

# Spofford SCAMPS 2010 Application

Child's Name: \_\_\_\_\_ DOB: \_\_\_ / \_\_\_ / \_\_\_ Gender: \_\_\_\_\_

School: \_\_\_\_\_ 2009-2010 Grade Level: K 1 2 3 4 5 6 7

School District: \_\_\_\_\_

Please indicate the session you wish your child to attend:

Session 1 (June 7th – July 2nd) \_\_\_\_\_ Session 2 (July 12<sup>th</sup> – August 6th) \_\_\_\_\_

Will your child need early/late care: 8:00 a.m. to 9:00 a.m. and 4:00 p.m. to 5:00 p.m. Yes / No

Home Address: \_\_\_\_\_ City, State, & Zip: \_\_\_\_\_

Work Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_ Home Phone: \_\_\_\_\_

Father/Guardian Name: \_\_\_\_\_ Employer: \_\_\_\_\_

Mother/Guardian Name: \_\_\_\_\_ Employer: \_\_\_\_\_

**Please list all individuals other than the parents/guardians who are authorized to pick up the child from camp. If individuals are not listed on your child's application staff will not release your child to them:**

Name: \_\_\_\_\_ Relationship to child: \_\_\_\_\_

Name: \_\_\_\_\_ Relationship to child: \_\_\_\_\_

Emergency Contact Name: \_\_\_\_\_

Work Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_ Home Phone: \_\_\_\_\_

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Child's Strengths & Interests: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**Current Diagnosis** (please check all that apply):

- ADHD/ADD     Depression     ODD     PTSD     Reactive Attachment  
 Autism     Conduct Disorder     Asperger's     Bipolar     Other (please describe below)

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My child has no current diagnosis

**Behavioral Concerns:**

1.) Please describe any concerning behaviors your child exhibits at home, school, or in the community? \_\_\_\_\_

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2.) What does your child do when they are upset? \_\_\_\_\_

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3.) What types of situations or triggers may cause problems for your child? \_\_\_\_\_

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4.) What tends to work in calming your child down when they are upset? \_\_\_\_\_

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5.) What types of rewards and/or consequences do you use at home, that are successful with your child? \_\_\_\_\_

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Please return completed form to:

SCAMPS, Spofford, 9700 Grandview Road, Kansas City, Missouri 64134, Fax 816-508-3425  
Questions or comments please contact: Jeannette Koster 816-508-3494 or Becky McClellan 816-508-3439

6.) Has your child exhibited any physical aggression at home, school or within the community and if so please describe in detail? \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Educational Information:**

- My child participates in regular education classes
- My child is currently in a self contained classroom at his/her school
- My child currently has an IEP or 504 plan (please attach copy to application)
- My child has been suspended or expelled from school in the past 6 months (please describe below)

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Please indicate how you heard about the SCAMPS summer program: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Health Concerns/Other Physical Ailments** (Physical impairments, conditions, or allergies that may interfere with daily activities):

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

- No specific medical conditions

**Consent for SCAMPS staff to administer the following over the counter medications:**

	<u>Circle</u>		<u>Comments</u>
Acetaminophen	YES	NO	_____
Ibuprofen	YES	NO	_____
Robitussin DM	YES	NO	_____
Cepacol Lozenges/spray	YES	NO	_____
Little noses saline drops	YES	NO	_____
Imodium AD	YES	NO	_____
Stool Softener	YES	NO	_____
Milk of Magnesia	YES	NO	_____
Calamine Lotion	YES	NO	_____
Caladryl Lotion	YES	NO	_____
Hydrocortisone cream	YES	NO	_____
Benadryl	YES	NO	_____
Triple antibiotic ointment	YES	NO	_____

**Current Medications:** (Please list all prescribed and over-the-counter medications, including inhalers, how long your child been on these medications and any side effects of the medications?)

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## Student Scholarship Information

1. What is the total monthly income for your household? \_\_\_\_\_
2. What amount, do you feel you can afford to pay toward camp fee's : \$\_\_\_\_\_ (Please note that payment must be received by Monday of each week in order for your child to attend camp)
3. Payment plans are available. Would you like to set up a payment plan? YES NO  
If yes, please indicate the amount \$\_\_\_\_\_ per week that you are able to pay.
4. Are there extenuating circumstances that we should know in order to consider you for a scholarship?

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- I give my permission for SCAMPS staff to contact my child's current teacher and/or mental health provider. Please indicate the name and contact information for the above stated individuals.

Name: \_\_\_\_\_ Agency/School: \_\_\_\_\_ Phone: \_\_\_\_\_

Name: \_\_\_\_\_ Agency/School: \_\_\_\_\_ Phone: \_\_\_\_\_

Name: \_\_\_\_\_ Agency/School: \_\_\_\_\_ Phone: \_\_\_\_\_

I, the undersigned, attest to the accuracy of the information I have provided. I understand that the information will be kept confidential, in accordance with HIPPA Laws and shall only be reviewed by those individuals directly involved in the care of my child.

\_\_\_\_\_  
Name (Please Print)

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

**AUTHORIZATION AND RELEASE FOR THE USE AND/OR DISCLOSURE OF PROTECTED HEALTH INFORMATION FOR PROGRAM PURPOSES**

I, the undersigned, do hereby authorize that photographs may be taken by Spofford of my child for publication in future web and print advertisements and literature for Spofford's SCAMPS Summer Day Camp. The purpose of any publication is to provide awareness of and publicize Spofford's activities, programs, and services. I understand that my child will not be identified by his/her full name.

I understand that I am not required to sign this Authorization and, if signed, I may revoke this at any time except to the extent that actions have been taken in reliance on this Authorization. To revoke the Authorization, I may contact the Privacy Officer, PO Box 480227, Kansas City, MO 64148-0227 or by telephone at 816-508-3499.

This Authorization expires \_\_\_\_\_ (if I do not provide a date in the blank, this Authorization expires 90 days from the date that I sign this Authorization). I understand that expiration of this Authorization will not cause any publication made as a result of this Authorization to be withdrawn from public circulation at the time of expiration or any time thereafter.

I understand that Spofford cannot condition treatment or payment on obtaining this authorization from me unless otherwise permitted by law. I understand that I have the right to inspect or copy the protected health information to be used or disclosed. I understand that Spofford may receive donations from third parties as a result of this Authorization.

I understand that if the person or entity that receives the information is not a health care provider that the information may be re-disclosed and is no longer protected by the privacy regulations.

I agree that neither my child nor I will receive any financial remuneration for the use of his/her image as described herein.

I hereby release and discharge Spofford and its affiliated agencies, their directors, officers, successors, and assignees and their respective employees, representatives, and agents from and against any and all liability, including reasonable attorneys' fees, arising out of the exercise of the rights granted by this authorization. It is further understood and agreed that this waiver and release is to be binding upon myself, the minor child, other family members, and my heirs and assigns.

I acknowledge that I have read and fully understand this Authorization and Release and am voluntarily signing this Agreement

\_\_\_\_\_  
Printed Name of Legal Custodian (if child is a minor)

\_\_\_\_\_  
Relationship to Client

\_\_\_\_\_  
Signature of Legal Custodian (if child is a minor)

\_\_\_\_\_  
Date

\_\_\_\_\_  
Printed Name of Legal Custodian (if child is a minor)

\_\_\_\_\_  
Relationship to Client

\_\_\_\_\_  
Signature of Legal Custodian (if child is a minor)

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of Witness

\_\_\_\_\_  
Date