Registration

YOUTH ORIOLES CAMP

June 20-30 2016

Fee: $275

A $125 non-refundable deposit is required to hold a spot on the list by May 13th. The remaining $150 balance is to be paid by June 3rd, 2016

All checks should be made payable to:

Maryland School for the Deaf
memo: summer camp

Please mail your payment and completed application to:

Touria Ouahid-Boren
Camp Director
Maryland School for the Deaf
101 Clarke Place PO box 250
Frederick, MD 21705

Or

Drop off the payment and application at Kent McCanner, Room #101
REGISTRATION DEADLINE is June 3, 2016

Child Name: ___________________________ Grade: _______ DOB: _______

Adult T-Shirt Size  S □ M □ L □   Youth T-Shirt Size  S □ M □ L □

Profile: Deaf □ HOH □ KODA □ Sibling of Deaf □

Does your child wear □ Hearing Aids □ Cochlear implant

Camper Information

All information will be kept confidential.

School District ____________________________________________________________

School Attending __________________________________________________________

Does she/he have any learning or physical disabilities? Please explain.

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________
CONTACT INFORMATION

Main Emergency Contact

Parent/Guardian Name:

_____________________________________________________________________________

Last               First

Address:

______________________________________________________________________________

Street or P.O. Box    Apt. #

______________________________________________________________________________

City                 State/Province              Zip/postal code

Telephone: ________________________ □Voice □VP

Email___________________________ Text_________________________

Additional Contact Person:

Name: ___________________________ Relationship: ___________________________

Telephone: ________________________ □Voice □VP

Email___________________________ Pager__________________________

Insurance Information:__________________________________________________________

*** Attach Photo Copy of all Insurance Cards (front and back)***
Medical Release

Camper Name____________________________________________________________

Age________ Date of Birth_________________________________________________

Allergies_________________________________________________________________

Date of Last Tetanus Shot_________________________________________________

Any known psychiatric and behavior health problems?_________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________

Medical Care

1. As the parent/guardian of the camper name above, I understand that I am responsible for
   immunization and physical examinations for my child, as well as the management of any fees for
   my child’s total health care. I understand that I am responsible for notifying the Maryland School
   for the Deaf of any aspects of my child’s medical history of which the School should be aware of
   in the event of an emergency (e.g., allergy to penicillin, or contagious illnesses such as pink eye
   or ringworm, heart conditions, and chronic medical conditions)

2. I give my consent to transport for emergency medical, psychological, or surgical care, if
   necessary, to be administered to my child by MSD health care providers where appropriate, or
   by persons or facilities on or off campus, while he/she is enrolled at the camp. I understand that
   I am responsible for all fees related to emergency medical or surgical care. This authorization
   does not include the right to authorize any surgical procedures of a non-emergency nature.

3. I give my permission for any medication prescribed to my child during the camp which I bring to
   the Student Health Center in the original container from the pharmacy, to be administered to
   my child by a School nurse. I understand that unlabeled medications will not be given. I
   understand that I must provide a Maryland State School Medication Administration
   Authorization Form signed by a physician or nurse practitioner and a parent/guardian for each
   prescribed medication to be given at School. I understand that if this form is not completed, the
   medication will not be given.

4. I understand that I must keep a weekend of any routine medications at home.

5. I give permission for my child to be administered over the counter medications by the Student
   Health Center Staff for treatment of minor medical issues as ordered by the Medical Director
   (e.g., Tylenol for headache, Robitussin for cough, and Chloraseptic for sore throat).

6. I have read, understood, and consented to the conditions of the Maryland School for the Deaf
   Medical policy. I understand that this policy shall apply to my child even as amended from
   time to time.

Parent/Guardian Signature ___________________________ Date ______________________
MEDICAL HEALTH ALERT

The following camper has been identified to have a specific health need. The information supplied is to help camp staff to deal with the day to day needs, manage emergency care, and provide a plan of action to follow.

Camper: _________________________________

Date: ________________________________

❖ ALERT FOR SPECIFIC HEALTH NEED:

________________________________________________________________________

Actions necessary by non-medical staff (counselors, teachers, and coaches)

________________________________________________________________________

________________________________________________________________________

❖ ALLERGY: ___________________________, actions necessary by non medical staff:

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

IF staff ever has any concerns medically, follow the motto: WHEN IN DOUBT – SEND OUT!!!

