Shannon Nazzal, Director
Karyn Molines, Division Chief

CALVERT COUNTY
DEPARTMENT OF PARKS AND RECREATION
NATURAL RESOURCES DIVISION

175 Main Street
Prince Frederick, Maryland 20678
410-535-5327
www.calvertcountymd.gov

Board of Commissioners
Earl F. Hance
Mike Hart
Thomas E. Hutchins
Kelly D. McConkey
Steven R. Weems

MEDICAL / IMMUNIZATION RECORD

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

Address: _____

City: _____ State: _____ Zip: _____

Date of last tetanus immunization: (Month/Year format) _____

Pertinent information on any significant medical problem_____

_____

Primary Physician:_____ Phone:_____

Does the child require any medication during summer camp hours? Yes: ____ No: ____
Both the MEDICATION RELEASE FORM and AUTHORIZATION FOR ANY MEDICINE including over-the-counter drugs must also be completed.

Is camper missing any immunization because of medical contraindication or exemption by religious belief? Yes____ No_____

Is child enrolled in a Maryland school? Yes __ No ____ If "yes" what is the name of the school?

_____

If camper is not registered in a Maryland school, you must furnish the Natural Resources Division required records of immunization, contraindication statement from child's physician or exemption by religious belief statement before child can be admitted to the program.

Parent/Guardian Name:_____

Home Phone:_____ Work Phone:_____ Cell Phone:_____

Parent/Guardian Name:_____

Home Phone:_____ Work Phone:_____ Cell Phone:_____

Emergency Contact: (Not Listed Above)

Name: _____Relation:_____

Home Phone:_____ Work Phone:_____ Cell Phone:_____

Name: _____Relation:_____

Home Phone:_____ Work Phone:_____ Cell Phone:_____

OFFICIAL USE ONLY: (include all camps for the current season)
CAMP _____ *LOCATION* _____
CAMP _____ *LOCATION* _____
CAMP _____ *LOCATION* _____

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

WAIVER RELEASE

I HEREBY GIVE PERMISSION FOR MY CHILD TO PARTICIPATE IN ALL ACTIVITIES AND ATTEND ALL TRIPS SPONSORED BY THE CALVERT COUNTY DIVISION OF NATURAL RESOURCES DIVISION. IN CONSIDERATION OF THE DIVISION'S ACCEPTING MY CHILD INTO THIS PROGRAM, I AGREE TO WAIVE AND FOREVER DISCHARGE CALVERT COUNTY, ITS EMPLOYEES AND AGENTS HARMLESS OF & FROM ANY INJURIES SUSTAINED BY MY CHILD WHICH OCCURS WHILE EN ROUTE TO OR FROM OR PARTICIPATING IN ANY ACTIVITY SPONSORED BY THE AFOREMENTIONED PARTIES.

NOTE: THIS RELEASE DOES NOT OBLIGATE YOUR CHILD TO ATTEND SCHEDULED TRIPS OR ACTIVITIES.

_____ _____
SIGNATURE OF PARENT OR GUARDIAN **DATE**

SIGN OUT RELEASE

UPON DROPPING OFF AND PICKING UP MY CHILD FROM THE CAMP, I AGREE TO INFORM THE DIRECTOR AND SIGN THE APPROPRIATE FORM, INCLUDING DATE AND TIME I DROPPED OFF AND PICKED UP MY CHILD. IN THE EVENT, I AM UNABLE TO PICK UP MY CHILD, I AGREE TO CALL THE SCHOOL/ CENTER AND INFORM THE DIRECTOR WITH THE NAME OF THE INDIVIDUAL I AUTHORIZE TO PICK UP MY CHILD. I AGREE TO PROVIDE THE NATURAL RESOURCES DIVISION WITH THE NAMES OF INDIVIDUALS I AUTHORIZE TO PICK UP MY CHILD WHEN I AM UNABLE TO DO SO MYSELF. (SEE NAMES LISTED BELOW.) I REALIZE IT IS MY RESPONSIBILITY TO KEEP THIS LIST UPDATED AND ACCURATE.

_____ _____
SIGNATURE OF PARENT OR GUARDIAN **DATE**

CHILD'S WALK/RIDE BIKE/SIGN-OUT PERMISSION RELEASE

I GIVE MY CHILD PERMISSION TO WALK AND/OR RIDE HIS/HER BIKE TO AND FROM THE CAMP SITE AND PERMISSION TO SIGN HIM/HER SELF IN AND OUT OF CAMP EACH DAY.

