CAMP REGISTRATION

Procedures

1 IMPORTANT INFORMATION

CAUTION: REGISTRATION FORMS MUST BE COMPLETED IN FULL in order to be processed.

Your registration email must include:

- **completed registration forms**
- **Proof of residency (Greenbelt residents only)**

CAMP REGISTRATION START DATES/TIMES:

GREENBELT RESIDENTS:
Monday, February 12 at 10 am

NON-RESIDENTS:
Tuesday, February 20 at 10 am

2 SUBMIT COMPLETED REGISTRATION FORMS

COMPLETED REGISTRATION FORMS should be submitted via email. All camp contact information is provided below. Forms will be accepted from Greenbelt residents* for Camps **beginning on Monday, February 12 at 10 am and non-residents beginning on Tuesday, February 20 at 10 am. Registrations received before the start date/time will not be accepted. Please submit proof of Greenbelt residency to receive the resident rate.** If registration via email is not possible, please contact the designated staff member. Camper registration forms will be accepted on an ongoing basis until all slots are filled. At that point, interested persons' names will be placed on a waiting list. Those persons will be contacted in the order in which names were taken if/when a slot becomes available.

Spring Camp, Camp Pine Tree I & II, and Youth on the GO:

cpracht@greenbeltmd.gov or call (301) 397-2200.

Creative Kids Camp, Circus Camp, Spring Circus Camp, Camp Encore, and Kinder Camp:

rcampbell@greenbeltmd.gov or call (301) 397-2208.

3 PAYMENTS, DEPOSITS, RESIDENCY, & FINANCIAL ASSISTANCE

FINANCIAL ASSISTANCE PROGRAM: Financial assistance is available to qualified Greenbelt residents. An application and supporting documentation are required. Prior to registration, please call (301) 397-2200 or email: csoter@greenbeltmd.gov for additional information.

A **DEPOSIT** of $50 per child/per camp session is required at the time of registration for ALL CAMP sessions.

DEPOSITS ARE NON-REFUNDABLE AND NON-TRANSFERABLE

CAMP PAYMENTS are DUE ten days prior to the session start date.

**** GREENBELT RESIDENCY:*** In order to qualify to receive the resident rates as listed in this brochure, you **MUST** provide CURRENT proof of Greenbelt residency in the form of a driver's license, MVA change of address form with a driver's license, or a lease. **If you are unable to provide one of these documents at the time of registration, you will be charged the non-resident rate.**

4 CAMPER REGISTRATION FORMS ARE AVAILABLE reserve your spot in camp.

On the following pages of this brochure you will find all of our registration forms. Registration forms must be complete to process your registration and to reserve your spot in camp. Priority goes to those who register first, so register today!

2024 Greenbelt Day Camp Registration Form

This form must be completed in full for each participant to be registered.

1. PARTICIPANT INFORMATION

Participant Name:______________________ Preferred Name: ______________________

Age:________ DOB:____________ Gender______________________ T-Shirt Size__________

Street Address:______________________________ City/State/Zip: ______________________

Parent/Guardian Name: __________________ Phone Number: ______________________

Parent/Guardian Name: __________________ Phone Number: ______________________

Email Address(es) for Parent/Guardian: ______________________________________

Emergency Contact Name:__________________ Phone Number: ______________________

Emergency Contact Name:__________________ Phone Number: ______________________

School attended this year: ____

2. HEALTH INFORMATION

Primary Care/Clinic Name: ______________________________ Phone Number: ______________

Are there any health problems including physical, psychiatric, or behavioral problems of which we need to be aware?	☐ YES ☐ NO
If YES, please 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
If YES, please explain:	

Participant requires medication during camp?

☐ YES ☐ NO *If yes, signed medication authorization form required prior to the first day of camp!

Participant requires emergency medication at camp?

☐ YES ☐ NO * If yes, signed medication authorization form required prior to the first day of camp!

If yes, please explain. (i.e. inhaler, epi-pen, etc.):

Please attach any additional information if needed.

