



Program Name: _____

Program Location: _____

JUNIOR COUNSELOR INFORMATION FORM

***YOU MUST FILL OUT BOTH SIDES OF THIS FORM
BRING IT WITH YOU ON THE FIRST DAY OF CAMP***

General Information: (Please Print)

Participant Name: _____ Date of Birth: _____

Address: _____ City: _____ Zip: _____

Home Phone: _____ Work Phone: _____

Cell Phone: _____ Grade entering in fall: _____

Email Address: _____

Individual(s) to be contacted in case of emergency:

Name: _____ Relationship: _____ Phone: _____

Name: _____ Relationship: _____ Phone: _____

Person (other than parent) authorized to drop off / pick up participant:

Name: _____ Relationship: _____

Home Phone: _____ Cell Phone: _____

Are there any custody issues we should be aware of? No Yes (if yes, attach a copy of court order)

Health issues and special accommodations:

Are there any health concerns that our staff should be aware of? (asthma, allergies, hypoglycemia, seizure disorder, etc.) No Yes (if yes, please specify) _____

What symptoms would your child exhibit? _____

Requested actions to be taken by staff: _____

Please indicate any of the following health problems or disability: (please check all that apply)

- Deaf / hard of hearing
- Seizures
- Development disability (i.e. autism, intellectual, etc.)
- Other (i.e. behavioral / emotional disorder, etc.) _____
- Vision impairment
- Uses mobility aids (i.e. wheelchair, braces, etc.)

Please explain any specific health issues or accommodations needed to participate in program:

- Inclusion Companion
- Other (please specify) _____
- Deaf interpretive services

Medication:

Is the participant taking any medication? No Yes

Will participant need to take medication during program hours? No Yes

(if yes, attach a Medication Authorization Form; available from HCRP office or online at <http://www.howardcountymd.gov/rap/medicationform.pdf>)

Sunscreen is considered a topical medication.

Parents wishing their child to apply sunscreen at camp, complete information below:

Brand of sunscreen: _____

Specific directions for application: _____

Information required by state regulations (for Summer Camps only):

Child's School: _____ MD Public/Private School Other

My child's immunizations are up to date. No Yes

Date of last tetanus: _____ Unknown

Participant's Primary Physician: _____ Physician's Phone: _____

I understand:

1. By registering for this program, I verify that my child's immunizations are up to date.
2. That there are inherent dangers in any recreational activity, program or camp.
3. That I must be aware of the hazards associated with each activity, such as use of equipment, slips and falls, personal level of fitness, training, and various athletic injuries.
4. I must read and understand all written material, which has been provided by the Howard County Department of Recreation and Parks.
5. The rules and regulations for each activity, as explained in any written materials and/or explained by staff.
6. That the possible consequences of participating in these activities include the possibility of serious injury.

I agree:

1. To obey the rules and regulations for each activity and to follow the directions of the staff.
2. To inform a staff member of any dangerous or potentially hazardous situation that I may observe.
3. That if I do not understand how an activity is performed or how a piece of equipment is to be used, I will ask a staff member prior to beginning that activity.
4. To inform a staff member if I have any problems meeting the physical requirements necessary for participation in any activities.

I am aware that while participating in a recreation activity or program arranged by the Howard County Department of Recreation and Parks, certain risks and dangers may be present, including but not limited to those generally associated with certain activities, the hazards of traveling the public highways, of accidents, of illness, and of those forces of nature.

I agree to indemnify and defend Howard County and hold it harmless from and against any and all claims, suits, damages, liabilities and expenses, including attorney's fees and the County's costs of defense, in connection with loss of life, personal or bodily injury and /or damage to or loss of property that arises from the participation of _____ (Name of Participant) in _____ (Name of activity or program), except to the extent that such loss or damage is occasioned by the negligent act or omission of the county, its officers, agents or employees and no negligence on the part of the Participant.

In **EMERGENCIES** requiring immediate medical attention, your child will be taken to the **NEAREST HOSPITAL EMERGENCY ROOM**. Your signature authorizes the responsible person at the program to have you or your child transported to that hospital.

Signature of Participant or Parent/Guardian if under 18: _____ Date: _____



Howard County Department of Recreation & Parks
7120 Oakland Mills Road, Columbia, MD 21046
www.howardcountymd.gov/RAP



JUNIOR COUNSELOR SIGN-IN/SIGN-OUT PERMISSION FORM

The Howard County Department of Recreation & Parks requires that each Junior Counselor be signed in and out each day by a parent/guardian or individuals designated on the Participant Information Form.

By signing below, you give your child permission to sign themselves in and out of the camp thus releasing Recreation and Parks from any liability. Junior Counselors must sign in and out at the scheduled start and end times of the camp. Any exceptions must be made in writing.

I understand that there are inherent risks when walking or biking to/from the program. By signing below, I hereby allow my child to sign himself/herself in and out of the program and agree to release Howard County, to indemnify and defend the County, and hold the County harmless from and against any and all claims, suits, damages, liabilities and expenses, including reasonable attorney's fees and the County's cost of defense, in connection with the loss of life, personal or bodily injury, and/or damage to or loss of property that arises from the participation of my child in this program, except to the extent that such loss, injury or damage is occasioned by the negligent act or omission of the County, its officers, agents or employees and not by negligence on the part of me or my child. I attest that I have reviewed and determined a safe route for my child to follow to the camp location.

