Health History & Emergency Form - 2019

THIS FORM IS DUE NO LATER THAN MAY 24th.

Camper's Last Name ________________________________, First______________________________

□ Male □ Female Birthdate _____/______/_____ Grade Entering Fall 2019 _________

Mother's/Guardian #1's Last Name _______________________________, First______________________________

Phone (H) __________________ Phone (W) __________________ Phone (C) __________________

Father's/Guardian #2's Last Name _______________________________, First______________________________

Phone (H) __________________ Phone (W) __________________ Phone (C) __________________

Emergency Contact Name (other than parent/guardian) ____

Phone (H) __________________ Phone (W) __________________ Phone (C) __________________

Alternate Emergency Contact Name (other than parent/guardian) ____

Phone (H) __________________ Phone (W) __________________ Phone (C) __________________

Primary Care Physician's Name _______________________________ Phone _____________________

Address ____

Health Insurance Co _____________________________________ ID/Policy # _____________________

Parents **MUST** carry health and accident insurance for each child in attendance.

Did your child reside WITHIN the United States, a United States Territory, or the District of Columbia? (Circle one)

Yes If YES, provide state/territory in which child resides: _____________________________________

No If NO, provide country in which child resides: ____
You must attach Maryland State form DHMH-896 (record of immunization or immunity)

Did your child attend a Maryland public or private school in 2018 - 2019? (Circle one)

______ Yes If YES, provide school's name, address, city and zip code of most recent school here:

____

______ No If NO, provide below State/territory or Country in which child attended school. Then attach a record of immunization or immunity exemption (Maryland State form DHMH-896)

Or if your child was home-schooled, provide below which state the child was home-schooled. Then attach Maryland State form DHMH-896.

Is your child exempt from any immunizations? (Circle one. List below, if applicable, then include immunity exemption)

No Yes (If yes, please list them here:) ____

Please complete Both Sides of Form - Continues on Reverse

Health History & Emergency Form, con't - 2019

Camper's Last Name ______________________________, (First)___________________

List and describe any CURRENT OR PREVIOUS PHYSICAL, PSYCHIATRIC, SOCIAL OR BEHAVIORAL PROBLEMS of which we need to be aware or to aid in a positive camp experience. Include signs/symptoms to look for, what to do if they occur, and any actions recommended to prevent incidents from occurring.

List and describe any CURRENT OR PREVIOUS HEALTH CONDITIONS OR PAST MEDICAL TREATMENTS REQUIRING MEDICATIONS, DIETARY RESTRICTIONS, ALLERGIES, SPECIAL RESTRICTIONS OR SPECIAL NEEDS you feel pertinent to your child's care and safety while at camp. DESCRIBE ANY EMERGENCY MEDICAL INSTRUCTIONS regarding allergies or medical conditions including signs/symptoms to look for, what to do if they appear, and any actions to take to prevent an incident.

____

My child will be bringing the following medication(s) to camp*:

- ☐ Epi-Pen
- ☐ Benadryl
- ☐ Albuterol type Inhaler
- ☐ Other (describe) ______________________

*Note: Any medication to be administered at It's All Fun & Games day camp (including OVER-THE-COUNTER and those checked above) **MUST** be accompanied by a Physician's note explaining dosage, accompanied by our Medication Authorization Form signed by the physician, must be in it's original labeled container, must be self-administered with physician and parent's signature authorizing self-administration, and upon arrival, must be dropped off directly at the Office for registration. Medication should not be left with a child under any circumstances!

CARE AND TREATMENT CONSENT

I, (print your name) ____, the parent/guardian of

(print child's name) ____, give *Valleybrook Country Club, LLC* and/or *It's All Fun & Games, LLC* staff authorization and consent to treat my child for illness and injury as needed. In case of a medical emergency, *Valleybrook Country Club, LLC* and/or *It's All Fun & Games, LLC* staff have my consent and authorization for a physician or medical facility to treat my child for injuries sustained in the event that I am not able to be contacted for the consent of treatment. In the event of a medical emergency, your child will be taken to the NEAREST HOSPITAL EMERGENCY ROOM. Your signature authorizes the responsible person at *Valleybrook Country Club, LLC* and/or *It's All Fun & Games, LLC* to have your child transported to that hospital by ambulance if necessary.

Signature of Parent/Guardian: ____Date: ______________________

Please complete Both Sides of Form - Continues on Reverse

IT'S ALL FUN & GAMES SUMMER DAY CAMP
2019 SUNSCREEN REGISTRATION / PERMISSION

Camper's First and Last Name: ____

Camper's Date of Birth _____/______/_____

The State of Maryland, Office of Environmental Health and Food Protection, no longer considers sunscreen a medication requiring a prescriptive order. It's All Fun and Games Summer Day Camp must, however, obtain authorization from parents/guardians before allowing the use of sunscreen, as required by the State of Maryland. Our camp will NOT provide campers with sunscreen due to allergies. Campers must bring and use their own sunscreen. Camp staff will supervise the child's application of sunscreen, and can only assist by applying lotion to the child's face, and sunscreen SPRAY ONLY to the rest of their exposed skin. Staff will NOT apply lotion to any area other than the face.

Parents wishing for their child to use sunscreen at camp, must SUPPLY their own sunscreen, as well as instruct their child on how to APPLY their own sunscreen and the importance of applying sunscreen.