NOTE: CALVERT COUNTY NATURAL RESOURCES DIVISION CAN NOT BE HELD ACCOUNTABLE ONCE YOUR CHILD HAS SIGNED OUT!

_____ _____
SIGNATURE OF PARENT OR GUARDIAN **DATE**

AUTHORIZED PERSONS FOR PICK-UP

	NAME	PHONE NUMBERS
1.	_____	_____
2.	_____	_____
3.	_____	_____

UNAUTHORIZED PERSONS FOR PICK-UP

	NAME	PHONE NUMBERS
1.	_____	_____
2.	_____	_____

Please notify Natural Resources Division Staff of any changes or additions immediately.

OFFICIAL USE ONLY: DATE RECEIVED: _____STAFF INITIALS: _____

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MEDICATION RELEASE WAIVER

Child's Name: _____

Does the child require any medication including over-the-counter drugs during summer camp hours?
Yes: ____ No: ____

If YES, parent or guardian complete the following:

I, _____, the parent/guardian of _____
(Print parent name) (Print campers name)

hereby request that identified members of the camp staff be caretakers of medication and administrators of medication for the camper named above and as directed by my physician.

_____ _____
Physician's Name Physician's Phone Number

I understand that members of the camp staff will be instructed to take any medication from the camper upon arrival at the camp and secure it in a safe location.

I understand that at a prescribed time, a staff member will retrieve the medication and hand it to the camper in the container. The staff member will then watch the camper take the medication.

I understand the Authorization for Medication Form must be fill out completely and signed by the camper's doctor before the start of camp.

I also understand the staff who administers this medication are medically untrained. I hereby state, without reservation that I will not hold the Calvert County Natural Resources Division, or any of their employees and volunteers liable for any harm or injury which may be incurred by the camper in connection with this medical assistance, or damage/loss of medical equipment.

_____ _____
Signature of Parent/Guardian Date

OFFICIAL USE ONLY:
DATE RECEIVED: _____STAFF INITIALS: _____

CAMP _____ LOCATION _____
CAMP _____ LOCATION _____
CAMP _____ LOCATION _____

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		This space may be used for the Prescriber's Address Stamp
TELEPHONE	FAX	
ADDRESS		
CITY	STATE / ZIPCODE	
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

Allergy Action Plan
Must be accompanied by a Medication Authorization Form (OCC 1216)

Place Child's Picture Here

CHILD'S NAME: _____ Date of Birth: _____

ALLERGY TO: _____

Is the child Asthmatic? ☐ No ☐ Yes (If Yes = Higher Risk for Severe Reaction)

TREATMENT

Symptoms: The child has ingested a food allergen or exposed to an allergy trigger:	**Give this Medication** Epinephrine	Antihistamine
But is ***not*** exhibiting or complaining of any symptoms		
Mouth: itching, tingling, swelling of lips, tongue or mouth ("mouth feels funny")		
Skin: hives, itchy rash, swelling of the face or extremities		
Gut: nausea, abdominal cramps, vomiting, diarrhea		
Throat*: difficulty swallowing ("choking feeling"), hoarseness, hacking cough		
Lung*: shortness of breath, repetitive coughing, wheezing		
Heart*: weak or fast pulse, low blood pressure, fainting, pale, blueness		
Other:		
If reaction is progressing (several of the above areas affected)		

*Potentially life-threatening. The severity of symptoms can quickly change.
*__IMPORTANT:__ Asthma inhalers and/or antihistamines cannot be depended on to replace epinephrine in anaphylaxis.

Medication		**Dose:**
Epinephrine:		
Antihistamine:		
Other:		

_____ _____
Doctor's Signature Date

EMERGENCY CALLS

1) Call 911 (or Rescue Squad) whenever Epinephrine has been administered. 2) Call the parent. State that an allergic reaction has been treated and additional epinephrine may be needed. 3) Stay with the child.

Doctor's Name:_____ Phone Number:_____

Contact(s)	Name/Relationship	Phone Number(s) Daytime Number	Cell
Parent/Guardian 1			
Parent/Guardian 2			
Emergency 1			
Emergency 2			

*EVEN IF A PARENT/GUARDIAN CANNOT BE REACHED, DO NOT HESITATE TO MEDICATE AND CALL 911.

