Required for entry to school in NYS: Requirements may vary by age/grade ** If IPV

Significant Medical/Surgical History __ see attached _____

Specify Current Disease: Diabetes: __Type 1 __Type 2 __Asthma __Hyperlipidemia __Hypertension __Other: _____

Allergies: __None __Food __Insect __Seasonal __Medication __LIFE THREATENING_____

PHYSICAL EXAM DATE: _____

__Check here if entire exam normal BP_____ Height_____ Weight_____ BMI_____ BMI Percentile_____

Weight Status Category (BMI Percentile): __<5th __5th-49th __50th-84th __85th-94th __95th-98th __>98th

	Normal	Abnormal	Comments
Nutrition - BMI			Scale of 1-5: 1=Cachectic (BMI<17.5) 3=WNL(BMI 18.5-24.9) 5=Obese (BMI>29.9)
General Appearance			
Extremities			
Skin			
Head			
Eyes			
Ears			
Nose, Throat, Teeth			
Lymph Nodes/Thyroid			
Lungs			
Heart			
Abdomen/Hernia			
Genitalia			Tanner - I. II. III. IV. V.
Musculoskeletal			Scoliosis — Negative — Positive
Neurological			

PHYSICAL EDUCATION / SPORTS / PLAYGROUND / WORK QUALIFICATION / CSE CONSIDERATION

__ Physically qualified for all sports or full playground

__Not qualified for full participation. May ONLY participate in the areas checked below.

__Contact/Collision: basketball, diving, field hockey, football, ice hockey, lacrosse, martial arts, soccer, wrestling, team handball, water polo

__Limited Contact/Endurance: baseball, cheerleading, cross-country, fencing, field events, floor hockey, gymnastics, handball, skiing, softball, swimming, track, volleyball

__Non-Contact: archery, badminton, bowl, crew, dance, golf, jump rope, rifle team, table tennis, tennis, walking, weights

__Knowledge based experience

__Physically qualified for employment OR specific accomodation _____

__Known or suspected disability _____

__Restrictions _____

PROVIDER'S SIGNATURE _____ Date: _____

PROVIDER'S NAME (STAMP) _____ Phone: _____ Fax: _____

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Student Name: _____ **Date of Birth:** _____ **Grade:** _____

If your child has had any of the following health problems or diseases, please check below and provide details in the comment column.

HEALTH HISTORY				COMMENTS Please use this space to provide details for any condition(s) checked.
Blood Disorders		Allergies		
Chicken Pox		Asthma		
Chronic Ear Infections		Birth Defects		
Hearing Loss		Bone/Joint Muscle Problems		
Hepatitis		Diabetes		
Mono		Heart Disease or Murmur		
Scarlet Fever/Strep		Lead Level Elevated		
Sickle Cell Disease		Operations/Hospitalizations		
Speech Problems		Seizure Disorders		
Tuberculosis		Serious Injuries		
Vision Problems		Other Health Issues		
Head Injury/Concussion (12 mo.)		Psychological/Emotional Health Issues		

Were there any complications during the pregnancy of this child? _____. If so, please describe. _____

_____

What was the length of the pregnancy? _____. What was your child's birth weight? _____

Were there any complications during the birth of this child? _____. If so, please describe. _____

_____

Does your child take any regular medications at school or at home? If so, please list. _____

_____

Does your child have any social or emotional problems that may impact his/her ability to learn and socialize in SCAMP? _____.

If so, please explain. _____

_____

New York State Education Law requires all new entrants and students in Pre-K or K, 2nd, 4th, 7th and 10th grades to have a physical exam. If a physical form is not returned to school before our school physicians come for physicals, your child will have a health appraisal in school.

Your signature authorizes health office personnel to share health related information with appropriate staff when that information is necessary to insure the health and safety of your child.

(Parent/Guardian Name) _____ Date: _____

(Parent/Guardian Signature) _____

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PHYSICIAN'S MEDICATION ORDER

(Student's Name)_____ has been under my care for (condition or diagnosis)_____. S/he may attend SCAMP, but must take (medication)_____.

This medication cannot be taken effectively outside SCAMP hours. Please administer the medication in SCAMP as follows:

Dose:_____ Route:_____ Frequency:_____ Duration:_____

Special Instructions: _____

_____

(Doctor's Name Printed) _____ Date: _____

(Doctor's Signature) _____

Telephone: _____

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PARENT/GUARDIAN PERMISSION

I have read and understand this form. I hereby grant permission for my child to receive the medication _____ as directed by his/her physician.

(Parent/Guardian Signature) _____ Date: _____

Telephone: _____

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PERMISSION TO APPLY SUNSCREEN

Child's name (printed) _____

I hereby grant permission to apply sunscreen to my child when he/she will be spending time outside. I understand that the sunscreen will be applied to exposed skin, including the head, shoulders, arms and legs.

____ Staff can apply **Babyganics Mineral-Based Baby Sunscreen Spray, SPF 50**. I have checked all applicable information and I do not know of any allergies my child has to this brand. (Children will not be sprayed directly in their faces. It will be sprayed on hands and rubbed on.)

____ Please only use the sunscreen I have provided (labeled with my child's name).

(Parent/Guardian Signature) _____ Date: _____