My child may be bringing or using the following sunscreen brands to It's All Fun & Games Summer Day Camp:

☐	Coppertone	☐	Banana Boat	☐	Neutrogena	☐	Aveeno
☐	Loreal	☐	Burt's Bees	☐	Jason	☐	Hawaiian Tropic
☐	Sun Bum	☐	Panama Jack	☐	Alba		
☐	Up & Up (Target)	☐	Great Value (Walmart)				

☐ Others (please list): ____

PLEASE PRINT CAMPER'S FIRST AND LAST NAME ON THE CONTAINER IN A VISIBLE MANNER WITH EITHER A PERMANENT MARKER OR A NON-REMOVABLE LABEL.

By signing below, I understand that It's All Fun & Games LLC staff will not apply sunscreen to my child unless they request help. I, hereby give permission to the staff of It's All Fun & Games LLC to supervise the application of sunscreen applied to my child by his or her own self, as well as assist with sunscreen lotion to their face, and sunscreen SPRAY to their arms, legs, shoulders, chest and back. I understand that if I do not supply sunscreen spray, staff will not be able to apply lotion to my child's body other than their face. I understand that the first application of sunscreen should be applied prior to my child's arrival at camp each day. Campers will be reminded to reapply sunscreen at the conclusion of their lunch period, as well as at the conclusion of their morning and afternoon snack times.

Print Parent or Guardian Name: ____

Sign Parent or Guardian Name: ____

Date: ___________________________________

Please note:

The following pages titled, “Medication Authorization” & “Medication Disposition”, do NOT need to be filled out and returned to the camp office UNLESS you plan to send some type of medication to camp for your child.

The “Medication Authorization” & “Medication Disposition” documents are only used for campers who have medication needs such as Epi-pens, Benadryl, Inhalers, prescription medications or over-the-counter medicines that they will be taking at the camp .

MEDICATION AUTHORIZATION

IT'S ALL FUN & GAMES, LLC 1810 Valleybrook Dr Kingsville MD 21087

In order for your child to have ANY type of medication or to receive ANY medication at camp, (including, but not limited to over-the-counter medications, inhalers, benadryl, or epi-pens), we must have specific directions from a physician, a physician's signature AND self-administration authorization/signatures from both a parent and physician. It is required that the first dose of any medication be administered at home. All medications must be self-administered by the camper; including the ability to read the container as well as determine the correct amount. A responsible camp staff person will observe and supervise the child during this process. If you do not feel the child can self-administer medication, the medication can NOT be brought to camp.

We do not supply any over-the-counter medications. You MUST send medication to camp in the original or a duplicate box or bottle with the current prescription label on the container, accompanied by this completed form. (Upon request, pharmacists will label containers that can be used.) HAVE YOUR PHYSICIAN COMPLETE THIS FORM AND SIGN IT IN BOTH PLACES AT THE BOTTOM. This form should be submitted to the camp office prior to the arrival of your child's medication.

Your permission and signature are also required with any medication. All forms and medication must be dropped off in the CAMP OFFICE!

PHYSICIAN'S INSTRUCTIONS FOR MEDICATION AT CAMP

Name of Camper ____ D.O.B. ______________________

Camper Address ____

Parents Primary Phone ___________________________ Parent's Alternate Phone ______________________________

Date of Commencement ________________________ Date of Discontinuation ______________________________

Medication Name ____ Medication Dosage ______________________

Frequency of Administration _________________________________ Route of Administration ______________________

If PRN, the frequency and for what symptoms should the medication be administered ____

This medication is to be used for emergency situations Y N

Condition for which medication is being administered ____

If side effects or a reaction can be expected, please describe ____

____

Please PRINT below the Physician's / Prescriber's Name, Title, Address, Phone Number and Fax Number:

____ ______________________________________

____

____ ______________________________________

____ ______________________________________

Physician's / Prescriber's Signature Date

AUTHORIZATION FOR SELF-MEDICATION

I authorize self-administration of the medication listed above, for the child named above, under the supervision of a designated staff member at It's All Fun & Games, LLC. I request the authorized youth camp operator or designated staff member at It's All Fun & Games, LLC, supervise the camper in self-administration as prescribed above by the authorized prescriber. I certify that I have legal authority to consent to medical treatment for the child named above, including self-administration of the medication at the facility. I understand at the end of the authorized period, an authorized individual must pick up the medication; otherwise it will be discarded. I authorize camp personnel to communicate with the authorized prescriber indicated on this form in compliance with HIPAA.

Physician's / Prescriber's Signature ____Date ________________________

Parent's Signature ____Date ________________________

MEDICATION FINAL DISPOSITION

IT'S ALL FUN & GAMES, LLC   1810 Valleybrook Dr   Kingsville MD   21087

Parents, please complete only the Camper Information section of this page!

CAMPER INFORMATION

Name of Camper ____ D.O.B. ______________________

Camper Address ____

____

Parent / Guardian's Primary Phone

____

Parent/Guardian's Alternate Phone

____

The bottom of this page is for camp staff use only.
Parents, please leave the following bottom section BLANK:

CAMP STAFF: COMPLETE AT END OF SESSION

1) Name of Medication (Listed on Reverse) ____

2) Date of Final Disposition of Medication Listed on Reverse ____________________________

3) This medication was returned to the parent or guardian (Circle one) Y N (If No, skip Items #4 & #5, then go to #6)

4) Name of the person to whom the medication was returned ____

5) Name of the Camp Staff Member who returned the medication ____

6) Signature of the Camp Staff Member responsible for returning or destroying the medication

____ Date ______________________________

7) Signature of the Person Witnessing the Destruction of the Medication

____ Date ______________________________