WICOMICO COUNTY DEPARTMENT OF RECREATION & PARKS
KIDS KLUB SUMMER ESCAPE
Participant Registration Form

KIDS KLUB SUMMER ESCAPE (2018)

Cost: $125.00/wk **Age:** 5-13 **Time:** 7:00AM - 5:30PM

PARTICPANT INFORMATION

Camp Location (circle): **Delmar** **North Salisbury** **Westside** **Willards**

Participant's Name ______________________ Phone ____________
Address ______________________ City/State ______________ Zip Code ________
Birth Date ______________ Grade __________ Male ______ Female ______

Mother/Guardian Name ______________________________
Address ______________________ City/State ______________ Zip Code ________
Home Phone __________ Work Phone __________ Cell Phone ______________
Email ______________________________
Employer ______________________________ Phone ____________

Would like to receive email updates on future activities from Wicomico County Recreation and Parks. Yes or No

Father/Guardian Name ______________________________
Address ______________________ City/State ______________ Zip Code ________
Home Phone __________ Work Phone __________ Cell Phone ______________
Email ______________________________
Employer ______________________________ Phone ____________

Would like to receive email updates on future activities from Wicomico County Recreation and Parks. Yes or No

Marital Status of Parents ____ Single ____ Married ____ Separated ____ Divorced
If Separated/Divorced, which parent has custody? ______________________
Is there a problem with either parent visiting, talking with or picking up participant?
__ No __ Yes If yes, explain ______________________________

Your child will be released only to the following in addition to the parent/guardian:

Name ______________________________ Phone ____________
Address ______________________ City/State ______________ Zip Code ________
Relationship ______________________

Name ______________________________ Phone ____________
Address ______________________ City/State ______________ Zip Code ________
Relationship ______________________

Emergency Information:
Person(s) other than parent (include a relative in the area who may be notified of an emergency).

Name ______________________________ Relationship ____________
Address ______________________ Home ____________ Work ____________

Name ______________________________ Relationship ____________
Address ______________________ Home ____________ Work ____________

Pick Up Instructions/ Considerations:
Are there any special considerations the staff needs to be aware of involving the pickup of your child? Please explain.

____
____
____
____

ELIGIBILITY FOR SUMMER CAMP

The Wicomico County Recreation and Parks is required to make reasonable accommodations for all participants in this program. The next few questions are asked to make sure your child has found a summer camp that matches his or her needs and provides a safe and suitable environment. We do not provide additional staff or resources for individual needs.

Can your child participate in all activities? __ No __ Yes

Does your child need any special accommodations? __No __ Yes

If yes, please explain ____
____

Please check any of the following that apply:

__ Hearing Aid
__ Wears Braces
__ Wears Diapers
__ Speaks little English
__ Uses Wheelchair (manual or electric)
__ Uses Sign Language
__ Use Crutches/Walker
__ Has Speech Impediment
__ Menstruates
__ Needs Assistance w/Walking
__ Needs Assistance w/toiletry
__ Needs Help Dressing
__ Needs Help with Feeding
___ Requires Additional Adult Support in School

Is your child on medication? __ No __ Yes
If Yes, what type? ____
When given? ________________________________ Who administers? ____________________________

**Our staff cannot administer medication. We are only permitted to supervise self-medication.*

Does your child have seizures? __ No __ Yes
If Yes, how often? ______________________________ How severe? ____________________________

Are there any significant medical or behavioral problems that we need to be aware of? __ No __ Yes
If Yes, please explain ____

If your child is enrolled in a Special Education program, what is their Special Education Classification?
____

Do you have any additional comments that would help us to know or assist your child?
____
____

ADDITIONAL INFORMATION

Does your child have any allergies or diet restrictions? __ Yes __ No
If yes, explain____

Does your child have specific fears? __ Yes __ No
If yes, explain____

What are your child's favorite indoor/outdoor activities? ____

Do you have any special skills or talents that you would like to share with the children as a special guest at our program (Firefighter, Artist, Musician etc.)____

Is your child exempt from immunizations for religious or medical reasons ____ No ____ Yes
If yes, please explain____

