Camp Pinehurst Special Needs Summer Camp 2018
FOLDER CHECKLIST

____ Participant Registration Form (4 pages)

____ Social Media Waiver

____ Camp Health Form

____ Camp Medication Administration Authorization Form (if needed)

____ Payment in Full

____ Payment Plan Proof (if not paying the total balance)

****

Transportation to and from camp is provided for Wicomico County residents.

Pick Up Address: _____

Drop off Address: _____

****

Parent/Guardian
I have reviewed, completed and signed off on all of the documents above and enclosed them in this registration folder.

Name: _____

Signature: _____ Date: _____

****

IMPORTANT REMINDERS

- Return completed registration packet any payment to Wicomico County Recreation and Parks.
- If **registration and payment/payment plan proof** must be submitted by registration deadline (6/1/2018)
- There is no part time enrollment.
- Space is limited

Camp Pinehurst
Summer Camp for Youth with Special Needs

Mission Statement:
To provide an opportunity for children with intellectual disabilities to enjoy summer activities through structured social settings.

Camp Pinehurst
Our summer camp serves children with a range of special needs in a safe, structured environment. It provides social and recreational experiences which promote social, emotional, and physical growth.

Days are action packed!
During the day the students will have the opportunity to participate in several physical activities such as; swimming, play sports, enjoying playgrounds, and walking adventures. Other activities such as music, drama, arts and crafts, and gardening are also included. Counselors lead activities and serve as role models and "coaches" to help campers participate positively in new and familiar experiences.

Fertile ground for friendship and growth
Adventures and friendships abound at Pinehurst, providing opportunities for campers to learn to participate within a group, form productive relationships, develop confidence, and recognize the benefits of good choices and the consequences of poor choices. Pinehurst promotes character values such as honesty, concern for others, responsibility, and the courage to do one's best.

Staff supervision
The Pinehurst counselor staff is mostly comprised of special education teachers, teacher assistants, and college students majoring in education. They are carefully selected for their leadership, personal values, enthusiasm, and maturity that enable them to relate to and motivate young people. Each counselor is closely supervised by an administration of knowledgeable and dedicated educators.

For questions please contact Brandi Belfield, Program Director at 410.548.4900 X109 or at bbelfield@wicomicocounty.org or the Camp Director Dorsey Cook at dcook@wcboe.org.

WICOMICO COUNTY DEPARTMENT OF RECREATION & PARKS
Participant Information

CAMP PINEHURST (2018)

June 27th – August 2nd, Monday – Thursday, 9:00AM – 3:00PM

Cost $400.00 (nonrefundable) ***Deadline: Friday, June 1st*** ***Age: 5-21***

****We do not supply a 1 on 1 assistant for participation in this program****
(1 on 1 must receive permission to attend camp with a camper)

REGISTRATION INFORMATION

Participant's Name _____ Phone _____
Address _____ City/State_____ Zip Code_____
Birth Date _____ Grade _____ Male _____ Female _____

Mother/Guardian Name _____
Address _____ City/State_____ Zip Code_____
Home Phone _____ Work Phone _____ Cell Phone _____
Email address: _____
Employer _____ Phone _____

Would like to receive email updates on future activities from Wicomico County Recreation and Parks? Yes or No

Father/Guardian Name _____
Address _____ City/State_____ Zip Code_____
Home Phone _____ Work Phone _____ Cell Phone _____
Email: _____
Employer _____ Phone _____

Would like to receive email updates on future activities from Wicomico County Recreation and Parks? Yes or No

Marital Status of Parents __ Single __ Married __ Separated __ Divorced
If Separated/Divorced, which parent has custody? _____

Is there a problem with either parent visiting, talking with or picking up participant?
__ No __ Yes If yes, explain _____

Your child will be released only to the following in addition to the parent/guardian:

Name _____ Phone _____
Address _____ City/State_____ Zip Code_____
Relationship _____

Name _____ Phone _____
Address _____ City/State_____ Zip Code_____
Relationship _____

Emergency Information: Person(s) other than parent (include a relative in the area who may be notified of an emergency).