Treatment is consistent with MSD medical protocols and policy.

All information is confidential and protected by FERPA and HIPPA

Above information faxed to Director of Summer Camps: 2014, ________________

By: ____________________________________________
# PART I – HEALTH ASSESSMENT
To be completed by parent or guardian

<table>
<thead>
<tr>
<th>Student's Name (Last, First, Middle)</th>
<th>Birthdate (Mo. Day Yr.)</th>
<th>Sex (MF)</th>
<th>Name of School</th>
<th>Grade</th>
</tr>
</thead>
<tbody>
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<table>
<thead>
<tr>
<th>Address (Number, Street, City, State, Zip)</th>
<th>Phone No.</th>
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<table>
<thead>
<tr>
<th>Parent/Guardian Names</th>
</tr>
</thead>
<tbody>
<tr>
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</table>

<table>
<thead>
<tr>
<th>Where do you usually take your child for routine medical care?</th>
<th>Phone No.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Name:</td>
<td></td>
</tr>
<tr>
<td>Address:</td>
<td></td>
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</table>

<table>
<thead>
<tr>
<th>When was the last time your child had a physical exam?</th>
<th>Month</th>
<th>Year</th>
</tr>
</thead>
<tbody>
<tr>
<td>Month:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Year:</td>
<td></td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Where do you usually take your child for dental care?</th>
<th>Phone No.</th>
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</thead>
<tbody>
<tr>
<td>Name:</td>
<td></td>
</tr>
<tr>
<td>Address:</td>
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**ASSESSMENT OF STUDENT HEALTH**

To the best of your knowledge has your child any problem with the following? Please check.

<table>
<thead>
<tr>
<th></th>
<th>Yes</th>
<th>No</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Allergies (Food, Insects, Drugs, Latex)</strong></td>
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<tr>
<td><strong>Allergies (Seasonal)</strong></td>
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<tr>
<td><strong>Asthma or Breathing Problems</strong></td>
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<tr>
<td><strong>Behavior or Emotional Problems</strong></td>
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<tr>
<td><strong>Birth Defects</strong></td>
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<td><strong>Bleeding Problems</strong></td>
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<tr>
<td><strong>Cerebral Palsy</strong></td>
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<tr>
<td><strong>Dental</strong></td>
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<tr>
<td><strong>Diabetes</strong></td>
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<tr>
<td><strong>Ear Problems or Deafness</strong></td>
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<tr>
<td><strong>Eye or Vision Problems</strong></td>
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<tr>
<td><strong>Head Injury</strong></td>
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<tr>
<td><strong>Heart Problems</strong></td>
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<td></td>
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<tr>
<td><strong>Hospitalization: When, Where</strong></td>
<td></td>
<td></td>
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<tr>
<td><strong>Lead Poisoning/Exposure</strong></td>
<td></td>
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<tr>
<td><strong>Learning problems/abilities</strong></td>
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<tr>
<td><strong>Limits on Physical Activity</strong></td>
<td></td>
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<tr>
<td><strong>Meningitis</strong></td>
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<tr>
<td><strong>Prematurity</strong></td>
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<tr>
<td><strong>Problem with Bladder</strong></td>
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<tr>
<td><strong>Problem with Bowels</strong></td>
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<td><strong>Problem with Coughing</strong></td>
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<tr>
<td><strong>Seizures</strong></td>
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<tr>
<td><strong>Serious Allergic Reactions</strong></td>
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<tr>
<td><strong>Sickle Cell Disease</strong></td>
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<td><strong>Speech Problems</strong></td>
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<tr>
<td><strong>Surgery</strong></td>
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<tr>
<td><strong>Other</strong></td>
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</tbody>
</table>

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**Does your child take any medication?**

<table>
<thead>
<tr>
<th>No</th>
<th>Yes</th>
<th>Name(s) of Medications:</th>
</tr>
</thead>
</table>