Date of participant's last tetanus immunization? **(MM/DD/YY)**____

What school does your child attend in Wicomico County or other county?
____

WICOMICO COUNTY DEPARTMENT OF RECREATION & PARKS
KIDS KLUB SUMMER ESCAPE WAVIERS & CONSENT FORMS

EMERGENCY CARE CONSENT FORM

In case of illness or accident while my child is under the care and supervision of the Summer Day Camp Program, I the undersigned, hereby consent to the Wicomico County Department of Recreation and Parks authorized staff to provide emergency first aid and/or administer emergency care and/or treatment through a clinic, a doctor and/or hospital should they feel it is advisable or necessary. I also agree to pay all of the cost and fees contingent upon an emergency medical care and/or treatment for my child as secured or authorized under this consent. This agreement shall continue as long as the participant is registered in the Summer Day Camp Program.

Name of Parent/Guardian ______________________________ Date__________________

Name of Physician or Clinic ______________________________ Phone__________________

Address of Physician or Clinic **(must have complete address with street number)**
____

Hospital Preference ____

My child's medical records are located at ____

______________________________ ______________________
Signature of Parent/Guardian **Date**

PERMISSION FOR TRIPS, EXCURSIONS AND USE OF PUBLIC PARKS AND FACILITIES

hereby given consent to the Wicomico County Department of Recreation & Parks Summer Day Camp to take ______________________________ **(Print Child's Name)** on walking or transported field trips to places of interest, including ıblic parks, with such understanding that such trips are under the supervision of authorized Summer Day Camp personnel and that l possible precautions are taken to ensure the health and safety of my child.

______________________________ ______________________
Parent/Guardian Signature **Date**

PERMISSION TO APPLY SUNBLOCK

I give the leader/director of the same sex permission to apply sunblock to my son/daughter when requested by the parent/guardian.
****It is your child's responsibility to seek out a counselor to apply sunblock. ****

______________________________ ______________________
Parent/Guardian Signature **Date**

WAIVER

urther agree that the medical information given above is correct. The undersigned do hereby expressly stipulate and agree to indemnify ıd hold forever harmless Wicomico County and the Wicomico County Department of Recreation, Parks and Tourism, its agents, officers ıd employees, against loss from any and all claims, demands, or actions in law or equity that may hereafter at any time be made or brought ' the participant listed above, or by anyone on behalf of said participant for the purpose of enforcing a claim for damages on account of any ıuries received or sustained by the participant arising out of his participation in the program. In signing this Release and Hold Harmless ıreement, each of the undersigned hereby acknowledges and represents that they are aware of the risks and hazards inherent in ırticipating in the program, that no insurance covering accident or injury has been provided for participants, that arrangements for any such surance would have to be made individually by the undersigned, and that at no time will my participation in a program be contingent on vulging any confidential medical information.

______________________________ Parent/Guardian Signature

______________________ Date

CONCUSSION WAIVER

ı compliance with Maryland HB 858 and SB 771, I hereby acknowledge that I have received the information regarding concussions ıblished by the United States Department of Health and Human Services Centers for Disease Control and Prevention (CDC). For ıdditional information I understand that I may call 1-800-232-4636 or go to www.dcd.gov/concussioninyouthsports.com

Participant's Name ______________________________ **Signature (If 18 or over)**______________________________

______________________________ **Parent/Guardian Signature**

______________________ **Date**

PHOTO RELEASE

I hereby grant Wicomico County, Maryland permission to use my likeness in a photograph, video or other digital reproduction in any and all of its publications, including any website entries and social media, without payment or any other consideration.

I understand and agree that these materials will become the sole property of Wicomico County, Maryland and will not be returned. I hereby irrevocably authorize Wicomico County, Maryland to edit, alter, copy, exhibit, publish or distribute this photo for purposes of publicizing its programs or for any other lawful purpose.

In addition, I waive the right to inspect or approve the finished product, including written or electronic copy, wherein my likeness appears. Additionally, I waive any right to royalties or other compensation arising or related to the use of the photograph. I hereby hold harmless and release and forever discharge Wicomico County, Maryland from all claims, demands, and causes of action which I, my heirs, representatives, executors, administrators, or any other persons acting on my behalf or on behalf of my estate have or may have by reason of this authorization.

I am 18 years of age and am competent to contract in my own name. I have read this release before signing below and I fully understand the contents, meaning, and impact of this release.