Participant requires or would benefit from inclusion support at camp? For more information, see **page 5****.**

☐ YES ☐ NO *If yes, please explain:

Please provide any additional information you would like to share:

Immunization Information: (Please Note)

- Is this participant exempt from immunization for religious or medical reasons? ☐ YES ☐ No
- If yes, the Maryland Department of Health Immunization Certificate must be completed and attached to this form. Program Staff can provide you with this form.
- A participant who does **NOT** reside within the United States, a United States territory or the District of Columbia must provide proof of immunization (MDH-896).

IMPORTANT REMINDER: Campers may not be admitted to camp until all required forms are signed and submitted. No exceptions. Our camps are licensed by the Maryland State Department of Health and are legally required to comply with safety standards for the benefit of all children in our camp programs.

A **Medication Authorization Form** is required in advance for any medication (including non-prescription) distributed at the program. A **Medication Authorization Form for Epi Pens, Inhalers and Insulin Pumps** is required in advance for any medical device/procedure used at the program.

FORM CONTNUES ON BACK

3. PARTICIPANT RELEASE AUTHORIZATION (OTHER THAN PARENT OR GUARDIAN ON PREVIOUS PAGE)

Greenbelt Recreation is authorized to release my Child,

____

Participant's Name:

to the following individuals who may pick up my child from Camp. I understand that each authorized person must be at least sixteen (16) years old, and my child will not be permitted to leave the camp with anyone not listed at the right. All authorized individuals will be required to show identification and sign the child out each day. My child may be released to the following people: *

Name	Phone Number	Relationship
1.		
2		
3.		
4.		

Departure Procedure:

Please notify your child's camp when one of the above people will be picking up your child.

*If you wish for your child to sign himself/herself out, please complete the camp sign-in/sign-out release permission form and return it to the camp office.

4. LATE PICK UP POLICY

A late fee will be assessed for participants who are not picked up by the program's scheduled closing time. The Greenbelt Recreation Department's Policy is $1 per minute in 5-minute increments.

We understand that emergencies do arise and request that parents call the camp's office if they are delayed. However, late charges may still be assessed. Payment is due by 4:30pm the next business day. **Thank you for your cooperation in ensuring your participant is picked up from the program on time.**

5. ACTIVITY/PROGRAM FIELD TRIP LIABILITY RELEASE/AUTHORIZATION

I understand that the participant will be subject to the regulations of the Greenbelt Recreation Department. I also agree that the participant will follow the instructions of the camp personnel and will treat other campers/adults with courtesy and respect. I understand that if the participant fails to do so, the participant will not be allowed to participate in the camp.

I hereby give permission for the applicant to participate in all program activities, including swimming pool and swim instruction activities, and field trips in approved vehicles and agree to release the City of Greenbelt and the Greenbelt Recreation Department, its officers, employees, and agents, from all liability arising from any harm or injury incurred by the participation of my child in the summer day camp program.

6. PHOTOGRAPHY/VIDEO RELEASE

I agree that photographs and video footage may be taken of participants during program activities for use in City of Greenbelt publications, cablecasts, and social media, as well as for the production of camp show keepsake videos, which may be ordered through the Recreation Department business offices.

7. MEDICAL CARE/HOSPITAL TREATMENT RELEASE

By way of copy of this form, I authorize the staff of The City of Greenbelt and the Greenbelt Recreation Department to obtain medical/hospital treatment for the above participant in the event of an emergency

I hereby represent and warrant that if the participant is a minor, I am his/her parent or guardian and am authorized to provide the releases, authorizations, and permissions as stated below.

____

SIGNATURE OF PARENT/GUARDIAN

____

PRINT NAME OF PARENT/GUARDIAN **DATE**

25 Crescent Road, Greenbelt, MD 20770
Business Office: (301)397-2200
Fax: (301)397-2203

Camper's Name: ____

Parent/Guardian's Name: ____

Please take a moment to fill out the front and back of this form to assure that your child is registered in the proper camp and session. Refer to the Camp Brochure for the correct registration number and session. For those needing Before Care and/or After Care until 6:00pm, please place an "X" in the appropriate box. If you are registering for Creative Kids Camp, please rank your preferences on the next page for your camper's Afternoon Art Adventure class.

Please total your fees at the bottom of the table and choose your payment option. A $50 deposit for each session of camp is due at the time of registration. Each session's payment is due in full ten days prior to the start of each session.

