



Washington County Recreation Department
11400 Robinwood Dr. Hagerstown, MD 21742
240-313-2805 / www.washco-md.net



CAMPER INFORMATION FORM

Do NOT return this form to the Recreation Department Office!

The STATE OF MARYLAND requires that one Camper Information Form/per camper be completed in its entirety and presented to the Campsite Director on the first day that your child attends Summer Camp or the child will not be permitted to attend Camp.

CAMPER PROFILE

CAMPER FULL NAME			
CAMPSITE LOCATION			
HOME ADDRESS			
BIRTH DATE	MONTH:	DAY:	YEAR:
GENDER	MALE		FEMALE

PARENT/GUARDIAN & PICK-UP CONTACT INFORMATION

STRICT PICK-UP POLICIES ARE IN PLACE. For the safety of each camper The WCRD Summer Camp Program is authorized to release your child only to the individuals listed on this form. Each authorized person must be at least sixteen (16) years old and show photo identification at time of sign-out. Campers will NOT be permitted to leave the camp with anyone not listed. Your cooperation is appreciated. Please list yourself and any adult permitted to pick your child up from camp. **The people listed will be contacted in an emergency in the order they are listed.** A late fee of \$5 per participant for every 15 min. will be assessed for campers not picked up by the closing time. Payment is due within 7 days of notification. PLEASE NOTE: A signed and dated statement must be delivered to the Campsite Director to receive permission for any adult not listed to retrieve your child.

PARENT/GUARDIAN (1)	FULL NAME:	PHONE NUMBER:
PARENT/GUARDIAN (2)	FULL NAME:	PHONE NUMBER:
PICK UP	FULL NAME:	PHONE NUMBER:
PICK UP	FULL NAME:	PHONE NUMBER:
PICK UP	FULL NAME:	PHONE NUMBER:

PARENT/GUARDIAN PERMISSION WAIVER

Camper Information: I have completed all areas of this form that apply to my camper to the best of my knowledge.

Pick-Up Policy: I have read and understand the WCRD Youth Summer Day Camper Pick Up Policy.

Medical Emergency Transportation: In the event of an emergency, I give permission for my child to be transported by ambulance.

Swim Permission: I give permission for my child to go swimming.

Walking Trips: I give permission for my child to walk to areas surrounding the campsite for special activities.

Authorization for use of Visual Likeness: On behalf of the Camper named above, his/her parents, guardians and heirs, I do hereby consent and agree that the Washington County Recreation Department, its employees and agents, shall have the right to record visual images of the Camper named above for purposes of promoting and publicizing Recreation Department programs and do hereby release and waive all rights, claims, or interests to own, control or receive compensation from the use of such visual images. I warrant that I am authorized to grant the consent and to make the release and waiver indicated herein.

Waiver of liability for injuries: On behalf of the Camper named above, his/her parents, guardians and heirs, I do hereby agree to assume the full risk of any injuries, including death, damages or loss which may be sustained by the Camper named above as a result of participating in any and all activities connected with or associated with the Summer Camp Program and to release, hold harmless, indemnify and covenant not to sue the Washington County Recreation Department, the Board of County Commissioners of Washington County, MD, the Washington County Public Schools, their agents, employees and volunteers for injuries, including death, damages or loss which may be sustained by the Camper named above as a result of participating in any and all activities connected with or associated with the Summer Camp Program. In the event of any injury to the Camper named above, I will notify the Recreation Department immediately. I warrant that I am authorized to make the release and waiver indicated herein.

PARENT/GUARDIAN PRINT NAME:	PARENT/GUARDIAN SIGNATURE:	DATE:
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NOTE: COMPLETE BOTH PAGES OF THIS FORM AND SUBMIT IT TO YOUR CAMPSITE THE FIRST DAY OF CAMP

CAMPER HEALTH INFORMATION

CAMPER FULL NAME:
(IN CASE FORMS ARE SEPARATED)

IMMUNIZATION HISTORY

All campers must be current on all immunizations, see www.EDCP.org (Immunization)

DOES THE CAMPER RESIDE WITHIN THE UNITED STATES, A US TERRITORY, OR D.C.?

☐ YES

☐ NO: Provide a record of vaccination or immunity on a form prescribed by Department.

IS THE CAMPER **EXEMPT** FROM ANY **IMMUNIZATION** ON PARENTAL/GUARDIAN OBJECTION, MEDICAL OR RELIGIOUS GROUNDS?

☐ YES:
Attach a signed copy of Maryland DHMH immunization is medically contra indicated, or the parent or guardian indicating that they object to immunizations for religious

☐ NO

ALLERGY INFORMATION

LIST ALL ALLERGIES (FOOD, MEDICINE, SUNSCREEN, ENVIRONMENT)

LIST WARNING SIGNS OF A REACTION

SUNSCREEN INFORMATION

The WCRD is required to obtain authorization from the parent/guardian before applying sunscreen at camp. The authorization shall include the camper's name, the parent or guardian's signature, the date signed, any known sunscreen allergies and whether staff may assist the camper in the application of the sunscreen. The WCRD will not provide sunscreen. Parents/guardians are encouraged to apply sunscreen to their child before the child attends camp for the day.