Health Care Provider and Parent Authorization for Self/Carry Self Administration
I authorize the child care provider to administer the above medications as indicated. Students may self carry/self administer [school-aged only] ☐ yes ☐ No

_____ _____
Parent/Guardian's Signature Date

Allergy Action Plan
(Continued)

Must be accompanied by a Medication Authorization Form (OCC 1216)

Place Child's Picture Here

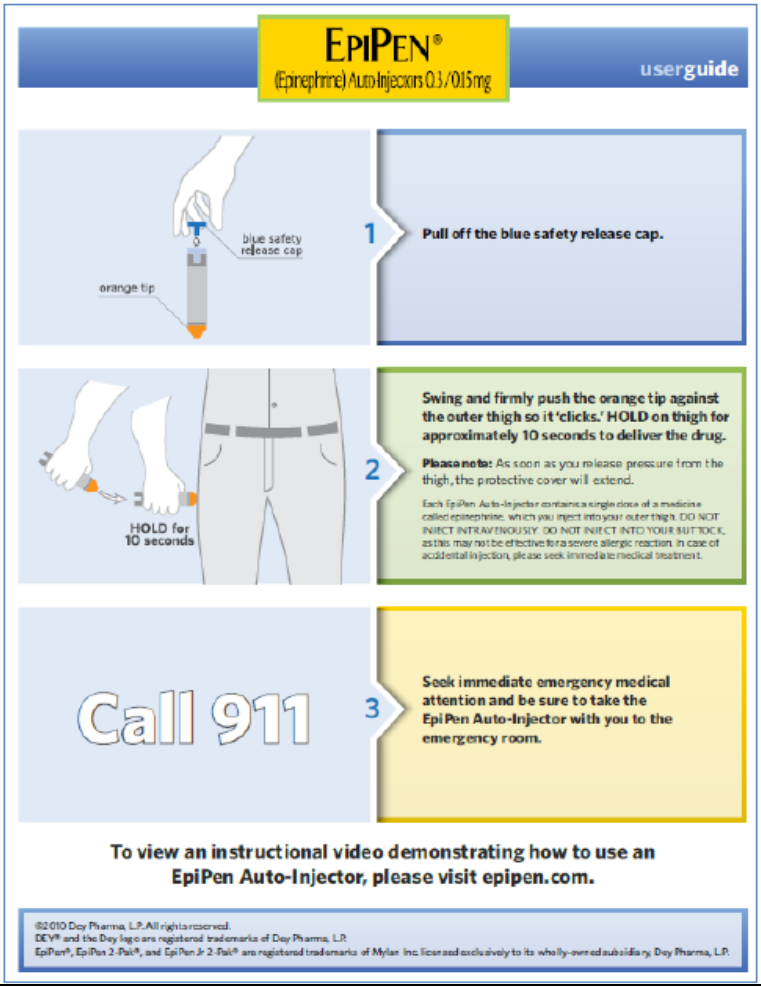
CHILD'S NAME: _____ **Date of Birth**: _____

ALLERGY TO: _____

Is the child Asthmatic? ☐ No ☐ Yes (If Yes = Higher Risk for Severe Reaction)

The Child Care Facility will:

- ☐ Reduce exposure to allergen(s) by: (no sharing food,
- ☐ Ensure proper hand washing procedures are followed.
- ☐ Observe and monitor child for any signs of allergic reaction(s).
- ☐ Ensure that medication is immediately available to administer in case of an allergic reaction (in the classroom, playground, field trips, etc.)
- ☐ Ensure that a person trained in Medication Administration accompanies child on any off-site activity.
- ☐



The Parent/Guardian will:

- ☐ Ensure the child care facility has a sufficient supply of emergency medication.
- ☐ Replace medication prior to the expiration date
- ☐ Monitor any foods served by the child care facility, make substitutions or arrangements with the facility, if needed.
- ☐

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EPINEPHRINE (EPI-PEN) TRAINING ACKNOWLEDGEMENT

Will the child require epinephrine during summer camp hours? Yes: ____ No: ____

If YES, parent or guardian *MUST* provide training to camp staff:

I _____, have been trained by
(Employee)

_____ to administer Epinephrine and/or to
Parent(s)/Guardian(s)/Designee(s)

provide other emergency care to _____, a child enrolled in a Calvert County Natural Resources Division Summer Camp, in the event the child has been exposed to _____ and is at risk of anaphylactic reaction, or if the child exhibits the symptoms described in the POLICY: ADMINISTERING EMERGENCY TREATMENT TO CHILDREN WITH SEVERE ALLERGIES which is attached to and made a part of this Acknowledgement.

