Applications should be emailed, mailed, or faxed to:
Florida School for the Deaf and the Blind
Sue Hill, Summer Quest Director
207 San Marco Avenue
St. Augustine, FL 32084
Fax: 904-827-2230
Email: hills@fsdbk12.org

FSDB Summer Quest 2023

*All pages must be completed and received by **APRIL 22, 2023**, even if an application to enroll in FSDB has been submitted.*

Summer Quest Dates (please select the date you will be attending)

☐ June 4-9, 2023 (ages 8-12) ☐ June 11-16, 2023 (ages 13-17)

Student Information (to be completed by parent/legal guardian)

Child's Name: _____ Gender ID: ☐ Male ☐ Female

Birth Date: _____ /_____ /_____ Age (*as of June 1, 2023*): _____ Height: _____ Weight: _____

Home Address (City, State, Zip): _____

Name of Current School: _____ Grade in August 2023: _____

Student is: ☐ Deaf/Hard of Hearing ☐ Blind/Visually Impaired ☐ DeafBlind

T-Shirt Size *(adult shirt sizing; please circle one)*: XS S M L XL XXL

Parent/Legal Guardian Information

Name of Parent/Legal Guardian: _____ Relationship to Child: _____

Home Address (if different from child): _____

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

VP: (____) _____ Email: _____

Best Number to Contact You: _____

Person to Contact in Case of Emergency

Name of Emergency Contact: _____ Relationship to Child: _____

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

VP: (____) _____ Email: _____

Best number to contact you: _____

Emergency Contact #2: _____ Relationship to Child: _____

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

VP: (____) _____ Email: _____

Best Number to Contact You: _____

PHYSICIAN'S FORM

This form must be signed by your child's physician, even if your child does not take any medications.

Child's Name: _____ Date of Birth: _____ /_____ /_____

Address (City, State, Zip): _____

Name of Parent/Legal Guardian: _____ Relationship to Child: _____

Address (*if different from child*): _____

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

VP: (____) _____ Email: _____

This section must be filled out by a physician, PA or ARNP. A school physical form may be used.

IMMUNIZATION HISTORY: Include all dates of basic immunizations and most recent boosters. (A vaccination history may be attached, but must include all information.)

DPT	1ST	2ND	3RD	Tetanus Booster
ORAL POLIO	1ST	2ND	3RD	Booster
HEP B	1ST	2ND	3RD	Booster
MEASLES VACCINE/MMR (LIVE)	1ST	2ND	3RD	PPD DATE (Optional)
OTHER:	DATE	OTHER	DATE	OTHER

PHYSICAL EXAMINATION

	Satisfactory	Not Satisfactory	Not Examined	Details
HEENT	_____	_____	_____	_____
Mental Health	_____	_____	_____	_____
Heart	_____	_____	_____	_____
Lungs	_____	_____	_____	_____
Abdomen	_____	_____	_____	_____
Genitourinary	_____	_____	_____	_____
Extremities	_____	_____	_____	_____
Posture/Spine	_____	_____	_____	_____
Metabolic	_____	_____	_____	_____

Additional Health Information: _____

_____

Applicant is under the care of physician for the following conditions: _____

_____

_____

Regularly Taken Medications: _____

_____

General Appraisal of Patient: _____

Restrictions for camp: ☐ None ☐ Other: _____

I HAVE EXAMINED THE PERSON HEREIN DESCRIBED AND REVIEWED THE HEALTH HISTORY. IT IS MY OPINION THAT THIS CHILD IS PHYSICALLY ABLE TO PARTICIPATE IN CAMP ACTIVITIES, EXCEPT AS NOTED ABOVE.

Dr./PA/ARNP Name: _____

Address: _____

Phone: _____ Fax: _____

Practitioner Signature: _____

Today's Date: _____

Office Stamp

AUTHORIZATION FOR THE ADMINISTRATION OF PRESCRIPTION MEDICATION

This Form must be completed by a physician assistant or ARNP, even if the child does not take any medications. Copy form as needed to list all prescriptions.

Child's Name: _____ Date of Birth: _____ /_____ /_____
Address (City, State, Zip): _____
Name of Parent/Legal Guardian: _____ Relationship to Child: _____
Address (if different from child): _____
Home Phone: (____) _____ Work Phone: (____) _____ Cell Phone: (____) _____
VP: (____) _____ Email: _____

KNOWN ALLERGIES: _____

Prescribed Medication	Dose	Frequency	Route	Indication/ Condition	Controlled? Y/N	Side Effects	Plan for Side Effects

Authorization for Over-the-Counter Medications:

Permission for the following over the counter medications to be administered to applicant if the medication is brought to camp with the appropriate labeling or permission for the following over-the-counter medications to be administered to applicant if deemed necessary by the camp medical staff. Please note that the name brand or its equivalent may be used. **Dosages will be administered according to the directions on the original container unless a physician directs otherwise.** If preferred, alternate over-the-counter medications may be sent with the child. **All medications, including vitamins or supplements, must be sent in the original containers with the dosage instructions provided and a signed order from a prescriber.**

PLEASE CROSS OUT ANY MEDICATIONS LISTED BELOW THAT IS NOT TO BE ADMINISTERED.