______________________________ **(Signature)**

______________________ **(Date)**

______________________________ **(Printed Name)**

If the person signing is under age 18, there must be consent by a parent or guardian, as follows:

I hereby certify that I am the parent or guardian of ______________________ **(Print Child's Name)**, named, and do hereby give my consent without reservation to the foregoing on behalf of this person.

______________________________ **(Parent/Guardian's Signature)**

______________________ **(Date)**

______________________________ **(Parent/Guardian's Printed Name)**

WICOMICO COUNTY DEPARTMENT OF RECREATION, PARKS AND TOURISM
Program Contract

Child's Name: ______________________________ **Program:** <u>**Kids Klub Summer Escape 2018**</u>

Please review the information below to ensure that you understand your responsibilities in enrolling your child in a Wicomico County Recreation, Parks and Tourism Summer Camp Program. A copy of this will be provided for your records upon request. Please initial each item. Also, print and sign your name and date on page 6.

_________ 1. All weekly payments are at drop off Monday mornings before 10AM. This is regardless of full time or part time status. Payments received after 10 AM on Mondays will be considered late and result in a $15.00 per child fee. You may pay early. Full-Time and Part-Time space is limited in the program. Prompt weekly payment ensures your child has a spot each week in our program.

_________ 2. Electronics, including cell phones and tablets will not be allowed at Kids Klub Summer Escape. Campers will be asked to put all electronic devices away in their bags or leave them at home. The staff will not be responsible for lost or damaged electronic devices.

_________ 3. Wicomico County Recreation, Parks and Tourism staff is not responsible for lost, damaged or stolen property.

_________ 4. Repeated late pick up may result in removal from the program and will result in a late pick up fee. **Refunds will not be made under these circumstances involving late pick up.** Late pick up fee is due at time of pick up. Camp begins at 7:00AM and ends promptly at 5:30PM.

_________ 5. I understand that camp is closed June 26th, 2018 and July 4th, 2018.

_________ 6. I understand that I may be asked to withdraw my child if their behavior patterns threaten their own health and safety or that of other children and staff. **Refunds will not be made under these circumstances.**

_________ 7. I understand that bullying of any nature is not tolerated and is grounds for suspension and or removal from the program. Threats of violence of any kind will not be tolerated and are grounds for suspension and or removal from the program. **Refunds will not be made under these circumstances.**

_________ 8. I understand that if my child breaks or damages equipment that belongs to Wicomico County Board of Education or Wicomico Country Recreation, Parks and Tourism, I am responsible for all costs.

_________ 9. I understand that my child cannot attend the program if he or she have any illness that threatens the health of other children. The Health Department regulations concerning periods of infection will be enforced.

_________ 10. I understand that if my child becomes ill during the program, it is my responsibility to arrange immediate pick up from the program. I understand that they cannot return to the program until he or she is well and or cleared by a doctor in severe cases.

_________ 11. If your child is found to have lice they will get sent home immediately. Your child will not be allowed to return until they are lice and nit free and you must supply a doctor's note or the box lid of the given treatment.

_________ 12. I understand that medication will not be administered by staff. If your child requires medication during camp hours you must supply written permission from the parents and written instructions from a physician. He or she must be able to administer the medication without assistance from the staff. The Medication Authorization form is available upon request and is required to be completed if medication during camp hours is needed.

_________ 13. Please provide an IEP or Behavior Intervention Plan if one is written. This is kept confidential and is only used for planning purposes. Please note we do not offer one-on-one care and only reasonable accommodations are made.

_________ 14. I understand that it is my responsibility to send my child with the appropriate attire which includes closed toe shoes (i.e. tennis shoes). Flip flops and sandals are not considered appropriate and are unsafe to participate in physical activity.

_________ 15. Wicomico County Child Care and Summer Camp programs follows the Board of Education policy on smoking, drugs, and alcohol on school and county grounds. Use of the before mentioned substances is grounds for immediate removal from the program. **Refunds will not be made under these circumstances.**

_________ 16. Discipline procedures are followed with the Board of Education guidelines. However, Wicomico County Recreation, Parks and Tourism reserves the right to remove a child from the program if the safety of that child and or other children in the program or staff are at risk. **Refunds will not be made under these circumstances.**

_________ 17. I understand that if my child receives **a write up**, it is up to the program director if the child will be suspended or removed from the program. If the child is removed from the program, **refunds will not be made under these circumstances.**

_________ 18. I understand that I am responsible for sending lunch and a snack everyday with my child.

I AGREE TO ADHERE TO THE WICOMICO COUNTY DEPARTMENT OF RECREATION, PARKS AND TOURISM'S
KIDS KLUB SUMMER ESCAPE SUMMER CAMP PROGRAM CONTRACT 2018
I GIVE MY CHILD PERMISSION TO PARTICIPATE IN THIS PROGRAM.

