MONTGOMERY VILLAGE FOUNDATION, INC.

10120 APPLE RIDGE ROAD
MONTGOMERY VILLAGE, MARYLAND 20886-1000

(301) 948-0110 FAX (301) 990-7071 www.montgomeryvillage.com

PERMISSION TO PARTICIPATE IN MONTGOMERY VILLAGE FOUNDATION, INC. PROGRAM

I, _____, the parent/guardian of _____, give him/her permission to participate in the following described program to be conducted by Montgomery Village Foundation, Inc., its agents, employees and staff for **Camp Tiny Feet Session(s) ☐ 1, ☐ 2, ☐ 3, ☐ 4**, 2018.

This permission includes my consent to the following *(please initial to complete consent)*:

_____He/she may be transported in vehicles operated by or on behalf of Montgomery Village Foundation, Inc. and its personnel.

_____He/she may be administered necessary emergency medical treatment in the event of an accident or injury. Due to Federal regulations, persons involved in a biting incident or injury involving an exchange of bodily fluids may be required to be tested for blood borne pathogens.

_____He/she may have his/her (photo/likeness) used in the MV News/Recreation Guide; website and/or Facebook page.

In the event of an emergency the following persons are to be contacted:

_____ _____
NAME PHONE NUMBER

_____
ADDRESS

_____ _____
NAME PHONE NUMBER

_____
ADDRESS

I am aware of the potential risks that may be associated with the above activity. In consideration of _____'s being allowed to participate in this program, for myself and as his/her parent/guardian and on his/her behalf, I hereby release Montgomery Village Foundation, Inc., its agents, employees and staff for any injury or damage which may befall him/her while he/she participates in this program, including all risks connected therewith, whether foreseen or unforeseen, and further I save and hold harmless Montgomery Village Foundation, Inc., its agents, employees and staff from any claim arising out of his/her participation in this program by his/her family, estate, heirs, representatives, or assigns. I understand and agree that Montgomery Village Foundation, Inc., its agents, employees and staff may not be held liable in any way for any occurrence in connection with the above program which may result in injury, death or other damages to him/her, or his/her family, heirs, representative or assigns.

While I understand that Montgomery Village Foundation and its employees will make every effort to see that Camp Tiny Feet swim program is conducted in a safe manner, I understand that there are inherent risks (including drowning/death) associated with swimming in general. Therefore, I am giving my permission for my child to participate in the swim program with that knowledge.

IN WITNESS WHEREOF, I have executed this permission on _____, 2018.

_____ _____
NAME PHONE NUMBER

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

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RELEASE AUTHORIZATION

Child's Name:_____

Camp Attending:_____Session(s)_____

MVF staff assumes that you will keep this list current, and that they are fully authorized to release your child to anyone listed until you remove the name from the list.

Montgomery Village Foundation staff has permission to release my child named above to the following people:

Parent/Guardian 1:_____Phone:_____

Address:_____

Parent/Guardian 2:_____Phone:_____

Address:_____

*E-mail for program communication_____

List below any other adult who may pick up child - include all adults in your carpool. (List any additional people on back.)

Name:_____Phone:_____

Address:_____

Name:_____Phone:_____

Address:_____

Name:_____Phone:_____

Address:_____

Name:_____Phone:_____

Address:_____

If an occasional situation arises under which a parent would like their child released to a person who is **not** listed on this release form, the parent **must present written permission to MVF staff at the beginning** of that camp day. Under no circumstance can MVF staff accept verbal permission either in person or by phone, nor may they release the child to ANYONE not named in writing.

I understand that MVF staff may request I.D. be shown if they do not know the individual.

Signature:_____ Date:_____

12/17

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PARENTAL AUTHORIZATION TO BRING AND APPLY SUNSCREEN/BUG REPELLENT

Please complete and return this authorization form to your child's camp director. This form must be on file with the camp director by the first day of the camp session your child is attending.

Montgomery Village Foundation Department of Recreation and the Maryland Department of Health and Mental Hygiene require a signed parental authorization for participants to self-apply sunscreen and/or bug repellent at camp. MVF does not provide sunscreen or bug repellent to campers and MVF staff is not permitted to apply sunscreen or bug repellent to campers. Sunscreen and/or bug repellent must be sent to camp in the original container and be labeled with your child's name.

