



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](http://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](mailto:SCAMP@doanestuart.org).

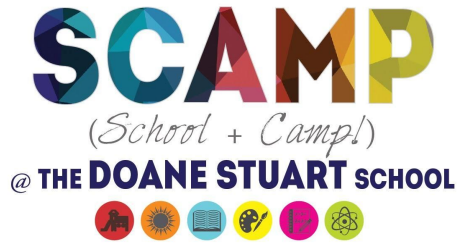
Please contact us (your SCAMP Co-Directors!) with any questions or concerns, or with any information you would like us to know about your SCAMPER. Also, if you have any questions about billing, please contact Connie Correa at (518) 465-5222 ext. 204 or at [ccorrea@doanestuart.org](mailto:ccorrea@doanestuart.org).

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](mailto:SCAMP@Doanestuart.org)

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



## SCAMPER INFORMATION FORM 2018

Rev. 5/8/17

### SCAMPER INFO

Last Name	First	Middle	Grade 2018	Date of Birth

Student(s) Address:	School District:
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### PARENT / GUARDIAN INFO

Parent/Guardian 1 Name <small>(Please indicate Ms., Mr., Mrs., Dr., etc.)</small>	Parent/Guardian 2 Name <small>(Please indicate Ms., Mr., Mrs., Dr., etc.)</small>
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 <i>(if different)</i> : 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:***

<i>Family Doctor</i>	<i>Phone number</i>	<i>Preferred Emergency Hospital</i>
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<i>Family friend or relative</i>	<i>Relationship</i>	<i>Phone</i>	<i>Address</i>
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<i>Family friend or relative</i>	<i>Relationship</i>	<i>Phone</i>	<i>Address</i>
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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**:

<b>Medical Insurance Company</b>	<b>Policy #</b>
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**Please list the names of people who have your permission to pick up your child(ren):**

<i>Name:</i>	<i>Relationship:</i>
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<i>Name:</i>	<i>Relationship:</i>
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<i>Name:</i>	<i>Relationship:</i>
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Signature:

Date:



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	SICKLE CELL SCREEN		Date
DTaP	*	*	*			Positive	Negative	
Tdap	*					PPD		Date
OPV/IPV/EIPV	*	*	*	**		Positive	Negative	
HIB	*	*	*			LEAD SCREEN		Date
Hep B	*	*	*			Results:		
Varicella	*		Disease/Date:					
MMR	*	*		Vision - without glasses/contact lenses		R	L	
Other					Vision - with glasses/contact lenses		R	L
PLEASE PROVIDE MO/D/YR FOR ALL IMMUNIZATIONS					Vision - near point		R	L
* Required for entry to school in NYS: Requirements may vary by age/grade ** If IPV					Hearing		R	L

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: \_\_\_\_\_



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. \_\_\_\_\_

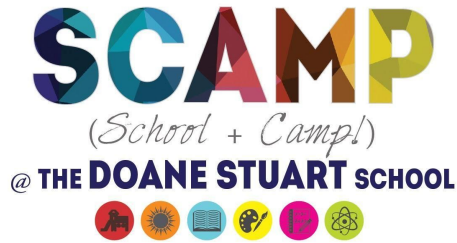
New York State Education Law requires all new entrants and students in Pre-K or K, 2<sup>nd</sup>, 4<sup>th</sup>, 7<sup>th</sup> and 10<sup>th</sup> grades to have a physical exam. If a physical form is not returned to school before our school physicians come for physicals, your child will have a health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



## 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: \_\_\_\_\_

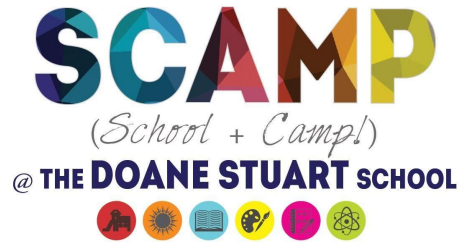
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## PARENT/GUARDIAN PERMISSION

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: \_\_\_\_\_



## 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: \_\_\_\_\_