SESSIONS	PAYMENT DUE DATES	TIME DUE
Summer Session 1	Friday, June 7, 2024	4:30 pm
Summer Session 2	Friday, June 21, 2024	4:30 pm
Summer Session 3	Friday, July 5, 2024	4:30 pm
Summer Session 4	Friday, July 19, 2024	4:30 pm
Summer Session 5	Friday, August 2, 2024	4:30 pm

CAMP NAME	SESSION	BEFORE CARE 7:30am - Start of Camp Day	AFTER CARE 3:30pm – 6:00pm
Example: Camp Pine Tree I	336503-1	☑	☐
		☐	☐
		☐	☐
		☐	☐
		☐	☐
		☐	☐
		☐	☐

CKC: RANK YOUR AFTERNOON ART ADVENTURE PREFERENCES ON THE NEXT PAGE.

AFTERNOON ART ADVENTURES (Creative Kids Camp Only)

See pages 14-18 for class descriptions.

Please rank **ALL** of the classes available for your child's age by placing a number next to each class title. "1" indicates your first choice, "2" indicates your second choice, etc.

Each camper will be enrolled in ONE class per session based on order of preference and class availability. Check your camp registration receipt (sent via email) to confirm their assignment.

	SESSION 1		SESSION 2		SESSION 3		SESSION 4
1	***Example:*** *First Choice*						
	SUMMER DANCE PARTY		SUMMER DANCE PARTY		SUMMER DANCE PARTY		SUMMER DANCE PARTY
	CERAMIC HAND-BUILDING		CERAMIC HAND-BUILDING		CERAMIC HAND-BUILDING		CERAMIC HAND-BUILDING
			VIDEO PRODUCTION		VIDEO PRODUCTION		
	MAKERSPACE				MAKERSPACE		MAKERSPACE
	PAINT PARTY		PAINT PARTY				PAINT PARTY
	CIRCUS SKILLS		CIRCUS SKILLS		CIRCUS SKILLS		CIRCUS SKILLS

COMPLETE THE FINANCIAL INFORMATION ON THE NEXT PAGE

PLEASE NOTE: A $50.00 Non-Refundable, Non-Transferable deposit, per child, per session is required at the time of registration. Registrations will not be processed until all paperwork is complete and the appropriate payments have been submitted.

PAYMENTS DUE

			TOTAL
Number of Camp Sessions		**X $50**	
Kids to Camp Fund (optional donation)			
Total Due at Registration:			

CREDIT CARD INFORMATION:

If you prefer, you may phone this information in, however, a signature is required.

Name on Card: ______________________________

Billing Address: ______________________________

Type of Card: ______________________________

Card Number: ☐☐☐☐ ☐☐☐☐ ☐☐☐☐ ☐☐☐☐

CVV#: ☐

Expiration Date: ☐☐ / ☐☐

Signature: ______________________________

☐ **YES! I would like to have my credit card charged for the remaining balance due for each session, on the due date. Initials:** ☐

FOR ADMINISTRATIVE USE ONLY:

Registration Received by: __________

Date Received: ____________________

Amount Received: _________________

☐ **CASH** ☐ **CREDIT** ☐ **CHECK**

VERIFY:

☐ **License**

☐ **Lease**

☐ **MVA Change of Address Card**

GREENBELT RECREATION
fun • fitness • friendship

PARTICIPANT PROFILE FOR TEACHERS, MANAGERS AND STAFF

Profiles are reviewed by staff and help them to better serve your child. Please take the time to complete.

Child's Name:	**Date:**
Child's Preferred Name:	**Age:**
Parent/Guardian:	
Camp:	
Child's likes:	
Child's dislikes:	
My child enjoys these activities:	
My child has difficulty with these activities:	
Skills or goals that the participant is working on:	
Fears and concerns of the participant:	
Current medications:	
What are you or the participant looking forward to the most about camp?	
Specific behavioral concerns:	
Triggers of the specific behavioral concerns:	
What behavioral techniques have been successful that can be maintained during programs?	
Are any special accommodations needed to give your child a positive learning experience during the program?	
Is there any other additional information that would help to ensure that your child is successful during the program?	
What is the main language spoken at home?	
If there is any confidential information you do not want to include on this form, but feel it is important to share with us, please contact Priya Gardner, Therapeutic Recreation Coordinator (Senior & Inclusion Programs) at (240) 542-2056.	