***By signing this sunscreen authorization form, I agree to allow my child to bring sunscreen and/or bug repellent to camp labeled with his/her name and to self-apply the sunscreen and/or bug repellent named below. I understand that MVF staff is not permitted to apply sunscreen to campers*.**

Campers Name:_____

Parent/Guardian Signature:_____

Date Signed:_____

Brand of Sunscreen:_____

Brand of Bug Repellent:_____

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MONTGOMERY VILLAGE FOUNDATION SUMMER CAMPS

We believe that appropriate behavior skills from every camp participant are necessary in order to provide a safe and positive atmosphere. Clear guidelines for behavior help participants know what is expected of them and to act accordingly. Please help your child read and understand the following expectations for behavior so that everyone will have an enjoyable summer experience in MVF programs:

Participant's Name: _____

The following expectations for behavior are based on the premise that we should treat others as we would like to be treated:

1. I will listen and not interrupt when others speak.

2. I will follow directions the first time they are given.

3. I will speak respectfully, not using inappropriate language, to staff and other participants.

4. I will be careful with property which is not mine and report any damage immediately.

5. I will keep my hands, feet, and other objects to myself.

6. I will stay with my group or in the program area until a counselor dismisses me.

7. I will not bring anything to camp which might hurt me or someone else - like alcohol, drugs or weapons.

MVF is not responsible for camper's personal items, including cell phones and games. Please do not bring cell phones to camp. If required for parent/guardian communication, they will be kept in the campers bags during camp activities.

Signature of Camper: _____

Signature of Parent: _____
Parent/Guardian signature acknowledges that the above guidelines have been reviewed and understood with the participant named above.

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SUMMER CAMP REFUND POLICY

Please read and keep on file for your information.

Except in the case of sudden illness, cancellations/requests for refund must be received **in writing and prior to the first day of the camp session** in question, in order to be considered.

Refunds will be made ***only*** under the following circumstances:

1. Cancellation of a program by the Montgomery Village Foundation.
2. Extended illness (doctor's certificate required).
3. Permanent relocation of participant out of Montgomery Village.
4. Failure to meet camp/class prerequisites.
5. MVF changes made to the meeting time/location, which prohibit participant's attendance.

Refund requests which are based on personal reasons including vacationing will only be granted if MVF is able to fill the requestor's spot in his or her camp with another paying participant. Absolutely no refunds will be granted once half of the program session has been concluded - no exceptions.

Except in the case that MVF cancels or changes the time/location of a program, a $25 non-refundable deposit included in the registration fee **will be held by MVF** in the event that a refund is granted.

Inter/Intra-Camp Transfers:
Requests from participants to transfer from one MVF camp to another MVF camp or to a different session of the same MVF camp will be accommodated if there are openings available. A $10 fee will be charged for this service.

For further information, please call 301-948-0110, Monday through Friday from 9:00 a.m. until 4:30 p.m.

ATTENTION!

If your child requires medication (self-administered), please complete and submit the Medication Administration Authorization Form.

If your child does not reside in the U.S. and is visiting for the summer, please complete and submit the Immunization Certificate.

These forms require a doctor's signature. Please print the necessary and applicable forms and have them completed by your doctor.

Both of these forms can be found on the following pages. For questions or more information, call 301-948-0110.

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 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

MARYLAND DEPARTMENT OF HEALTH IMMUNIZATION CERTIFICATE

CHILD'S NAME_____
LAST FIRST MI

SEX: MALE ☐ FEMALE ☐ BIRTHDATE_____/_____/_____

COUNTY _____ SCHOOL_____ GRADE_____

PARENT OR GUARDIAN NAME _____ PHONE NO. _____

ADDRESS _____ CITY _____ ZIP_____

RECORD OF IMMUNIZATIONS (See Notes On Other Side)

Vaccines Type

Dose #	DTP-DTaP-DT Mo/Day/Yr	Polio Mo/Day/Yr	Hib Mo/Day/Yr	Hep B Mo/Day/Yr	PCV Mo/Day/Yr	Rotavirus Mo/Day/Yr	MCV Mo/Day/Yr	HPV Mo/Day/Yr	Dose #	Hep A Mo/Day/Yr	MMR Mo/Day/Yr	Varicella Mo/Day/Yr	History of Varicella Disease Mo/Yr
1									1				
2									2				
3										Td Mo/Day/Yr	Tdap Mo/Day/Yr	MenB Mo/Day/Yr	Other Mo/Day/Yr
4										_____	_____	_____	_____
5										_____	_____	_____	_____
										_____			

To the best of my knowledge, the vaccines listed above were administered as indicated.

