CAMP IMAGINATION 2017 REGISTRATION FORM

Child's Name: _____Date of Birth __/__/_____

Age: Gender: M or F Grade completed: School:

Parent or Legal Guardian: Email

Home Phone: Cell Phone Work Phone: Work Phone:

Address:

_____ (initial) I understand that I am registering my child to attend the Camp Farthest Out, Inc. Camp Imagination 2017 for the following weeks: (initial the weeks that you want your child to attend camp)

____ June 26-30 ____July 3-7 ____ July 10 – 14 ____ July 17-21 ____ July 24-28

I understand that registration fees are non refundable and any change to the last day of Baltimore City schools may result in a change in the start date of camp. There will be no adjustments to the ending date of camp.

Standard Waivers and Permissions:

I grant permission for my child _____ to participate in the following activities:
(Please initial each)

_____ programmed activities of Camp Farthest Out, (CFO) Inc., Camp Imagination 2017.
_____ ride the chartered bus to and from the CFO campsite and on scheduled field trips.
_____ swim activities at the CFO campsite or the designated swim site
_____ CFO can use my child's picture in program literature and/or on the website for promotional purposes
_____ photographed by CFO staff or professional photographers for CFO publications, website and/or newspaper or magazine articles.
_____ sunscreen applied as needed**
_____ bug spray applied as needed**

**Sunscreen and bug spray are applied to each camper daily upon arrival at the campsite unless your child has an allergy or you deny CFO permission to apply.

I acknowledge that there are natural hazards associated with camping and related activities in the outdoor setting. I affirm that my child is in good health and physically capable of performing the required activities of camp. I release and forever discharge Camp Farthest Out, Inc., its members, program participants, the board of directors or its employees and any organization co-sponsoring the program, from and against any and all liability for injury which may be suffered arising out of or in any way connected with my child participating in the previously mentioned activities.

Signature: Date:

CHILD PICK-UP FORM

I give permission for my child, _____ to be picked up by the people listed on this form. I understand that my child will not be released to anyone who is not listed on this form. Identification will be required for each individual authorized to pick up my child. **NO CHILD IS ALLOWED TO SIGN HIS/HERSELF OUT FROM CAMP. THE INDIVIDUALS AUTHORIZED TO PICK UP A CHILD MUST BE 18 YEARS OF AGE. Parents of the child need to be listed on this form.**

1. _____
   Name Phone Number Relationship to child

2. _____
   Name Phone Number Relationship to child

3. _____
   Name Phone Number Relationship to child

4. _____
   Name Phone Number Relationship to child

5. _____
   Name Phone Number Relationship to child

6. _____
   Name Phone Number Relationship to child

Campers are dropped off at 8 am and picked up by 4 pm every day. If your child arrives late and misses the bus, the parent/guardian is responsible for transporting to the campsite. Pick up time is 4 pm daily and 5 pm on field trip days (unless a different return time is designated). If your child is not picked up 10 minutes after the end of camp, there is a $10 charge for each 5 minutes late up to $80. Your child will not be able to return to camp until late fees are paid. If you are not able to pick up your child at the appointed time, extended care is available.

Parent Signature: _____ Date: _____

RELEASE FOR MEDICAL TREATMENT

Child's Name: _____

The parent(s) or legal guardians of the above named person, a minor, authorize Directors, Employees, and Board of Directors (collectively of Camp Farthest Out, Inc. (CFO)) consent to any X-ray examination, anesthetic, medical or surgical diagnosis or treatment and hospital care (medical care) to be rendered to the minor under the general or special supervision and upon the advice of a physician or surgeon licensed under the laws of the state or other jurisdiction in which medical or dental care is sought. For the purpose of medical or dental care obtained in Maryland, this authorization is given pursuant to the provisions of the Maryland Civil Code as amended.

It is understood that if time and circumstances reasonably permit, CFO will endeavor to communicate with at least one of the undersigned prior to the rendering of medical or dental care for the child named in this authorization. The undersigned understand and agree that CFO shall not be legally or financially liable for any claim arising from any medical or dental care.

In the event of any emergency CFO is given permission to provide treatment and necessary transportation to a medical facility for my child.

This authorization is given to CFO for use in conjunction with any event operated by CFO.