Parent Name: _____

Parent Signature: _____ Date: _____

Program / Activity Name: _____ Location: _____

Junior Counselor Name: _____ Age: _____

Junior Counselor Signature: _____ Date: _____

Parent Notes: _____

MEDICATION ADMINISTRATION AUTHORIZATION FORM



Howard County
RECREATION & PARKS

This form must be completed fully in order for Howard County Recreation & Parks 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, 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.
- Nonprescription medication must be in the original container with the instructions for use. Nonprescription 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.

I. PRESCRIBER'S AUTHORIZATION

1. CHILD'S NAME		2. DATE OF BIRTH ____/____/____ Month Day Year		
3. CONDITION FOR WHICH MEDICATION IS BEING ADMINISTERED:		4. EMERGENCY MEDICATION <input type="checkbox"/> YES -If yes, see Section III below. <input type="checkbox"/> NO		
5. MEDICATION NAME	6. DOSE	7. METHOD TO GIVE		
8. TIME/FREQUENCY OF ADMINISTRATION		9. IF PRN, FREQUENCY		
10. IF PRN, FOR WHAT SYMPTOMS				
11. KNOWN SIDE EFFECTS SPECIFIC TO CHILD				
12. MEDICATION SHALL BE ADMINISTERED during the year in which this form is dated in 14b below unless more restrictive dates are specified in 12a and 12b. This authorization is NOT TO EXCEED 1 YEAR.		12a. FROM ____/____/____ Month Day Year	12b. TO ____/____/____ Month Day Year	
13. PRESCRIBER'S NAME/TITLE		This space may be used for the Prescriber's Address Stamp		
TELEPHONE	FAX			
ADDRESS				
CITY	STATE			ZIPCODE
14a. PRESCRIBER'S SIGNATURE (Parent/guardian cannot sign here) <small>(ORIGINAL SIGNATURE OR SIGNATURE STAMP ONLY)</small>				14b. DATE

II. PARENT/GUARDIAN AUTHORIZATION

I request Howard County Recreation & Parks to administer the medication or supervise the camper in self administration 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 the administration of medication at the facility. 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.

15a. PARENT/GUARDIAN SIGNATURE		15b. DATE
15c. HOME PHONE #	15d. CELL PHONE #	15e. WORK PHONE #

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

This section should only be completed if this medication is approved for self administration. Self carry is only permitted for emergency medications such as inhalers, insulin 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 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 youth camp operator/staff member. If indicated below, the child named above may self carry emergency medication.

16a. PRESCRIBER'S SIGNATURE authorizing self administration	16b. SELF CARRY/ADMINISTER EMERGENCY MEDICATION (Check One) <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> N/A - Not emergency medication	16c. DATE
17a. PARENT/GUARDIAN'S SIGNATURE authorizing self administration	17b. SELF CARRY/ADMINISTER EMERGENCY MEDICATION (Check One) <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> N/A - Not emergency medication	17c. DATE

**MEDICATION
ADMINISTRATION FORM**



**Howard County
RECREATION & PARKS**

I. FACILITY RECEIPT AND REVIEW			
MEDICATION RECEIVED FROM			PROGRAM NAME
PLAN OF ACTION RECEIVED		[] YES [] NO [] N/A	TR/ACCOMMODATIONS MANAGER NOTIFIED
		[] YES [] NO	
MEDICATION RECEIVED BY	QUANTITY	STAFF SIGNATURE	DATE

II. MEDICATION ADMINISTRATION RECORD

Each administration of the listed medication shall be noted on the child's record below. Each nonprescription and prescription medication requires a separate medication authorization form and the administration of the listed medication is required to be recorded on the corresponding administration record.

Child's Name:				Date of Birth:	
Medication Name:				Dosage:	
Route:				Time(s) to Administer:	
DATE	TIME	DOSAGE	REACTION OBSERVED (IF ANY)	STAFF OR SELF ADMINISTERED	ADMINISTERED OR SUPERVISED BY SIGNATURE

III. FINAL DISPOSITION OF MEDICATION

Child's Name:	Date of Birth:
Medication Name:	Final Disposition: [] Returned (Complete Section A) [] Destroyed (Complete Section B)

Section A

MEDICATION RETURNED TO (PRINT & SIGN NAME):	DATE
MEDICATION RETURNED BY (STAFF NAME & SIGNATURE)	DATE

Section B

The above indicated medication was not retrieved by the parent/guardian within 1 week of the camper leaving camp; therefore, it has been destroyed according to COMAR 10.16.07.14.

STAFF NAME & SIGNATURE OF PERSON RESPONSIBLE FOR DESTROYING MEDICATION	DATE
NAME & SIGNATURE OF PERSON WITNESSING THE DESTRUCTION OF THE MEDICATION	DATE