Name _____ Relationship _____
Address _____ Home _____ Work _____

Name _____ Relationship _____
Address _____ Home _____ Work _____

ABOUT YOUR CHILD

What are your child's favorite indoor/outdoor activities? _____
_____

Do you have any special skills or talents that you would like to share with the children?
_____

Do you have any additional comments that would help us to know or assist your child?
_____
_____

What school does your child attend in Wicomico County or other county? _____
_____

BEHAVIOR MANAGEMENT

Does your child have a behavior management plan/BIP? Y or N
If yes, please attach the appropriate paperwork.

If your child is enrolled in a Special Education program, what is their Special Education Classification?
_____

Please check with the Program Director, 410-548-4900 x 109, to see if your child is eligible for this camp. Camp Pinehurst is unable to provide 1 on 1 assistant for any participants.

EMERGENCY CARE CONSENT FORM

In case of illness or accident while my child is under the care and supervision of the Summer Day Camp Program, I the undersigned, hereby consent to the Wicomico County Department of Recreation and Parks authorized staff to provide emergency first aid and/or administer emergency care and/or treatment through a clinic, a doctor and/or hospital should they feel it is advisable or necessary. I also agree to pay all of the cost and fees contingent upon an emergency medical care and/or treatment for my child as secured or authorized under this consent. This agreement shall continue as long as the participant is registered in the Summer Day Camp Program.

Name of Parent/Guardian _____ Date _____

Name of Physician _____ Phone _____

Address of Physician **(must have complete address with street number)**
_____

Hospital Preference _____

My child's medical records are located at _____

_____ _____
Signature of Parent/Guardian Date

WICOMICO COUNTY DEPARTMENT OF RECREATION & PARKS
CAMP PINEHURST – SPECIAL NEEDS CAMP

PERMISSION FOR TRIPS, EXCURSIONS AND USE OF PUBLIC PARKS AND FACILITIES

I hereby given consent to the W/C Department of Recreation & Parks Summer Day Camp to take

(Child's Name) _____ on walking or transported field trips to places of interest, including public parks, with such understanding that such trips are under the supervision of authorized Summer Day Camp personnel and that all possible precautions are taken to ensure the health and safety of my child.

_____ _____
Parent/Guardian Signature Date

PERMISSION TO APPLY SUNBLOCK

I give the leader/director of the same sex permission to apply sunblock to my son/daughter when requested by the parent/guardian.

_____ _____
Parent/Guardian Signature Date

WAVIER

CONCUSSION WAIVER

In compliance with Maryland HB 858 and SB 771, I hereby acknowledge that I have received the information regarding concussions published by the United States Department of Health and Human Services Centers for Disease Control and Prevention (CDC). For additional information I understand that I may call1-800-232-4636 or go to www.dcd.gov/concussioninyouthsports.

_____ _____
Parent/Guardian Signature Date

GENERAL WAIVER

The undersigned do hereby expressly stipulate and agree to indemnify and hold forever harmless Wicomico County and the Wicomico County Department of Recreation, Parks and Tourism, its agents, officers and employees, against loss from any and all claims, demands, or actions in law or equity that may hereafter at any time be made or brought by the participant listed above, or by anyone on behalf of said participant for the purpose of enforcing a claim for damages on account of any injuries received or sustained by the participant arising out of his participation in the program. In signing this Release and Hold Harmless Agreement, each of the undersigned hereby acknowledges and represents that they are aware of the risks and hazards inherent in participating in the program, that no insurance covering accident or injury has been provided for participants, that arrangements for any such insurance would have to be made individually by the undersigned, and that at no time will my participation in a program be contingent on divulging **any** confidential medical information.

_____ _____
Parent/Guardian Signature Date

PHOTO RELEASE

I hereby grant Wicomico County, Maryland permission to use my likeness in a photograph, video or other digital reproduction in any and all of its publications, including any website entries and social media, without payment or any other consideration.