Parent Signature: ______________________________ **Date:** __________

____
(Parent/Guardian's Printed Name)

****Please check with the Program Director of Kids Klub Summer Escape if you have questions about any of the above questions in this section. 410-548-4900 x 109 or bbelfield@wicomicocounty.org****

YOUTH CAMP HEALTH HISTORY
CAMPER

Child's Name: ______________________________

Current residence: ______________________________

____

EMERGENCY CONTACT INFORMATION:

Emergency Contact
(Parent or Legal Guardian): ______________________ Phone: ______________

2nd Emergency Contact
(Other than Parent Above): ______________________ Phone: ______________

Primary Care Physician or
other provider of medical care: ______________________ Phone: ______________

HEALTH INFORMATION:

Are there any health problems including physical, psychiatric, or behavioral problems of which we need to be aware? ☐ NO

☐ YES, Explain: ______________________________

____

____

____

Are there any medications, dietary restrictions, allergies, or special needs that we need to be aware of to ensure that your child's camp experience is positive? ☐ NO

☐ YES, Explain: ______________________________

____

____

____

IMMUNIZATION INFORMATION:
Must list current residence above.

For campers who currently reside **within** the United States, a United States territory, or the District of Columbia: Does the camper have any immunization exemptions because of a parental or guardian objection or medical contraindication? ☐ NO

☐ YES, List: ______________________________

For campers who reside **outside** the United States, a United States territory, or the District of Columbia: Attach record of vaccination or immunity on Department form MDH-896.

____

Parent or Legal Guardian's Signature Date

MEDICATION ADMINISTRATION AUTHORIZATION FORM

for Youth Camps in Maryland

Maryland Department of Health (MDH)
Center for Healthy Homes and Community Services (CHHCS)
(410) 767-8417 Toll Free 1-877-4MD-MDH ext. 8417

This form must be completed fully in order for youth camp operators and staff members to administer the required medication or for the camper to self-administer medication. A new medication administration form must be completed at the beginning of each camp season, for each medication, and each time there is a change in dosage or time of administration of a medication.

- **Prescription medication must be in a container labeled by the pharmacist or prescriber.**
- **Nonprescription medication must be in the original container with the instructions for use. Nonprescription medication includes vitamins, homeopathic, and herbal medicines.**
- **An authorized individual must bring the medication to the camp and give the medication to an adult staff member.**

I. PRESCRIBER'S AUTHORIZATION

1. CHILD'S NAME

2. DATE OF BIRTH ____/____/________ (Month / Day / Year)

3. CONDITION FOR WHICH MEDICATION IS BEING ADMINISTERED:

4. EMERGENCY MEDICATION [ ] YES *-If yes, see Section III below.* [ ] NO

5. MEDICATION NAME

6. DOSE

7. ROUTE

8. TIME/FREQUENCY OF ADMINISTRATION

9. IF PRN, FREQUENCY

10. IF PRN, FOR WHAT SYMPTOMS

11. KNOWN SIDE EFFECTS SPECIFIC TO CHILD

12. MEDICATION SHALL BE ADMINISTERED during the year in which this form is dated in 14b below unless more restrictive dates are specified in 12a and 12b. This authorization is ***NOT TO EXCEED 1 YEAR.***

12a. FROM ____/____/________ (Month / Day / Year)

12b. TO ____/____/________ (Month / Day / Year)

13. PRESCRIBER'S NAME/TITLE

TELEPHONE

FAX

ADDRESS

CITY

STATE

ZIPCODE

This space may be used for the Prescriber's Address Stamp

14a. PRESCRIBER'S SIGNATURE ***(Parent/guardian cannot sign here)***
(ORIGINAL SIGNATURE OR SIGNATURE STAMP ONLY)

14b. DATE

II. PARENT/GUARDIAN AUTHORIZATION

I request the authorized youth camp operator, staff member or volunteer to administer the medication or supervise the camper in self-administration as prescribed by the above authorized prescriber. I certify that I have legal authority to consent to medical treatment for the child named above, including the administration of medication at the facility. I understand that at the end of the authorized period, an authorized individual, as listed in 15c below, which may include the child, must pick up the medication, otherwise it will be discarded. I authorize camp personnel and the authorized prescriber indicated on this form to communicate in compliance with HIPAA.

