

CARROLL COUNTY FARM MUSEUM

FARM CAMP

2020 REGISTRATION

___ Session I July 13 – 17 For children entering 4th, 5th, or 6th Grade

Camp will be held from 9 a.m. to 4 p.m. each day, rain or shine.

Camper's Name: _____ Parent's Name: _____

Address: _____

Phone: (H) _____ (W) _____ (C) _____

Camper's Birthdate: _____ Sept. 2020 Grade Level: _____

Parents' Email: _____

Camper's T-shirt size: Child M Adult S Adult M

EARLY BIRD DISCOUNT (BY MARCH 2, 2020)

Session I \$175 per camper (\$195 after March 2)

\$160 for each additional camper in the same household/immediate family (\$180 after March 2)

Please complete all of the forms in this packet and mail with payment BY APRIL 6, 2020.

Spaces are limited. Spots are filled based on date of payment.

To pay by credit card (Visa, MasterCard or Discover only) please fill out the following:

Card Type: _____ Name on Card: _____

Card Number: _____

Expiration Date _____ CLV (number on back of card) _____

To pay by check, please make your check out to the Carroll County Farm Museum.

Completed applications should be mailed to: **Carroll County Farm Museum, 500 S. Center St. Westminster, MD 21157** and marked **Attention: Farm Camp**

Camper Pick-up Form

This form must be completed and turned in before the first day of camp. Anyone who will be picking up your camper from camp, including a parent/guardian, must be listed. Siblings attending camp at the same time may be listed on the same form.

NOTE: For campers' safety we will be checking identification and requiring signatures at pick-up. Campers will only be released to the individuals listed below.

No child will be released to a person not included on this list.

Dates camper will attend camp: from _____ to _____

Camper Name: _____

Sibling Name: _____

Primary Pick-up

Name: _____ Relationship to Camper: _____

Phone Number #1 (____) _____ Home Cell Work

Phone Number #2 (____) _____ Home Cell Work

Email: _____

I hereby authorize the following person(s) to pick up my child from camp:

Name (First, Last) Relationship Phone Number

Name (First, Last) Relationship Phone Number

Name (First, Last)	Relationship	Phone Number
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Name (First, Last)	Relationship	Phone Number
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My child needs to be picked up early. Myself or the person(s) listed above will pick my child up on: _____ at _____.

(Day) (Date) (Time)

Signature of Parent/Guardian: _____

Date: _____

Camper Code of Conduct

The Carroll County Farm Museum Farm Camp has rules that we follow to make sure everyone has a safe and fun experience at camp. This Code is our guide for behavior at Farm Camp. It is to be read and signed by both parent/guardian and child participant.

I understand that rules are made to protect me and others; to help make sure program activities are safe, fun, and successful, and to create a welcoming camp community.

I will treat other people, myself, property, and equipment with respect.

I understand that the following are unacceptable:

- Violence
- Bullying including name calling and put-downs as well as using technology, such as computers, text messaging, web site postings, etc. for these behaviors
- Cursing or verbally abusing anyone for any reason
- Fighting, threatening, stealing, damaging property
- Endangering the wellbeing of self or others
- Leaving the group without permission
- Leaving the Farm Museum property without a counselor

I understand the following are NOT allowed at camp:

- **Cell phones**

- Headphones, CD/MP3 players, radios
- Weapons or look-alike weapons
- Alcohol, Illegal substances, or tobacco products
- Medication which is not turned in to the Camp Coordinator

All medications must have a medication authorization form signed by the prescribing physician and be turned in to the Camp Director in the original container with the specific, unaltered directions of a licensed physician on the original prescription bottle. Please do not send expired medication to camp.

- The camp staff strives to create a successful and positive camp experience for every camper. While at camp your camper deserves to have fun, try new things, make new friends and enjoy the camp experience. We have a firm policy against all types of verbal, physical and relational bullying.
- The Carroll County Farm Museum reserves the right to send any camper home who exhibits unsafe and/or unacceptable behavior that endangers other campers, staff or property.
- Should this occur, parents/guardians are responsible for picking up their child in a reasonable timeframe as deemed necessary by the Camp Director. Persons listed as emergency contacts may be notified if parents/guardian cannot be reached.
- No refund will be given if a camper is sent home due to unacceptable behavior.
- Both the camper and parent/guardian have read, understand and agree to comply with the Code of Conduct Agreement while at Farm Camp.

Signature of Parent/Guardian _____ Date _____

Signature of Camper _____ Date _____

FARM CAMP

PHOTO RELEASE

I hereby consent to the use and reproduction by the Carroll County Farm Museum and Carroll County Government of my child's photographic image while attending the Museum's 2020 Farm Camp. Future publication includes newspaper stories, the Farm Museum website and Farm Museum brochures and publications.

I agree not to hold the publication or its agents responsible, under any circumstance, for any action, which occurs as a result of this advertisement. I understand that my child's photographic images taken during camp will become the exclusive property of the Carroll County Farm Museum and will be used only for promotional purposes.

I agree that I will not be compensated for the use of my child's photographic image.

Check ONE of the following AND fill out the information below:

I AGREE to the terms above: _____

I DO NOT AGREE to the terms above: _____

Date: _____

Child's Name: _____

Parent / Guardian Signature: _____

Parent / Guardian Printed Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Camp Registration Packet Checklist

- Registration Form
- Camper Pick-up Form
- Camper Health History Form
- Camper Code of Conduct Agreement
- Photo Release Form
- Medication Administration Authorization Form

**Only needed if you are sending medicine to camp.

Must be signed by the prescribing physician.

