CARROLL COUNTY FARM MUSEUM
SUMMER CAMP
2024 REGISTRATION

___ **Farm Camp:** Farming Around the World June 24 – 28
___ **Farm Camp:** Farming Around the World July 8 – 12
___ **Living History Camp:** Cooking Through the Ages July 22 – 26
___ **Living History Camp:** Exploring 1800-2000 August 5 – 9

All sessions open to rising 2nd through rising 6th graders.

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. 2024 Grade Level: _____

Parents' Email: _____

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

EARLY BIRD DISCOUNT (BY MARCH 15, 2024)

$195 per camper ($215 after March 15)

Please complete all forms in this packet and mail or email with payment* BY MAY 24, 2024.
Spaces are limited. Spots are filled based on date of payment.
Only if you are **NOT registering online.*

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: Summer 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. NOTE: For the 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.**

PLEASE BRING A PHOTO ID TO PICK UP YOUR CAMPER EACH DAY.

Camper Name: _____

Primary Pick-up

Name: _____ Relationship to Camper: _____

Phone Number #1 (___) _____ □Home □ Cell □ Work

Phone Number #2 (___) _____ □Home □ Cell □ Work

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

_____

Name (First, Last) Relationship Phone Number

Signature of Parent/Guardian: _____

Date: _____

Camper Code of Conduct

The Carroll County Farm Museum Summer Camp Programs have rules that we follow to make sure everyone has a safe and fun experience at camp. This Code is our guide for behavior at Summer Camp. It is to be read and signed by both the parent/guardian and the 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 the 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 and 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**, **Smart Watches and Tablets**
- Headphones, CD/MP3 players and 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, the 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 the parents/guardian cannot be reached.
- No refund will be given if a camper is sent home due to unacceptable behavior.
- Both the camper and the parent/guardian have read, understand and agree to comply with the Code of Conduct Agreement while at Summer Camp.

Signature of Parent/Guardian _____ Date_____

Signature of Camper_____ Date_____

SUMMER 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 2024 Summer 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.
  This **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.

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

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-adminster 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, homeophathic, 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) ____/____/_____

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) ____/____/_____

	Medication Name	Condition Being Treated/PRN Parameters	Dose	Route	Frequency	OK to Self-Administer	OK to Self-Carry (Emerg Meds Only)
1						☐ Yes ☐ No	☐ Yes ☐ No ☐ Not emergency med
			Emergency Medication: ☐ Yes ☐ No Known side effects:				
2						☐ Yes ☐ No	☐ Yes ☐ No ☐ Not emergency med
			Emergency Medication: ☐ Yes ☐ No Known side effects:				
3						☐ Yes ☐ No	☐ Yes ☐ No ☐ Not emergency med
			Emergency Medication: ☐ Yes ☐ 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) (original signature or signature stamp only)	5b. DATE (mm/dd/yyyy)

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

ASTHMA ACTION PLAN AND MEDICATION ADMINISTRATION AUTHORIZATION FORM

for Youth Camps in Maryland

Please complete both pages of this form if the child has an inhaler or other asthma-related medication

Maryland Department of Health (MDH)
Office of Healthy Homes and Communities
(410) 767-8417 or 1-877-463-3464 ext. 78417

1. CHILD'S NAME (First Middle Last)	2. DATE OF BIRTH (mm/dd/yyyy) ____/____/_____	3. PEAK FLOW PERSONAL BEST:

4. ASTHMA SEVERITY (check one): ☐ Mild Intermittent ☐ Mild Persistent ☐ Moderate Persistent ☐ Severe Persistent ☐ Exercise Induced

5. ASTHMA TRIGGERS (check all that apply): ☐Colds ☐Exercise ☐Animals ☐Dust ☐Smoke ☐Food ☐Weather ☐Other_____

Section I. ASTHMA ACTION PLAN

6. THIS ASTHMA ACTION PLAN SHALL BE EFFECTIVE FOR AND MEDICATION SHALL BE ADMINISTERED during the year in which this form is dated in 9b below unless more restrictive dates are specified in 6a and 6b. This authorization is NOT TO EXCEED 1 YEAR.	6a. FROM (mm/dd/yyyy) ____/____/_____	6b. TO (mm/dd/yyyy) ____/____/_____

GREEN ZONE - DOING WELL

You have **ALL** of these
- Breathing is good
- No cough or wheeze
- Can walk, exercise, & play
- Can sleep all night
- **If known, peak flow greater than _____ (80% personal best)**

Exercise Zone

Rescue Medication	Dose	Route	Frequency	OK to Self-Administer	OK to Self-Carry
				☐ Yes ☐ No	☐ Yes ☐ No
	Known side effects:				

☐ Prior to all exercise/sports
☐ When the child feels they need it

YELLOW ZONE - GETTING WORSE

You have **ANY** of these
- Some problems breathing
- Wheezing, noisy breathing
- Tight chest
- Cough or cold symptoms
- Shortness of breath
- Other:_____
- **If known, peak flow between ____ and _____ (50% to 79% personal best)**

Emergency Medication	Dose	Route	Frequency	OK to Self-Administer	OK to Self-Carry
				☐ Yes ☐ No	☐ Yes ☐ No
	Known side effects:				
				☐ Yes ☐ No	☐ Yes ☐ No
	Known side effects:				
				☐ Yes ☐ No	☐ Yes ☐ No
	Known side effects:				

RED ZONE - MEDICAL ALERT/DANGER

You have **ANY** of these
- Breathing hard and fast
- Lips or fingernails are blue
- Trouble walking or talking
- Medicine is not helping (15-20 mins?)
- Other:_____
- **If known, peak flow below _____ (0% to 49% personal best)**

Emergency Medication	Dose	Route	Frequency	OK to Self-Administer	OK to Self-Carry
				☐ Yes ☐ No	☐ Yes ☐ No
	Known side effects:				
				☐ Yes ☐ No	☐ Yes ☐ No
	Known side effects:				
				☐ Yes ☐ No	☐ Yes ☐ No
	Known side effects:				

ASTHMA ACTION PLAN AND MEDICATION ADMINISTRATION AUTHORIZATION FORM

for Youth Camps in Maryland

Please complete this form if the child has an inhaler or other asthma-related medication

Maryland Department of Health (MDH)
Office of Healthy Homes and Communities
(410) 767-8417 or 1-877-463-3464 ext. 78417

CHILD'S NAME (First Middle Last)	DATE OF BIRTH (mm/dd/yyyy) ____/____/_____

Section II. PRESCRIBER'S AUTHORIZATION

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

9a. PRESCRIBER'S SIGNATURE (Parent/guardian cannot sign here) (original signature or signature stamp only)	9b. DATE (mm/dd/yyyy)

Section III. 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

10a. PARENT/GUARDIAN SIGNATURE	10b. DATE (mm/dd/yyyy)	10c. INDIVIDUALS AUTHORIZED TO PICK UP MEDICATION
10d. HOME PHONE #	10e. CELL PHONE #	10f. WORK PHONE #

Section IV. 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: Asthma Action Plan* 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: Asthma Action Plan* , the child named above may self-carry emergency medications checked as "OK to self-administer and self-carry."

11a. PRESCRIBER'S SIGNATURE FOR SELF-ADMINISTRATION/SELF-CARRY	11b. DATE (mm/dd/yyyy)
12a. PARENT/GUARDIAN'S SIGNATURE FOR SELF-ADMINISTRATION/SELF-CARRY	12b. DATE (mm/dd/yyyy)

Section V. CAMP MEDICAL STAFF USE ONLY

Camp Medical Staff Notes:	
Reviewed by:	DATE (mm/dd/yyyy)