



**Marjory Stoneman Douglas Biscayne Nature Center
Summer by the Sea Camp 2018
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 weeks you would like to register your camper to attend...

Week 1: June 11 – June 15

Week 2: June 18 –June 22

Week 3: June 25 – June 29

Week 4: July 2- July 6*

**no camp on July 4*

Week 5: July 9- July 13

Week 6: July 16- July 20

Week 7: July 23- July 27

Week 8: July 30- August 3



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.



Sandra St. Hilaire, Program Coordinator 305-361 6767 x 119 Reservations@biscaynenaturecenter.org



Camper Information

Child's full name and nickname _____

Date of Birth _____ Age _____ male/female _____

Race _____

Ethnicity _____

School Your Child Attends

_____ Grade _____

Parent's name (please print) Mother _____

Father _____

Parent's Address (please print) _____

Home Phone # _____ 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 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
BISCAYNE NATURE CENTER
SUMMER BY THE SEA MARINE SCIENCE CAMP**

Name of child _____

Age _____ male ____ female ____

EMERGENCY CONTACT INFORMATION

Name of parent/guardian _____

Home Phone _____ Work Phone _____

Cell Phone _____

IN THE CASE A PARENT CANNOT BE REACHED, CONTACT:

Name _____ Phone _____

Relationship to camper _____

PHYSICIAN INFORMATION

Doctor's Name _____ Doctor's Phone _____

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 _____



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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 day 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 and Concerns?

Contact: Sandra St. Hilaire, Program Coordinator

Phone: 305-361-6767 x119

Email: reservations@biscaynaturecenter.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

Child's Last Name _____, First _____ Middle _____

Child's Date of Birth (mo/day/yr)

--	--	--	--	--	--	--

 Child's Gender Male Female

Last 4 Digits ONLY of Child's Social Security#

--	--	--	--

 No SSN

Miami-Dade County Public School ID#

--	--	--	--	--	--	--	--

 No MDCPS ID

Child's Current School _____

Is your Child Proficient in English? Yes No

Other Language(s) Spoken in the Home Spanish Haitian-Creole Other _____ None

Street Address _____ City _____ ZIP Code _____

Child's Ethnicity Hispanic Haitian Other

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)

Child's Primary Caregiver (full name) _____

Primary Caregiver Email _____

Primary Phone

--	--	--	--	--	--	--	--	--	--

(You may be contacted by The Children's Trust to ask about your satisfaction with these services)

We want to get to know your child better so we can provide the best possible experience in our programs. Please tell us more about your child...

What are the main ways your child communicates? (Mark all that apply)

- Speaks and is easily understood
- Speaks but is difficult to understand
- Uses sign language
- Uses communication devices like pictures or a board
- Uses gestures like pointing, pulling or blinking
- Uses sounds that are not words like crying or grunting

What, if any, help does your child receive at this time? (Mark all that apply)

- Speech/language therapy
- Occupational therapy (OT)
- Physical therapy (PT)
- Daily medication (not including vitamins)
- Special education services in school
- Behavioral therapy or services
- Counseling for emotional concerns
- None

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

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

If you marked "None of the above" on the question above, please skip the next two questions and sign below. If you marked any other answer 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

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 _____

FOR STAFF USE ONLY (MUST BE COMPLETED)

ORGANIZATION _____ SITE _____

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