If medication is to be sent to camp for your child, the Medication Administration Authorization Form MUST BE completed by you, signed by the prescribing physician and brought to camp with the medication in its proper marked container on the first day of the session. For questions, please call Makenzie Gawel, camp director, at 410-386-3888 or call 800-654-4645 and ask to speak to Ms. Gawel.

CARROLL COUNTY FARM MUSEUM

LIVING HISTORY CAMP

2020 REGISTRATION

___ Session I June 22 – 26 For children entering 3rd or 4th Grade

___ Session II July 6 – 10 For children entering 5th or 6th Grade

Camp will be held from 9 a.m. to 4 p.m. each day, rain or shine.

Camper's Name: _____ Parent's Name: _____

Address: _____

Phone: (H) _____ (W) _____ (C) _____

Camper's Birthdate: _____ Sept. 2020 Grade Level: _____

Parents' Email: _____

Camper's T-shirt size: Child M Adult S Adult M

EARLY BIRD DISCOUNT (BY MARCH 2, 2020)

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No child will be released to a person not included on this list.

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Camper Name: _____

Sibling Name: _____

Primary Pick-up

Name: _____ Relationship to Camper: _____

Phone Number #1 (____) _____ Home Cell Work

Phone Number #2 (____) _____ Home Cell Work

Email: _____

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Name (First, Last) Relationship Phone Number

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Name (First, Last)	Relationship	Phone Number
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Name (First, Last)	Relationship	Phone Number
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(Day) (Date) (Time)

Signature of Parent/Guardian: _____

Date: _____

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- Both the camper and parent/guardian have read, understand and agree to comply with the Code of Conduct Agreement while at Living History Camp.

Signature of Parent/Guardian _____ Date _____

Signature of Camper _____ Date _____

LIVING HISTORY CAMP

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I agree that I will not be compensated for the use of my child's photographic image.

Check ONE of the following AND fill out the information below:

I AGREE to the terms above: _____

I DO NOT AGREE to the terms above: _____

Date: _____

Child's Name: _____

Parent / Guardian Signature: _____

Parent / Guardian Printed Name: _____

Address: _____

City: _____ State: _____ Zip: _____

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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? YES 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? YES 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? YES 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

MEDICATION ADMINISTRATION AUTHORIZATION FORM for Youth Camps in Maryland

Maryland Department of Health (MDH)
Office of Healthy Homes and Communities
(410) 767-8417 or 1-877-463-3464 ext. 78417
Draft Revision Date: 4/4/2018

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, 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. Non prescription 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.

Section I. PRESCRIBER'S AUTHORIZATION

1. CHILD'S NAME (First Middle Last)	2. DATE OF BIRTH (mm/dd/yyyy) ____/____/____
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3. MEDICATION SHALL BE ADMINISTERED during the year in which this form is dated in 7b below unless more restrictive dates are specified in 3a and 3b. This authorization is NOT TO EXCEED 1 YEAR.	3a. FROM (mm/dd/yyyy) ____/____/____	3b. TO (mm/dd/yyyy) ____/____/____
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Medication Name	Condition Being Treated/PRN Parameters	Dose	Route	Frequency	OK to Self-Administer	OK to Self-Carry (Emerg Meds Only)
1					<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not emergency med
Emergency Medication: <input type="checkbox"/> Yes <input type="checkbox"/> No Known side effects:						
2					<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not emergency med
Emergency Medication: <input type="checkbox"/> Yes <input type="checkbox"/> No Known side effects:						
3					<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not emergency med
Emergency Medication: <input type="checkbox"/> Yes <input type="checkbox"/> No Known side effects:						

4. PRESCRIBER'S NAME/TITLE	This space may be used for the Prescriber's Address Stamp
TELEPHONE FAX	
ADDRESS	
CITY STATE ZIP CODE	

5a. PRESCRIBER'S SIGNATURE (Parent/guardian cannot sign here) <i>(original signature or signature stamp only)</i>	5b. DATE (mm/dd/yyyy)
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Section II. PARENT/GUARDIAN AUTHORIZATION

I request the authorized youth camp operator, staff member or volunteer to administer the medication or to 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 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

6a. PARENT/GUARDIAN SIGNATURE	6b. DATE (mm/dd/yyyy)	6c. INDIVIDUALS AUTHORIZED TO PICK UP MEDICATION
6d. HOME PHONE #	6e. CELL PHONE #	6f. WORK PHONE #

Section III. AUTHORIZATION FOR SELF-ADMINISTRATION / SELF-CARRY (OPTIONAL)

THIS SECTION SHOULD ONLY BE COMPLETED IF ANY MEDICATIONS IN THE ASTHMA ACTION PLAN ABOVE ARE 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 all of the medications listed in *Section I* above that are checked as "OK to self-administer" or "OK to self-administer and self-carry" for the child named above under the supervision of the youth camp operator, a designated staff member or volunteer. If indicated in *Section I*, the child named above may self-carry emergency medications checked as "OK to self-administer and self-carry."

7a. PRESCRIBER'S SIGNATURE <small>FOR SELF-ADMINISTRATION/SELF-CARRY</small>	7b. DATE	8a. PARENT/GUARDIAN'S SIGNATURE <small>FOR SELF-ADMINISTRATION/SELF-CARRY</small>	8b. DATE
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