Clinic / Office Name
Office Address/ Phone Number

1. _____
Signature Title Date
(Medical provider, local health department official, school official, or child care provider only)

2. _____
Signature Title Date

3. _____
Signature Title Date

Lines 2 and 3 are for certification of vaccines given after the initial signature.

COMPLETE THE APPROPRIATE SECTION BELOW IF THE CHILD IS EXEMPT FROM VACCINATION ON MEDICAL OR RELIGIOUS GROUNDS. ANY VACCINATION(S) THAT HAVE BEEN RECEIVED SHOULD BE ENTERED ABOVE.

MEDICAL CONTRAINDICATION:

Please check the appropriate box to describe the medical contraindication.

This is a: ☐ Permanent condition OR ☐ Temporary condition until _____/_____/_____
Date

The above child has a valid medical contraindication to being vaccinated at this time. Please indicate which vaccine(s) and the reason for the contraindication, _____

Signed: _____ Date _____
Medical Provider / LHD Official

RELIGIOUS OBJECTION:

I am the parent/guardian of the child identified above. Because of my bona fide religious beliefs and practices, I object to any vaccine(s) being given to my child. This exemption does not apply during an emergency or epidemic of disease.

Signed: _____ Date: _____

How To Use This Form

The medical provider that gave the vaccinations may record the dates (using month/day/year) directly on this form (check marks are not acceptable) and certify them by signing the signature section. Combination vaccines should be listed individually, by each component of the vaccine. A different medical provider, local health department official, school official, or child care provider may transcribe onto this form and certify vaccination dates from any other record which has the authentication of a medical provider, health department, school, or child care service.

Only a medical provider, local health department official, school official, or child care provider may sign 'Record of Immunization' section of this form. This form may not be altered, changed, or modified in any way.

Notes:

1. When immunization records have been lost or destroyed, vaccination dates may be reconstructed for all vaccines except **varicella, measles, mumps, or rubella.**

2. Reconstructed dates for all vaccines must be reviewed and approved by a medical provider or local health department no later than 20 calendar days following the date the student was temporarily admitted or retained.

3. Blood test results are NOT acceptable evidence of immunity against diphtheria, tetanus, or pertussis (DTP/DTaP/Tdap/DT/Td).

4. Blood test verification of immunity is acceptable in lieu of polio, measles, mumps, rubella, hepatitis B, or varicella vaccination dates, but **revaccination may be more expedient**.

5. History of disease is NOT acceptable in lieu of any of the required immunizations, except varicella.

Immunization Requirements

The following excerpt from the MDH Code of Maryland Regulations (COMAR) 10.06.04.03 applies to schools:

"A preschool or school principal or other person in charge of a preschool or school, public or private, may not knowingly admit a student to or retain a student in a:
(1) Preschool program unless the student's parent or guardian has furnished evidence of age appropriate immunity against Haemophilus influenzae, type b, and pneumococcal disease;
(2) Preschool program or kindergarten through the second grade of school unless the student's parent or guardian has furnished evidence of age-appropriate immunity against pertussis; and
(3) Preschool program or kindergarten through the 12th grade unless the student's parent or guardian has furnished evidence of age-appropriate immunity against: (a) Tetanus; (b) Diphtheria; (c) Poliomyelitis; (d) Measles (rubeola); (e) Mumps; (f) Rubella; (g) Hepatitis B; (h) Varicella; (i) Meningitis; and (j) Tetanus-diphtheria-acellular pertussis acquired through a Tetanus-diphtheria-acellular pertussis (Tdap) vaccine."

Please refer to the "**Minimum Vaccine Requirements for Children Enrolled in Pre-school Programs and in Schools**" to determine age-appropriate immunity for preschool through grade 12 enrollees. The minimum vaccine requirements and MDH COMAR 10.06.04.03 are available at www.health.maryland.gov. (Choose Immunization in the A-Z Index)

Age-appropriate immunization requirements for licensed childcare centers and family day care homes are based on the Department of Human Resources COMAR 13A.15.03.02 and COMAR 13A.16.03.04 G & H and the **"Age-Appropriate Immunizations Requirements for Children Enrolled in Child Care Programs"** guideline chart are available at www.health.maryland.gov. (Choose Immunization in the A-Z Index)