CHECK	
<input type="checkbox"/>	I give permission for staff to assist my camper in the application of the sunscreen. In emergency situations staff may also provide sunscreen for my camper.
<input type="checkbox"/>	My child has no known allergies to any brand of sunscreen.
<input type="checkbox"/>	My child is allergic to a particular brand of sunscreen. (List brand)

MEDICAL CONDITION AND OTHER CAMPER INFORMATION

DOES THE CAMPER HAVE AN ASTHMA CONDITION?	NO:	YES: List symptoms and treatment that should be associated with the onset of an asthma attack for the camper.
IS THE CAMPER PRONE TO SEIZURES?	NO:	YES: Provide date of last seizure and list symptoms that should be associated with the onset of a seizure for the camper.
OTHER MEDICAL CONDITIONS OR SPECIAL CONSIDERATIONS:	Provide information on any medical conditions, psychological conditions, behavioral conditions, dietary restrictions, physical activity restrictions, or special needs that we need to be aware of to ensure that your child's camp experience is positive:	

DOES CAMPER USE PRESCRIPTION OR OVER-THE-COUNTER MEDICATION/DEVICE?

NAME OF MEDICATION(S)/DEVICE	
TYPICAL TIME OF DAY THAT MEDICATION IS TAKEN	
WILL CAMPER BRING MEDICATION TO CAMP?	<input type="checkbox"/> YES: 1. Must Provide Prescriptive order 2. Complete and submit MEDICATION ADMINISTRATION AUTHORIZATION FORMS 3. Include signature of the Primary Care Physician
REASON FOR MEDICATION(S)	<input type="checkbox"/> NO
POSSIBLE SIDE EFFECTS	

PARENT/GUARDIAN PRINT NAME:

PARENT/GUARDIAN SIGNATURE:

DATE:

NOTE: COMPLETE BOTH PAGES OF THIS FORM AND SUBMIT IT TO **CAMP SITE** THE FIRST DAY OF CAMP

MEDICATION ADMINISTRATION FORM

Department of Health & Mental Hygiene (DHMH)
Center for Healthy Homes and Community Services (CHHCS)
6 St. Paul Street, Suite 1301
Baltimore, Maryland 21202-1608
(410) 767-8417 FAX (410) 333-8926
Toll Free 1-877-4MD-DHMH ext. 8417

[illegible]

REQUIRED FOR CAMPERS THAT BRING MEDICATION TO CAMP 2/3

MEDICATION ADMINISTRATION AUTHORIZATION FORM for Youth Camps in Maryland

Department of Health & Mental Hygiene (DHMH)
Center for Healthy Homes and Community Services (CHHCS)
(410) 767-8417 Toll Free 1-877-4MD-DHMH 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 adult 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 <input type="checkbox"/> YES -If yes, see Section III below. <input type="checkbox"/> 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		This space may be used for the Prescriber's Address Stamp	
TELEPHONE	FAX		
ADDRESS			
CITY	STATE		
14a. PRESCRIBER'S SIGNATURE (Parent/guardian cannot sign here) <small>(ORIGINAL SIGNATURE OR SIGNATURE STAMP ONLY)</small>		14b. DATE	

II. PARENT/GUARDIAN AUTHORIZATION

I request the authorized youth camp operator/staff to administer the medication or supervise the camper in self administration if authorized as prescribed by the above 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 adult must pick up the medication, otherwise it will be discarded. I authorize camp personnel to communicate with the prescriber as allowed by HIPAA.

15a. PARENT/GUARDIAN SIGNATURE		15b. DATE
15c. HOME PHONE #	15d. CELL PHONE #	15e. 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, insulin 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 consent that the child named above is able to self administer the medication listed. I authorize self administration of the above listed medication for the child named above under the supervision of an authorized youth camp operator/staff member. 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) <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> N/A - Not emergency medication	16c. DATE
17a. PARENT/GUARDIAN'S SIGNATURE authorizing self administration	17b. SELF CARRY EMERGENCY MEDICATION (Check One) <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> N/A - Not emergency medication	17c. DATE

REQUIRED FOR CAMPERS THAT BRING MEDICATION TO CAMP 3/3

MEDICATION FINAL DISPOSITION FORM for Youth Camps in Maryland

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

I. FINAL DISPOSITION OF MEDICATION	
Child's Name:	Date of Birth:
Medication Name:	Final Disposition: <input type="checkbox"/> Returned (Complete Section A) <input type="checkbox"/> 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



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MEDICATION ADMINISTRATION POLICY

Any medication or medical device that is brought onto campsite premises, including a nonprescription (over the counter) medication, requires a prescriptive order and the completion of the MEDICATION ADMINISTRATION AUTHORIZATION FORM, to included the signature of the Primary Care Physician. Camp Staff are NOT authorized to administer ANY medication. Campers must receive medication outside of camp hours OR self-administer during camp. Staff may remind individuals and distribute the medication container to the participant for self-administration. Director or Assistant Director must supervise and document all medication self-administration. To qualify, the child must be capable of safely self-administering the medication appropriately. All medications must be presented to Campsite Staff and are to be kept in an area only accessible by Campsite Staff. All containers must be presented in original pharmaceutical packaging and contained in a plastic baggy clearly labeled with the camper's full name. All medicines must be self-administered under the supervision of the Campsite Director or Assistant Director. Any failure to complete forms accurately or any failure to provide medication to the Campsite Director may result in termination of the Camper from the program and forfeiture of any fees paid. Please communicate with your campsite Director on health/medical issues. Any participant who requires that an Epi-pen and / or asthma inhaler be kept on his/her person while participating in a WCRD activity may do so. Due to the potential necessity for immediate medication distribution imposed by my child's life-threatening condition, parents may request that the camper be allowed to keep the appropriate prescribed Epi-pen and/or Asthma Inhaler on his/her person while participating in all WCRD activities. To qualify for this exemption, this child must be capable of safely storing the Epi-pen or asthma inhaler on his/her person and using the device appropriately.