15a. PARENT/GUARDIAN SIGNATURE

15b. DATE

15C. INDIVIDUAL(S) AUTHORIZED TO PICK UP MEDICATION

15d. HOME PHONE #

15e. CELL PHONE #

15f. WORK PHONE #

III. AUTHORIZATION FOR SELF-ADMINISTRATION / SELF-CARRY (OPTIONAL)

This section should only be completed if this medication is approved for self-administration. Self-carry is only permitted for emergency medications such as inhalers and epinephrine. Both the prescriber and the parent/guardian must consent to self-administration below. However, youth camp operators are not required to permit self-administration or self-carry.

I authorize self-administration of the above listed medication for the child named above under the supervision of the youth camp operator, a designated staff member or volunteer. If indicated below, the child named above may self-carry emergency medication.

16a. PRESCRIBER'S SIGNATURE
authorizing self-administration

16b. SELF-CARRY EMERGENCY MEDICATION (Check One)
[ ] YES [ ] NO [ ] N/A - Not emergency medication

16c. DATE

17a. PARENT/GUARDIAN'S SIGNATURE
authorizing self-administration

17b. SELF-CARRY EMERGENCY MEDICATION (Check One)
[ ] YES [ ] NO [ ] N/A - Not emergency medication

17c. DATE

MEDICATION ADMINISTRATION FORM
for Youth Camps in Maryland

Maryland Department of Health (MDH)
Center for Healthy Homes and Community Services (CHHCS)
(410) 767-8417 Toll Free 1-877-4MD-MDH ext. 8417

I. FACILITY RECEIPT AND REVIEW

MEDICATION RECEIVED FROM		DATE
PLAN OF ACTION RECEIVED [ ] YES [ ] NO [ ] N/A	HEALTH SUPERVISOR NOTIFIED [ ] YES [ ] NO	
MEDICATION RECEIVED BY	PERSON'S SIGNATURE	DATE

II. MEDICATION ADMINISTRATION RECORD

Each administration of the listed medication shall be noted on the child's record below. Each nonprescription and prescription medication requires a separate medication authorization form and the administration of the listed medication is required to be recorded on the corresponding administration record.

Child's Name:	**Date of Birth:**
Medication Name:	**Dosage:**
Route:	**Time(s) to Administer:**

DATE	TIME	DOSAGE	REACTION OBSERVED (IF ANY)	STAFF OR SELF ADMINISTERED	NAME OF INDIVIDUAL WHO ADMINISTERED OR SUPERVISED SELF-ADMINISTRATION

KEEP FOR 3 YEARS

MEDICATION FINAL DISPOSITION FORM
for Youth Camps in Maryland

Maryland Department of Health (MDH)
Center for Healthy Homes and Community Services (CHHCS)
(410) 767-8417 Toll Free 1-877-4MD-MDH ext. 8417

I. FINAL DISPOSITION OF MEDICATION	
Child's Name:	**Date of Birth:**
Medication Name:	**Final Disposition:** [ ] **Returned** *(Complete Section A)* [ ] **Destroyed** *(Complete Section B)*
Section A	
MEDICATION RETURNED TO (NAME)	**DATE**
MEDICATION RETURNED BY (PERSON'S SIGNATURE)	**DATE**
Section B	
The above indicated medication was not retrieved by the parent/guardian or authorized individual within 1 week of the camper leaving camp; therefore, it has been destroyed according to COMAR 10.16.07.14.	
SIGNATURE OF PERSON RESPONSIBLE FOR DESTROYING MEDICATION	**DATE**
SIGNATURE OF PERSON WITNESSING THE DESTRUCTION OF THE MEDICATION	**DATE**

KEEP FOR 3 YEARS