Signed: _____ Date: _____

Signed: _____ Date: _____

Medical Insurance Company _____

Policy # _____ Effective Date: _____

MEDICATION AUTHORIZATION FORM

Camp Farthest Out does not have a licensed health care professional on the staff and camp staff are not authorized to administer medications to campers. Parents/legal guardians must complete this form in order for the Camp Farthest Out staff to supervise a camper in self-administering medication at 1325 Madison Avenue and at the campsite 5915 Farthest Out Drive, Sykesville, MD 21784. The authorization for a camper to self-administer medication(s) require the following criteria:

- **A new medication authorization form must be completed at the beginning of the 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 its original container labeled by a pharmacist or the prescriber.**
- **Nonprescription medication must be in the original container with the instructions for use. Nonprescription medication includes vitamins, homeopathic and herbal medicines.**
- **A parent/legal guardian or an adult must bring the medication to the camp and give the medication to the Camp Director.**

I. Prescriber Authorization:

Camper's Name _____ Date of Birth _____

Condition for which medication is being administered: _____

Medication Name: _____ Dose: _____

Emergency medication: Y or N Time/Frequency of Administration: _____

If PRN, Frequency: _____ If PRN, for what symptoms: _____

Special instructions (if any): _____

Known side effects specific to child: _____

Medication Administered FROM: _____ TO: _____

Prescribers Name/Title: _____ Telephone: _____

Address: _____ Fax: _____

City _____ State: _____ Zip: _____

Prescribers Signature: _____ Date: _____

II. Parent/Legal Guardian Authorization:

I request that authorized camp staff supervise the camper in self-administration of medication 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 supervision of self-administration of medication at the campsite. 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.

Parent/Legal Guardian Signature: _____ Date: _____

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

III. Authorization for Self Administration and 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 camp staff member. The child named above may self-carry emergency medication if indicated below:

Prescriber's Signature: _____ Date: _____

Self Carry Emergency Medication (Circle one) Yes No Not emergency medication

Parent/Legal Guardian Signature: _____ Date: _____

Self Carry Emergency Medication (Circle one) Yes No Not emergency medication

CAMPER MEDICAL REPORT

Child's Name: _____ Date of Birth __/__/____

PART I: Completed by parent/guardian:

1st Emergency Contact: (Parent or Guardian)
_____ Phone: _____

2nd Emergency Contact (Other than Parent Above)
_____Phone: _____

Child's Physician: _____Phone: _____

Health Information:

1. Are there any health problems including physical, psychiatric, or behavioral problems of which we need to be aware? Circle Yes or No If yes, explain:
_____
_____

2. 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? Circle Yes or No If yes, explain:
_____
_____

Immunization Information:

1. State/territory in which child resides:
_____

2. Is this child exempt from any immunizations? Circle Yes or No If yes, list them:
_____

OR

For campers who reside outside the United States, a United States territory, or the District of Columbia:

1. Country in which child resides:
_____

2. Attach Department from DHMH-896 (Record of vaccination or immunity)

Authorization of Treatment:

In the event of an emergency, I give permission to the Camp Farthest Out staff to provide treatment and necessary transportation to a medical treatment facility for my child. In the event that I cannot be reached in an emergency, I hereby give my permission for a medical professional to administer treatment to my child.

Parent or Legal Guardian's Signature: Date:

PART II. Physical Examination by Physician:

Child's Name:
_____

Height: _____ Weight: _____ B.P. _____ HCA _____

1. Any evidence of current ailment or disease? Circle Yes or No If yes, explain:
_____
_____

2. Any allergies noted or revealed? Circle Yes or No If yes, please list:
_____
_____

3. Does the child have a health condition(s), which may require emergency action while he/she is at camp? (i.e. insect stings, asthma, allergy, bleeding problems, heart problems, etc.) If yes, please describe:
_____
_____

4. Is the child taking any medications? If so, please list the medications, dosage and times required to administer.
_____
_____

5. Does the child have any restrictions to physical activity at camp? If so, describe restrictions.
_____

6. Has child received all of the required immunizations for their age? If not, please list
_____

7. Does the child have any psychiatric or behavioral problems that require attention? If so, please explain:
_____
_____

8. Physician's comments on general health of applicant:
_____
_____
_____

Physician's Signature: _____Date: _____

Print Name: _____ License # _____ Phone: _____

Office Address: _____ City/State _____

THE MEDICAL REPORT MUST BE COMPLETED AND TURNED IN BY 5:00 PM ON MAY 31, 2017
ATTACH RECORD OF VACCINATION OR IMMUNITY TO THIS FORM BEFORE SUBMITTING