Date of Training: _____

Signature: _____

(Employee)

Signature: _____

(Parent(s)/Guardian(s))

Maryland State Child Care/Nursery School
Asthma Medication Administration Authorization Form
ASTHMA ACTION PLAN for ___/___/__ to ___/___/___ (not to exceed 12 months)

Maryland State Department of Education
PREPARING WORLD CLASS STUDENTS

Triggers (list)

_____
_____
_____
_____
_____
_____

Student's

Name:_____ DOB:_____ PEAK FLOW PERSONAL BEST:_____

ASTHMA SEVERITY: ☐ Exercise Induced ☐ Intermittent ☐ Mild Persistent ☐ Moderate Persistent ☐ Severe Persistent

CHECK SYMPTOMS/INDICATIONS FOR MEDICATION USE

GREEN ZONE : Long Term Control Medication — use daily at home unless otherwise indicated

☐ Breathing is good
☐ No cough or wheeze
☐ Can work, exercise, play
☐ Other: _____
☐ Peak flow greater than _____ (80% personal best)

Medication	Dose	Route	Frequency
(Rescue Medication)			

☐ Prior to exercise/sports/ physical education

If using more than twice per week for exercise, notify the health care provider and parent/guardian.

YELLOW ZONE: Quick Relief Medications — to be added to Green zone medications for symptoms

☐ Cough or cold symptoms
☐ Wheezing
☐ Tight chest or shortness of breath
☐ Cough at night
☐ Other: _____

☐ Peak flow between _____ and _____ (50%-79% personal best)

Medication	Dose	Route	Frequency

If symptoms do not improve in _____ minutes, notify the health care provider and parent/guardian.
If using more than twice per week, notify the health care provider and parent/guardian.

RED ZONE: Emergency Medications— Take these medications and call 911

☐ Medication is not helping within 15-20 mins
☐ Breathing is hard and fast
☐ Nasal flaring or skin retracts between ribs
☐ Lips or fingernails blue
☐ Trouble walking or talking
☐ Other:_____
☐ Peak flow less than _____ (50% personal best)

Medication	Dose	Route	Frequency

Contact the parent/guardian after calling 911.

Health Care Provider and Parent Authorization

I authorize the child care provider to administer the above medications as indicated. By signing below, I authorize to self-carry/self-administer medication and authorize the child to self-carry/self-administer the medications indicated during any child care and before/after school programs. Student may self-carry medications:

[School-age children) ☐Yes ☐No

Prescriber signature: _____ Date: _____ Parent / Guardian Signature: _____ Date: _____

Reviewed by Child Care Provider: Name: _____ Signature: _____ Date: _____

3/20/2014

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

AUTHORIZED PERSONS FOR PICK-UP

	NAME	PHONE NUMBERS
1.	_____	_____
2.	_____	_____
3.	_____	_____

UNAUTHORIZED PERSONS FOR PICK-UP

	NAME	PHONE NUMBERS
1.	_____	_____
2.	_____	_____
3.	_____	_____

Please notify Natural Resources Division Staff of any changes or additions immediately.

OFFICIAL USE ONLY:
DATE RECEIVED: _____STAFF INITIALS: _____
include all camps for the current season)
CAMP _____ LOCATION _____
CAMP _____ LOCATION _____
CAMP _____ LOCATION _____

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FIELD TRIP PICK UP FORM

FOR USE ONLY IF SOMEONE OTHER THAN AUTHORIZED PERSON IS PICKING UP CAMPER FROM THE FIELD TRIP LOCATION.

This form is not necessary for pick up at regular camp location.

Name of Child: _____

Camp Location: _____

Trip Location: _____

Trip Date: _____

Approximate Time of Trip: _____

Reason For Field Trip Location Pick Up: _____

_____

_____

Name of individual picking child up and phone number: _____

Relationship: _____ Phone Number: _____

Parent's Home Phone Number: _____

Parent's Work Phone Number: _____

Parent's Cell Phone Number: _____

_____ _____

Signature of Parent Date