

park century school

SCAMP

3939 Landmark Street Culver City, CA 90232
310.840.0500

Please print or type all information

CHILD

Child's Name: _____ Birth Date: _____ Age: _____

Current School: _____ Grade: ____ Teacher: _____

Name of School Contact: _____

Child's Home Address: _____
(Please include City and Zip Code)

Home Phone Number(s): _____

How did you hear about Park Century School?: _____

Marital Status of Parents: _____

PARENT

Name: _____

Home Address (If different from Child's):
(Please include City and Zip Code)

Home Phone: _____

Cell Phone: _____

Business Phone: _____

Fax: _____

Occupation: _____

Email: _____

PARENT

Name: _____

Home Address (If different from Child's):
(Please include City and Zip Code)

Home Phone: _____

Cell Phone: _____

Business Phone: _____

Fax: _____

Occupation: _____

Email: _____

Park Century School SCAMP Application

Has your child received any of the following?

Type	Yes/No	With whom?	Current (yes/no)?	How Frequently?	For how long?
Educational or Neuropsychological Testing					
Speech & Language Therapy					
Private Tutoring					
Other					

Child's Special Interests:

Parent/Guardian Signature:

Date:

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FAMILY INFORMATION

family, child is # _____ of _____ children

Brother and sisters (ages) _____

If your child is adopted, at what age did he/she join your family? _____

HEALTH INFORMATION

Please list any special health issues, including allergies _____

Does your child have a history of any of the following?

- | | | | |
|---|-------------------------------------|--|---|
| <input type="checkbox"/> Constant Cold | <input type="checkbox"/> Asthma | <input type="checkbox"/> Respiratory Infections | <input type="checkbox"/> Surgery |
| <input type="checkbox"/> Headaches | <input type="checkbox"/> Migraines | <input type="checkbox"/> Dizziness/Fainting Spells | <input type="checkbox"/> Adenoids |
| <input type="checkbox"/> Bladder Problems | <input type="checkbox"/> Bedwetting | <input type="checkbox"/> Accidents/Broken Bones | <input type="checkbox"/> Whooping Cough |
| <input type="checkbox"/> Abdominal Pain | <input type="checkbox"/> Seizures | <input type="checkbox"/> Ear Infections | <input type="checkbox"/> Tonsils |
| <input type="checkbox"/> Allergies | <input type="checkbox"/> Measles | <input type="checkbox"/> Chicken Pox | <input type="checkbox"/> Other |

Please explain if you checked "Other"? _____

Is your child taking any medication? Yes No (If yes, please list below):

Medication	Dosage	Times per day	Condition	Supervising physician
1 _____	_____	_____	_____	_____
2 _____	_____	_____	_____	_____
3 _____	_____	_____	_____	_____

EARLY DEVELOPMENT

BIRTH

Premature Normal Late Complications if any: _____

INFANT DEVELOPMENT

Activity Level: Active Passive Moderate
General Reactions: Very Alert Slow Hard to tell
Health: Good Colic Celiac difficulties Feeding problems Toilet Problems
 Other _____

Age when child: Sat up _____ Started walking _____ Spoke Words _____ Spoke in sentences _____

Hand preference: Right Left Both

CURRENT DEVELOPMENT

Name of child's pediatrician _____ Date of last physical exam _____

Address _____ Telephone _____

Date eyes last examined _____ By whom? _____ Vision problems? _____ Glasses? _____

Date hearing last examined _____ By whom? _____ Hearing difficulties? _____ Hearing aid? _____

Has your child had a neurological examination? _____ If so, when? _____ Physician's name _____

Address _____ Telephone _____

SCHOOL HISTORY- Previous schools your child has attended (DO NOT LIST CURRENT SCHOOLS HERE)

_____/_____/_____
SCHOOL ADDRESS GRADES ATTENDED

_____/_____/_____
SCHOOL ADDRESS GRADES ATTENDED

_____/_____/_____
SCHOOL ADDRESS GRADES ATTENDED

What are your child's strengths? _____

What has your child liked most in school? _____

What has your child disliked most in school? _____

Does your child have any difficulties with fine or gross motor skills?

What are you hoping to accomplish this summer?

EDUCATIONAL HISTORY

Date of most recent psychoeducational testing _____ Examiner _____

Address _____ Telephone _____

Date of most recent speech and language evaluation _____ Examiner _____

Address _____ Telephone _____

Is your child being tutored? _____ If yes, by whom? _____ How often? _____

Subject: area(s) _____

Has your child ever received counseling? _____ If yes, list

Beginning date	Ending date	Frequency	Therapist(s)	Addresses
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

SOCIAL DEVELOPMENT

Where does your child usually play?

Does your child prefer younger or older children?

Is your child a leader or a follower?

What after-school or summer programs has your child attended?

What are your most frequent discipline problems with your child?

How do you discipline?

Please describe any concerns you may have about your child's social, emotional, or behavioral functioning:

Please add any additional comments about your child that you think would be helpful:

Application completed and signed by:

Parent/Guardian Signature Print Name Date

**A two hundred dollar (\$200) processing and record review fee must be enclosed with this form.
Please make check payable to Park Century School**

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Authorization for Exchange of Confidential and Privileged Information

I hereby give my consent for all relevant information regarding:

NAME _____ DATE OF BIRTH _____

to be exchanged between Park Century School and:

NAME OR AGENCY _____

ADDRESS _____

PHONE NUMBER _____

This information is for the confidential use of school personnel.

SIGNATURE _____

RELATIONSHIP TO CHILD _____

ADDRESS _____

DATE _____

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Teacher Recommendation

Name of Applicant _____

Name of Teacher Completing Form: _____ Grade(s) Taught: _____

Subject(s) Taught: _____

To the Teacher:

The above named student is an applicant to Park Century School's Summer Academic Skills and Enrichment Program (SCAMP). So that we may better understand the applicant's learning style, we would appreciate your response to the questions below. Please return this form at your earliest convenience in the self addressed envelope. Thank you for your assistance.

1. How long have you worked with this student?

2. Current reading level _____

Comments: _____

3. Current math level _____

Comments: _____

4. Current written expression level _____

Comments: _____

5. What do you consider to be this student's greatest strengths?

Academically: _____

Personally: _____

6. What do you consider to be this student's greatest areas of need?

Academically: _____

Personally: _____

7. Explain any academic or disciplinary issues this student may have encountered

8. How does this student respond to rules and authority?

9. Address how this student interacts with his or her peers?

10. Address how this student interacts with adults?

11. List any teaching techniques and/or accommodations that have proven to be helpful?

12. How do you imagine this student would benefit from small classes, and one-to one intensive instruction in reading and math?

13. What do you hope this student would gain from attending SCAMP?

Please Continue on the Next Page

Academic and Personal Ratings

Please check all appropriate responses.

	Outstanding	Excellent	Good	Average	Below Average
Leadership	_____	_____	_____	_____	_____
Character and Integrity	_____	_____	_____	_____	_____
Responsibility	_____	_____	_____	_____	_____
Emotional Maturity	_____	_____	_____	_____	_____
Emotional Stability	_____	_____	_____	_____	_____
Motivation	_____	_____	_____	_____	_____
Homework Completion	_____	_____	_____	_____	_____
Organization	_____	_____	_____	_____	_____
Attention Span	_____	_____	_____	_____	_____
Self-confidence	_____	_____	_____	_____	_____

Please provide any additional comments.

Signature _____ Printed Name _____

School Name _____ City _____

E-mail _____ School Phone _____

Please return to Kyle Hay, SCAMP Coordinator at Park Century School
3939 Landmark Street, Culver City, CA 90232