I understand and agree that these materials will become the sole property of Wicomico County, Maryland and will not be returned. I hereby irrevocably authorize Wicomico County, Maryland to edit, alter, copy, exhibit, publish or distribute this photo for purposes of publicizing its programs or for any other lawful purpose.

In addition, I waive the right to inspect or approve the finished product, including written or electronic copy, wherein my likeness appears. Additionally, I waive any right to royalties or other compensation arising or related to the use of the photograph. I hereby hold harmless and release and forever discharge Wicomico County, Maryland from all claims, demands, and causes of action which I, my heirs, representatives, executors, administrators, or any other persons acting on my behalf or on behalf of my estate have or may have by reason of this authorization.

I am 18 years of age and am competent to contract in my own name. I have read this release before signing below and I fully understand the contents, meaning, and impact of this release.

_____ _____

(Signature) (Date)

_____

(Printed Name)

If the person signing is under age 18, there must be consent by a parent or guardian, as follows:

I hereby certify that I am the parent or guardian of _____, named above, and do hereby give my consent without reservation to the foregoing on behalf of this person.

_____ _____

(Parent/Guardian's Signature) (Date)

_____

(Parent/Guardian's Printed Name)

SOCIAL MEDIA/PHOTO CONSENT

May we use still and/or moving image(s) being photographs, video footage and/or audio footage of your child(ren), if under 18, in printed publicity or promotional literature produced by Wicomico Recreation & Parks, including advertising, leaflets, posters, newsletters and other display material?

YES_____ NO_____

May we use still and/or moving image(s) being photographs, video footage and/or audio footage of your child(ren), if under 18, on Wicomico Recreation & Parks' website and other social media sites, including, but not limited to, Facebook, Twitter and YouTube?

YES_____ NO_____

HOW DID YOU HEAR ABOUT CAMP PINEHURST SPECIAL NEEDS PROGRAM (Check all that apply)

___ Delmarva Kids Expo ___ Bennett Kids Expo ___ Brochure in Mail

___ School Office ___ Brochure at School ___ Kids Klub After School Program

___ Word of Mouth ___ Rec & Parks Website ___ Previously Attended

___ Other _____

Camp Pinehurst Special Needs Camp Health Form

Participant's Name _____DOB _____Age _____ M or F

Physician's Name _____
Phone Number _____

Health Insurance Company _____
Policy#" _____

Does your child have any allergies and if so, to what? (meds, foods, bees, etc)
_____ EPI-PEN Yes or No

Does your child have allergies or a history of seizures? Yes or No Diastat? Yes or No
Type of seizures _____ Last seizures? _____

Is your child diabetic? Yes or No. If yes, attach protocol (insulin amounts for blood sugars, snack schedule, doctor orders, etc.) and supplies.

Does your child have a special diet or any diet restrictions (pureed, tube fed, nothing by mouth, etc.)? _____

Does your child have any Diagnosis?

_____

Are there any other specific medical problems that we need to be aware of?

_____

Is your child on medication? Yes or No

Name of Medication, Dosage and Reason why they take?

_____
_____
_____

Is your child exempt from immunizations for religious or medical reasons? Yes or No
If yes, please explain _____

Last Tetanus immunization? (Must have date) _____

Does your child have a Behavior Management Plan? Yes or No
If yes, a copy must be attached.

Do you give permission for staff to apply sunblock to your child? Yes or No

Is your child bothered by the heat? If so, please describe: _____
_____
_____

Does your child have specific fears? If so, please describe: _____

_____

_____

Please check or circle any of the following that apply?