**Is your child on any special treatments?** (nebulizer, epi-pen, etc.)

<table>
<thead>
<tr>
<th>No</th>
<th>Yes</th>
<th>Treatment:</th>
</tr>
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</table>

**Does your child require any special procedures?** (catheterization, etc.)

<table>
<thead>
<tr>
<th>No</th>
<th>Yes</th>
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</thead>
</table>

Parent/Guardian Signature: ___________________________ Date: ____________

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Maryland Schools – Record of Physical Examination Revised 12/04
CAMPER HEALTH HISTORY

Child's Name: ____________________________________________

The following information is required:

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

2nd Emergency Contact  Phone:
(Other than Parent Above):

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?  □ NO
   □ 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?  □ NO
   □ YES, Explain:__________________________________________

IMMUNIZATION INFORMATION:

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

1. State/territory in which child resides: ________________________

2. Is this child exempt from any immunizations?  [ ] NO  [ ] 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 form DHMH-896 (record of vaccination or immunity)

Parent or Legal Guardian's Signature: ________________________ Date: ________________________

DHMH-4768 (1/15)
Transportation Authorization

Child’s Name________________________________

_____ YES, I do give permission

_____ NO, I do not give permission

My child may be transported by Youth Orioles Camp to and from Baker Park Public Swimming Pool. I will be notified with each trip by email or text, to verify permission. I will be asked to fill out an additional permission form for the pool activity off site.

Parent (Print Name)__________________________________________

Parent (Signature)____________________________________________

Date: __________
Expectations & Agreements

Personal Loss:

I understand that Maryland School for the Deaf does not cover theft, loss, or damage to my child’s personal equipment or property. I understand that Maryland School for the Deaf recommends that I check with my personal insurance coverage to confirm my insurance will cover any loss.

Parent/Guardian Initials_______ Student Initials_______

Damage to Maryland School for the Deaf Property:

I understand that I will be responsible for all costs incurred if my child damages any Maryland School for the Deaf property. I understand that if the damage is serious enough, the local law enforcement will be involved.

Parent/Guardian Initials_______ Student Initials_______

Expectations:

The primary responsibility of MSD staff is to keep participants safe. We expect you to follow the rules to keep all campers safe.

Camp is a group experience; your attitude influences the group. A positive attitude is expected; you don’t have to love everything we do, only appreciate that you have done it.

We expect human kindness and appreciation of differences:

I agree to the following:

- I will treat each group member with equal respect and fairness.
- I agree that any disregard for these guidelines, may result in my dismissal from camp.
- I understand that my parent/guardian will be responsible to pick me up immediately if I violate the rules.
- I have read the above agreements with my parent/guardian and agree to abide by them.

There will be no monetary refunds for participants who are dismissed for disciplinary reasons. There will be no monetary refunds or reduction in fees for participants who arrive late or leave early. I have read the above agreements with my parents/guardians and agree to abide by them.

Camper Signature___________________________________________Date__________

Parent/Guardian Signature___________________________________ Date__________
Behavior Agreement

Camper Code of Conduct

- Who treat each other with respect
- Who value other’s rights to have a fun experience at camp
- Who are not disrespectful, violent, or mean
- Who do not bully, tease, harass or isolate other campers
- Who do not use foul language

In the event that your child fails to meet the above Code of Conduct at any time during the camp session there will be a discussion with the camper and parents or guardians will be contacted. Your child may be sent home and no fund will be given. We are committed to help each and every camper have a fun and rewarding experience.

Camper’s Agreement

I have read this Code of Conduct, understand the behavior and consequences, and agree to abide by them.

Camper Signature __________________________ Date ________________

Parent’s Agreement

I have reviewed this Code of Conduct with my child and agree to support the consequences as outlined. If requested, I agree to pick up my child or make arrangements with another adult to be available in my absence. Name of other adult: ________________________________

Parent/Guardian Signature __________________________ Date ________________
Photo Release

Photo Release:

I ☐ do ☐ do not give Maryland School for the Deaf (MSD) the right to use my child’s photograph in all forms of media and in all manners, including composite or other representations, for advertising, trade or other lawful purposes.

Parent/Guardian Signature___________________________ Date__________________