



**Marjory Stoneman Douglas Biscayne Nature Center
Summer by the Sea 2019
Marine Science Camp**

PERMISSION AND RELEASE FORM

My child _____ is in good health and has my permission to attend Camp at the Marjory Stoneman Douglas Biscayne Nature Center. I, the undersigned, hereby release and hold harmless the Marjory Stoneman Douglas Biscayne Nature Center Inc, its officers, employees, agents, directors, naturalists, independent contractors, teachers, and supervisors from any and all liability for mishap or injury, whether caused by their negligence or otherwise, incurred during the summer camp program. I assume all risk incident thereto with respect to myself and/or any other individuals for whom this permission and release form is made. Any photographs or video taken during the summer camp program may be used for promotional use at the Biscayne Nature Center.

Signature of Parent/Guardian: _____ Date: _____

Please circle the session you would like to register your camper to attend.

**TO BE ELIGIBLE FOR A SCHOLARSHIP,
YOUR CHILD MUST ATTEND A FULL 4 WEEKS OF SUMMER CAMP**

Session 1:
June 10 - July 5, 2019
(No camp on Thursday, July 4th)

Session 2:
July 8 - August 2, 2019



The Summer by the Sea Science Camp is funded by The Children's Trust. The Children's Trust is a dedicated source of revenue established by voter referendum to improve the lives of children and families in Miami-Dade County by making strategic investments in their future.





**"Summer by the Sea"
Marine Science Camp 2019**

CAMPER INFORMATION

Child's Full Name: _____ Nickname: _____

Date of Birth: _____ Age: _____ Male/Female: _____

Race: _____ Ethnicity: _____

School Your Child Attends: _____ Grade: _____

Parent/Guardian Names (please print):

Mother: _____ Father: _____

Parent/Guardian Address (please print): _____

Home #: _____ Cell#: _____ Work#: _____

Email Address: _____

Please list names that are authorized to pick your child up from the Biscayne Nature Center. (ID will be required) Any persons NOT on this list will NOT be allowed to pick up your child.

1. _____
2. _____
3. _____



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SWIMMING ABILITY

On a scale of 1-10 (1 being “can’t swim,” and 10 being “competitive swimmer”) how well can your child swim? Please circle one of the numbers below.

1 2 3 4 5 6 7 8 9 10

Things we should know about your child: _____

Please answer the following questions:

1. All children will be provided with sunscreen and insect repellent. Is your child allergic to either of these?

2. Does your child have any food or environmental allergies?

3. My child has the following medical problems:

4. My child takes the following medications regularly:

5. My child has the following allergies:

6. Other important information we should know:

7. How did you find out about our summer camp?



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MEDICAL INFORMATION AND RELEASE FORM

Name of Child: _____

Age: _____ Male/Female: _____

EMERGENCY CONTACT INFORMATION

Name of Parent/Guardian: _____

Home #: _____ Work #: _____ Cell #: _____

IMPORTANT

I AUTHORIZE EMERGENCY MEDICAL TREATMENT FOR MY CHILD IN CASE OF ACCIDENT OR ILLNESS WHILE ATTENDING THE "SUMMER BY THE SEA" CAMP.

Parent/Guardian Signature: _____ Date: _____

IN CASE A PARENT CANNOT BE REACHED, CONTACT:

Name: _____

Phone #: _____

Relationship: _____

PHYSICIAN INFORMATION

Doctor's Name: _____

Doctor's Phone #: _____



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SCHOLARSHIP APPLICATION
To be filled out by the parent/guardian

Statement of Need

Please describe below why your child is in need of a scholarship to attend our summer camp:

As the parent of _____, I guarantee my child will attend **four weeks/ all 20 days** of “Summer by the Sea” marine science summer camp. I will drop him/her off at 9:00am Monday thru Friday and pick him/her up at 5:00pm Monday thru Friday. He/she will attend 20 days total of summer camp. I understand that if my child misses two consecutive days of camp he/she may lose their scholarship and be responsible for payment of days attended.

Signature of Parent _____ Date _____

Phone Number _____

Questions or concerns?

Contact: Nhung Nguyen, Program Coordinator

Phone: 305-361-6767 x119

Email: reservations@biscaynenaturecenter.org



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SCHOLARSHIP APPLICATION
To be filled out by the child

Name: _____

Grade: _____ School: _____

1. Please describe below why you would like to attend "Summer by the Sea" Camp.

2. What is your favorite outdoor activity?

3. What is your favorite animal? Tell us why.

4. What is your favorite subject in school? Tell us why.



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CHILD INFORMATION FORM

Required as of 8/1/2018

Child's Last Name _____ First _____ Middle Name _____

Child's Date of Birth (MM/DD/YYYY) Child's Gender Male Female

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

Child's current school _____

Is your child proficient in English? Yes No

Other language(s) spoken in your home Spanish Haitian Creole Other: _____ None

Street Address _____ City _____ Zip Code _____

Child's ethnicity Hispanic Haitian Other, please specify: _____

Child's race (select only one) American Indian or Alaskan Asian Black or African-American
 Pacific Islander White Other Multiracial

Child's current grade

Does child have health insurance? (ex., private insurance, KidCare, Medicaid) Yes No
(If not, we may be able to help you find affordable coverage – call 211 or visit www.thechildrenstrust.org/parents/health-connect/insurance.)

Child's primary caregiver (full name) _____

Primary caregiver email address _____

Primary Phone Number Is this a cell/mobile phone? Yes No

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

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 receive at this time? (Mark all that apply)

- | | |
|--------------------------------------------------------------------|---------------------------------------------------------------|
| <input type="checkbox"/> Behavioral therapy or services | <input type="checkbox"/> Physical therapy (PT) |
| <input type="checkbox"/> Counseling for emotional concerns | <input type="checkbox"/> Special education services in school |
| <input type="checkbox"/> Daily medication (not including vitamins) | <input type="checkbox"/> Speech/language therapy |
| <input type="checkbox"/> Occupational therapy (OT) | <input type="checkbox"/> None of the above |

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

- | | |
|-----------------------------------------------------------------------------|---------------------------------------------------------------------------|
| <input type="checkbox"/> Autism spectrum disorder | <input type="checkbox"/> Physical disability or impairment |
| <input type="checkbox"/> Developmental delay (only if under age 5) | <input type="checkbox"/> Problems with aggression or temper |
| <input type="checkbox"/> Intellectual/developmental disability (over age 5) | <input type="checkbox"/> Problems with attention and hyperactivity (ADHD) |
| <input type="checkbox"/> Hearing impairment or deaf | <input type="checkbox"/> Problems with depression or anxiety |
| <input type="checkbox"/> Learning disability (school age) | <input type="checkbox"/> Speech or language condition |
| <input type="checkbox"/> Medical condition or illness | <input type="checkbox"/> Visual impairment or blind |
| | <input type="checkbox"/> None of the above |

If you marked "None of the above" 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 marked above make it harder for your child to do things that other children of the same age can do? Yes No

To support your child's successful participation in this program, in what areas might s/he 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 take into account 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:

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, visit www.advocacynetwork.org or www.thechildrenstrust.org/cwd

I give my permission for this information to be submitted to The Children's Trust for program quality and evaluation purposes. The Children's Trust provides funding for the program.

PARENT/GUARDIAN SIGNATURE _____	DATE _____
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FOR STAFF USE ONLY (MUST BE COMPLETED)

ORGANIZATION _____ SITE _____

POPULATION MEMBERSHIP (check all that apply): Dep Syst Delin Syst