Inclusion Support Services

Inclusion Services Available

What is Inclusion? Inclusion is extra support so that everyone participates in recreation together!

Greenbelt Recreation offers full and active participation for individuals with varying abilities. We provide individuals with reasonable accommodations that will enhance their recreation experience. We facilitate social, physical, educational, and cultural development for individuals of differing abilities, as needed.

We also share information on Therapeutic Recreation (TR) Camps offered through PG Parks. The TR Camps offer smaller staff to camper ratios and are sometimes the best fit for a camper in need of specialized support.

See page 5 for more details.

Medical Care & Services

New Medical Forms for Allergies and Asthma

Our staff is here to help assist your camper with their allergy, asthma, medication, or other medical care needs. The medical forms on the following 6 pages provides essential information to staff in the event of a medical emergency.

Medication Forms Map

The Medication Forms Map on page 32 will assist you in finding and filling out the proper medical forms for your camper. As they are required to be authorized and signed by your camper's health care provider, we recommend they be filled out as soon as possible. The checklist at the bottom of page 32 will ensure that all forms have been completed and that you are all set for camp!

MEDICATION FORMS MAP

Which Form Do I Use?

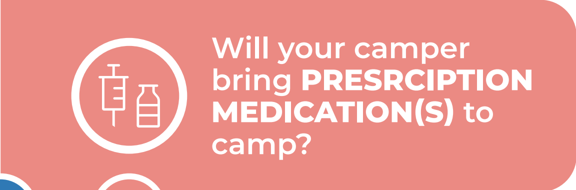
YES

These forms communicates essential information to staff in the event of a medical emergency. As they are required to be authorized and signed by your camper's health care provider, please have them filled out as soon as possible.

If your camper has asthma, complete the **ASTHMA ACTION PLAN FORM** on pages 36 & 37.

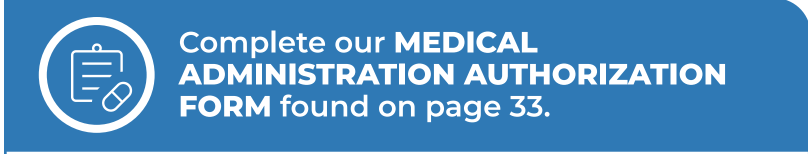
If your camper has an allergy, complete the **ALLERGY ACTION PLAN FORM** on pages 34 & 35. This form should be completed if your camper will require prescription medication or over-the-counter (OTC) medication.

NO



YES / NO

YES / NO



This form is required to be authorized and signed by your camper's health care provider so it is important to have it filled out as soon as possible. Each form provides authorization for up to three (3) medications, prescription or OTC.

Is your Medical Administration Authorization Form complete? **Ensure all information is provided and medication is ready** by using the checklist below.

MEDICAL FORM CHECKLIST
If you have ANSWERED YES to all questions below, you're set for camp!

- [ ] **[Prescription Medication]** Is the medication in its original container or box with intact pharmacy label including directions, dosage, child's name, and expiration date?
- [ ] **[Over-the-Counter (OTC) Medication]** Is the medication in its original packaging with directions, dosage, and expiration date?
- [ ] Are all columns completed for **EACH** medication? (name, condition, dose, route, frequency, self-administer, emergency medication)
- [ ] Is the **prescriber's information** filled out in full?
- [ ] Does the form have an **original prescriber's signature** or signature stamp?
- [ ] Is the **parent/guardian signature** included with the names of the individiuals authorized to pick up medication?