_____ Wears glasses, hearing aides
_____ Wears braces (legs, arms)
_____ Uses Wheelchair (manual or electric)
_____ Use sign languages
_____ Uses crutches or walker
_____ Needs assistance with walking
_____ Has speech impediment
_____ Menstruates
_____ Requires Tube Feedings ___ Has Mickey ___ Special Diet
_____ Feeds self _____ Must be fed _____ Needs help with feeding
_____ Dresses self _____ Must be dressed _____ Needs help with dressing
_____ Self Toilets _____Wears diapers or pull-ups _____ Needs assistance with Toileting
_____ Has one on one assistant during the school year
_____ Uses harness on bus

Health History: (add comments)

Vision _____
Hearing _____
Speech _____
Heart _____
Breathing _____
Digestion _____
Elimination _____
Circulation _____
Emotional _____
Behavioral _____
Thinking/Cognitive _____
Balance _____
Orthopedic _____
Muscular _____
Neurologic _____
Skin _____
Pain _____

Do you have any additional comments that would help us to know or assist your child?

_____

_____

_____

_____

_____

_____

MARYLAND STATE DEPARTMENT OF EDUCATION
OFFICE OF CHILD CARE
MEDICATION ADMINISTRATION AUTHORIZATION FORM

Child Care Program: Camp Pinehurst Special Needs Camp

Child's Picture (Optional)

This form must be completed fully in order for child care providers and staff to administer the required medication. A new medication administration form must be completed at the beginning of each 12 month period, 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.**
- **Non-prescription medication must be in the original container with the label intact.**
- **Parent/Guardian must bring the medication to the facility.**
- **Must pick up the medication at the end of authorized period, otherwise it will be discarded.**

PRESCRIBER'S AUTHORIZATION

Child's Name:_____ Date of Birth: _____

Condition for which medication is being administered: _____

Medication Name:_____ Dose:_____ Route: _____

Time/frequency of administration:_____ If PRN, frequency: _____ (PRN=as needed)

If PRN, for what symptoms: _____

Possible side effects &special Instructions:_____

Medication shall be administered from:_____ (Month / Day / Year) to _____ (Month / Day / Year (not to exceed 1 year))

Known Food or Drug: Allergies? Yes No If Yes, please explain_____

Prescriber's Name/Title: _____ (Type or print)

Telephone:_____ FAX: _____

Address: _____

Prescriber's Signature:_____ (Original signature or signature stamp ONLY) Date:_____

This space may be used for the Prescriber's Address Stamp

PARENT/GUARDIAN AUTHORIZATION

I/We request authorized child care provider/staff to administer the medication as prescribed by the above prescriber. I attest that I have administered at least one dose of the medication to my child without adverse effects. I/We certify that I/we have legal authority, understand the risk and consent to medical treatment for the child named above, including the administration of medication. I agree to review special instruction and demonstrate medication administration procedure to the child care provider.

Parent/Guardian Signature:_____ Date: _____

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

SELF CARRY/SELF ADMINISTRATION OF EMERGENCY MEDICATION AUTHORIZATION/APPROVAL

(Only school-aged children may be authorized to self carry/self administer medication.)

Self carry/self administration of **emergency** medication noted above may be authorized by the prescriber.

Prescriber's authorization: _____ (Signature) _____ (Date)

Parental approval: _____ (Signature) _____ (Date)

FACILITY RECEIPT AND REVIEW

Medication was received from:_____ Date: _____

Special Heath Care Plan Received: ☐ YES ☐ NO

Medication was received by: _____ (Signature of Person Receiving Medication and Reviewing the Form) _____ (Date)

MEDICATION ADMINISTERED

Each administration of a medication to the child shall be noted in the child's record. Each administration of prescription or non-prescription to a child, including self-administration of a medication by a child, shall be noted in the child's record. Basic care items such as: a diaper rash product, sunscreen, or insect repellent, authorized and supplied by the child's parent, may be applied without prior approval of a licensed health practitioner. These products are not required to be recorded on this form, but should be maintained as a part of the child's overall record. Keep this form in the child's permanent record while the child remains in the care of this provider or facility.

Child's Name:	**Date of Birth:**
Medication Name:	**Dosage:**
Route:	**Time(s) to administer:**

DATE	TIME	DOSAGE	REACTIONS OBSERVED (IF ANY)	SIGNATURE