



Reading Camp 2016: June 27-July 1

Student's Full Name _____

Student's address: _____

Gender: M F Student's age now : _____

grade most recently completed: _____

Can you child attend all 5 days of camp? : Yes NO

Important! Student's school: _____ **County** _____

Reading Teacher _____ **What grade will student be in this fall 2016:** _____

If your child attended Reading Camp Last Year, did you see a difference in interest in reading, attending class or an ability to keep trying to read in spite of difficulties? Please give us feedback:

With whom does the child live? _____ **Gender:** M F

Parent/ Guardian #1 Full Name: _____

Phone: Home (____) _____ Work (____) _____ Cell (____) _____

Email Address: _____

Parent/ Guardian #2 Full Name: _____ **Gender:** M F

Phone: Home (____) _____ Work (____) _____ Cell (____) _____

Email Address: _____

Photography/Videography Permission: I give permission for my child's photograph to be taken and used for Reading Camp publicity and marketing purposes: yes no

We offer pick up and drop off only to St. John's House Learning and Development Center (at the Marcum Terrace Community Center) we pick up at 8:30 a.m.each day and bring them home at 3:30. You will need to be there to pick them up if the St. John's House is closed. Most of our students are drive to and from camp by parents or family. **Will you be using the Marcum Terrace Transportation each day:** ___ Yes ___ No If not, how will your child get to and from camp? _____

We will be sending a form to your child's teacher to get a better understanding of where your child is with reading skills and ability. Do you give your permission for his/her school to release this information?

Yes: Signature: _____ **date** _____

No: Why? _____

Student's reading level (in your opinion) circle where YOU think your child is reading now:

K . 1 . 2 . 3 . 4 .

Recent standardized test scores Test Score Date
(If available to you)

Has the child ever had psycho-educational testing or been referred for testing? yes no

Results: _____

Does your child become upset with children or adults when frustrated?

Child's allergies (food, bee stings, medicines, other?) _____

___ Special food needs _____

We have a nurse on staff, please list all medicines to be given at camp:

.....
Reading Ability Questionnaire:

How would you describe the child's reading abilities?

- Excellent
- Above average
- Average
- Slightly below average
- Struggling greatly

How would you describe the child's attitude toward reading?

- Loves to read!
- Likes to read sometimes
- Doesn't care
- Dislikes reading
- Hates to read

Reading Strengths (check all that apply):

- Comprehension
- Decoding
- Phonics
- Reading Strategies
- Fluency, expression
- Other _____

(specify)

Reading Weaknesses (check all that apply):

- Comprehension
- Decoding
- Phonics
- Reading Strategies
- Fluency, expression
- Other _____

(specify)

If applicable, student's DIBELS TESTING info for current grade level: _____

.....
By law, no prescription medications will be given unless in the original labeled bottle with the camper's name, prescriber's name, medication name, dosage and instructions for administration. No samples used without label.

_____ This camper takes **no** medications. _____ This camper **will take** the following medications at camp:

Circle if the student has had: Measles, Mumps, Chicken Pox, German Measles, Hepatitis A, Hepatitis B, Hepatitis C.

Please circle any of the following conditions that apply to the participant:

- | | | | |
|---------------------|---------------|---------------------------|---------------------|
| Asthma | Head injury | Passed out after exercise | Surgery of any type |
| Infectious disease | Seizures | Diabetes | Hospitalized |
| Heart Murmur | Back Problems | Skin problems | Eating disorder |
| High blood pressure | Joint pain | Frequent ear infections | Frequent headaches |

Please explain any circled answers:

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Has the child had mononucleosis in the past year? ___Yes ___No Has the child had abnormal menstrual history? ___Yes ___No

Has the child ever had emotional difficulties where professional help became necessary? ___Yes ___No

Are immunizations up-to-date? _____ If not, explain _____

Last tetanus injection ____/____/____ Last TB skin test ____/____/____ Result? _____

Has child been treated for

- ___ (ADD) Attention Deficit Disorder ___ (ADHD) Attention Deficit/Hyperactivity Disorder
___ mental/emotional health concerns ___ emotional or behavioral difficulties or an eating disorder
___ has child experienced a significant life event (History of abuse, death of a loved one, death of a pet, family change, adoption, foster care, new sibling, survived a disaster) _____

Any restrictions from camp activities? _____

Permission to Treat and Emergency Authorization: The health history is correct and complete as far as I know, and the person herein described has permission to engage in all camp activities except as noted. I hereby give permission to the camp to provide routine first aid, administer prescribed medications and seek emergency medical treatment including x-rays or interventions as deemed necessary. I also grant permission to the licensed provider selected by this camp to hospitalize, secure proper treatment, order injections and/or anesthesia and/or surgery as judged appropriate for the situation. I further authorize the release of medical information to any provider, insurance company and medical facility that may need access to complete their care. I understand that if I do not have medical insurance, I, as the participant/parent/ guardian, will be responsible for any medical expenses in the event of illness and/or injury. I understand that there are risks involved in participating in camp and its activities. I also give permission for my child's school to provide my son/daughter's health and immunization records.

SIGNATURE OF PARENT/GUARDIAN _____

Printed Name _____ Date: ____/____/____