MEDICATION ADMINISTRATION AUTHORIZATION FORM

For Youth Camps in Maryland

Maryland Department of Health
Consumer Health and Safety
(410) 767-8417 Toll Free1-877-4MD-DHMH ext. 8417

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. 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

CHILD'S NAME			DATE OF BIRTH ____/____/________	
1 MEDICATION NAME	DOSE	ROUTE	TIME/FREQUENCY OF ADMINISTRATION	SIDE EFFECTS
CONDITION BEING TREATED/PRN PARAMETERS			EMERGENCY MEDICATION [ ] YES ***-If yes, see Section III below.*** [ ] NO	
2 MEDICATION NAME	DOSE	ROUTE	TIME/FREQUENCY OF ADMINISTRATION	SIDE EFFECTS
CONDITION BEING TREATED/PRN PARAMETERS			EMERGENCY MEDICATION [ ] YES ***-If yes, see Section III below.*** [ ] NO	
3 MEDICATION NAME	DOSE	ROUTE	TIME/FREQUENCY OF ADMINISTRATION	SIDE EFFECTS
CONDITION BEING TREATED/PRN PARAMETERS			EMERGENCY MEDICATION [ ] YES ***-If yes, see Section III below.*** [ ] NO	

MEDICATION SHALL BE ADMINISTERED during the year in which this form is dated below unless more restrictive dates are specified. This authorization is ***NOT TO EXCEED 1 YEAR***.	FROM ____/____/________ Month Day Year	TO ____/____/________ Month Day Year

PRESCRIBER'S NAME/TITLE		This space may be used for the Prescriber's Address Stamp
TELEPHONE	FAX	
ADDRESS		

CITY	STATE	ZIPCODE

PRESCRIBER'S SIGNATURE ***(Parent/guardian cannot sign here)*** *(ORIGINAL SIGNATURE OR SIGNATURE STAMP ONLY)*	DATE

II. PARENT/GUARDIAN AUTHORIZATION

I request the authorized youth camp operator, staff member or volunteer 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, which may include the child, 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.

PARENT/GUARDIAN SIGNATURE	DATE	INDIVIDUAL(S) AUTHORIZED TO PICK UP MEDICATION
HOME PHONE #	CELL PHONE #	WORK PHONE #

III. EMERGENCY MEDICATION

Camp Staff will be responsible for carrying emergency medication during the camp day. Medication will be stored in a secured space over night. Participants requiring emergency medication must maintain a non-expired supply of the emergency medication at the camp facility while enrolled in camp. Participants may not be admitted to camp without the signed medication administration (forms) and the prescribed medication(s).

*Edited for Greenbelt Recreation Department Camps 2022

Maryland State Department of Education
Office of Child Care

Allergy and Anaphylaxis
Medication Administration Authorization Plan

This form must be completed fully in order for Child Care Providers/staff to administer the required medication and follow the plan. **This authorization is NOT TO EXCEED 1 YEAR.**
Page 1 to be completed by the Authorized Health Care Provider.
FOR ALLERGY AND ANAPHYLAXIS MEDICATION ONLY - THIS FORM REPLACES OCC 1216

Place Child's Picture Here (optional)

CHILD'S NAME: ______________________ Date of Birth: ____/______/______ **Date of plan**: ______________
Child has **Allergy** to ______________________ ☐Ingestion/Mouth ☐ Inhalation ☐Skin Contact ☐Sting ☐Other_____________
Child has had anaphylaxis: ☐ Yes ☐ No
Child has asthma: ☐ Yes ☐ No (If yes, higher chance severe reaction)

Child may self-administer medication: ☐ Yes ☐ No

Allergy and Anaphylaxis Symptoms	Treatment Order	
If child has ingested a food allergen, been stung by a bee or exposed to an allergy trigger	Antihistamine :Oral /By Mouth ☐ Call Parent ☐ Call 911	Epinephrine(EpiPen) IM Injection in Thigh ☐ Call 911 ☐ Call Parent
is Not exhibiting or complaining of any symptoms, OR		
Exhibits or complains of any symptoms below:		
Mouth: itching, tingling, swelling of lips, tongue ("mouth feels funny")		
Skin: hives, itchy rash, swelling of the face or extremities		
Throat*: difficulty swallowing ("choking feeling"), hoarseness, hacking cough		
Lung*: shortness of breath, repetitive coughing, wheezing		
Heart*: weak or fast pulse, low blood pressure, fainting, pale, blueness		
Gut: nausea, abdominal cramps, vomiting, diarrhea		
Other:		
If reaction is progressing (several of the above areas affected)		