Condition Treated	**Medication Used**
Burns	Burn, Gel, Burn Cream
Chapped/Dry Lips	Chapstick, Vaseline
Colds	Pseudoephedrine
Cough	Guaifenesin syrup (e.g. Robitussin), cough drops
Diarrhea	Imodium, bismuth, subsalicylate
Dry Eyes	Moisturizing eye drops, saline solution
Emergency Allergy	Dyphenhydromene
Eye Wash	Saline solution, eye wash
Headache	Acetaminophen, Ibuprofen
Heat Rash	Medicated powder, cooling spray
Insect Bite	Medicaine, Afterbite, Afterbite Jr.
Poison Ivy	Caladryl, Calagel, Calamine Lotion
Rash	Hydrocortisone cream, Benadryl cream
Seasonal Allergies	Pseudoephedrine, Benadryl
Skin Break	Bacitracin, triple antibiotic cream/ointment, povidone, antiseptic, isopropyl alcohol, hydrogen peroxide
Sore Throat	Throat lozenges
Swimmer's Ear	Swim Ear drops
Toothache	Orasol, Oragel, Anbesol
Upset Stomach	Bismuth subsalicylate, antacid tablets
Other	Bug repellent, sunscreen

AUTHORIZED PRESCRIBER MUST SIGN BELOW
Prescriber Signature: _____ Date: _____
Prescriber Address: _____
Prescriber Phone: (_____) _____ Prescriber Fax: (_____) _____

SOCIAL HISTORY

Child's Name: _____

Address (City, State, Zip): _____

Date of Birth: _____ /_____ /_____ Gender ID: ☐ Male ☐ Female

Home Phone: (_____) _____ Cell Phone: (_____) _____ VP: (_____) _____

Cause of Deafness: _____ Hearing Loss: Right Ear _____ Left Ear _____

Hearing Aid/CI Model: _____ Serial # _____ Age hearing loss occurred: _____

Child's primary mode of communication? ☐ Sign ☐ Oral ☐ Gestures

PLEASE INCLUDE A COPY OF RECENT AUDIOLOGICAL REPORT.
If the audiological report is not included with your application, it will not be processed!

Cause of Blindness: _____ Visual Acuity: _____

Does your child wear glasses? ☐ Yes ☐ No If yes, at what age did he/she start? _____

Age vision loss occurred: _____ Student Reads: ☐ Braille ☐ Large Print ☐ Regular-Size Print

PLEASE INCLUDE A COPY OF RECENT EYE REPORT.
If the eye report is not included with your application, it will not be processed!

Does your child have any additional disabilities? If yes, please describe in detail:

_____

_____

Does your child need assistance in: ☐ Toileting ☐ Eating ☐ Dressing

Been away from home before? ☐ Yes ☐ No

Where? _____ and for how long? _____

Please comment regarding any other special needs your child may have:

_____

_____

_____

_____

_____

FIELD TRIP, RELEASE OF INFORMATION, AND PICK UP PERMISSION

Child's Name: _____ Date of Birth: _____ /_____ /_____

FIELD TRIPS

A variety of field trips may be offered for Summer Quest participants.

All trips are approved by the Program Director; supervision and transportation are provided.

Please indicate your permission for your child to participate in field trips by signing below:

*****I grant permission for my child to take part in Summer Quest sponsored field trips.**

Signature of Parent/Legal Guardian: _____ Date: _____

RELEASE OF INFORMATION

While your child is at FSDB, the School's Communication and Public Relations department may release to the public information about the summer camp participants and activities. School policy requires that only "directory information" may be released. Directory information includes: child's name, address, telephone number, date and place of birth, participation in activities and sports, dates of attendance, as well as pictures and video takes.

Please indicate your permission for your child's information to be released by signing below.

*****I grant permission for directory information about my child to be released to the public.**

Signature of Parent/Legal Guardian: _____ Date: _____

CHILD PICK-UP

NAME	RELATIONSHIP TO CHILD	PICK-UP
_____	_____	☐
_____	_____	☐
_____	_____	☐

Signature of Parent/Legal Guardian: _____ Date: _____

HOW DID YOU HEAR ABOUT US?

Internet ☐ Teacher ☐ DBS ☐ Newspaper ☐ School Counselor ☐ Other ☐

If other, please explain: _____

During FSDB Summer Quest, notes will be recorded on your child's strengths and their areas of opportunity. We will keep this document for you if you decide to enroll in our school.