Potentially life threatening. The severity of symptoms can quickly change

Medication	Medication: Brand and Strength	Dose	Route	Frequency
Epinephrine(EpiPen)				
Antihistamine				
Other:				

EMERGENCY Response:

1) **Inject epinephrine right away! Note time when epinephrine was administered.**
2) Call 911: Ask for ambulance with epinephrine. Advise rescue squad when epinephrine was given. Stay with child.
3) Call parents. Advise parent of the time that epinephrine was given and 911 was called.
4) Keep child lying on his/her back. If the child vomits or has trouble breathing, place child on his/her side.
5) Give other medicine, if prescribed.

PRESCRIBER'S NAME/TITLE		Place stamp here
TELEPHONE	FAX	
ADDRESS		

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

Maryland State Department of Education
Office of Child Care

Allergy and Anaphylaxis
Medication Administration Authorization Plan

Child's Name:____Date of Birth:_________________________

PARENT/GUARDIAN AUTHORIZATION

I request the authorized child care staff to administer the medication or to supervise the child in self-administration as prescribed above. 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 child care staff and the authorized prescriber indicated on this form to communicate in compliance with HIPAA. I understand that per COMAR 13A.15, 13A.16, 13A.17, and 13A.18, the child care program may revoke the child's authorization to self-carry/self-administer medication.

PARENT/GUARDIAN SIGNATURE	DATE (mm/dd/yyyy)	INDIVIDUALS AUTHORIZED TO PICK UP MEDICATION

CELL PHONE #	HOME PHONE #	WORK PHONE #

Emergency Contact(s)	Name/Relationship	Phone Number to be used in case of Emergency
Parent/Guardian 1		
Parent/Guardian 2		
Emergency 1		
Emergency 2		

Section IV. CHILD CARE STAFF USE ONLY

Child Care Responsibilities:

1. Medication named above was received ☐ Yes ☐ No
2. Medication labeled as required by COMAR ☐ Yes ☐ No
3. OCC 1214 Emergency Card updated ☐ Yes ☐ No
4. OCC 1215 Health Inventory updated ☐ Yes ☐ No
5. Modified Diet/Exercise Plan ☐ Yes ☐ No ☐N/A
6. Individualized Plan: IEP/IFSP ☐ Yes ☐ No ☐N/A
7. Staff approved to administer medication is available onsite, field trips ☐ Yes ☐ No

Reviewed by (printed name and signature):	DATE (mm/dd/yyyy)

DOCUMENT MEDICATION ADMINISTRATION HERE

DATE	TIME	MEDICATION	DOSAGE	ROUTE	REACTIONS OBSERVED (IF ANY)	SIGNATURE

Maryland State Department of Education
Office of Child Care

ASTHMA ACTION PLAN AND MEDICATION ADMINISTRATION AUTHORIZATION FORM

1. CHILD'S NAME (First Middle Last)	2. DATE OF BIRTH (mm/dd/yyyy) ____/____/______	3. Child's picture (optional)

Section I. ASTHMA ACTION PLAN – MUST BE COMPLETED BY THE HEATLH CARE PROVIDER

4. ASTHMA SEVERITY: ☐Mild Intermittent ☐ Mild Persistent ☐ Moderate Persistent ☐ Severe Persistent☐ Exercise Induced ☐Peak Flow Best___%

5. ASTHMA TRIGGERS (check all that apply): ☐Colds ☐ URI ☐ Seasonal Allergies ☐Pollen ☐ Exercise ☐Animals ☐Dust ☐Smoke ☐ Food ☐Weather ☐Other__________________

6. **This authorization is NOT TO EXCEED 1 YEAR FROM_____/_____/_____ TO _____/_____/_____**
FOR ASTHMA MEDICATION ONLY – THIS FORM IS USED WITHOUT OCC 1216

7. SCHOOL AGE ONLY: OK to Self-Carry/Self Administer ☐ Yes ☐ No

GREEN ZONE - DOING WELL: Long Term Control Medication- Use Daily At Home unless otherwise indicated

The Child has ALL of these	**Medication Name & Strength**	**Dose**	**Route**	**Time & Frequency**	**Special Instructions**
☐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 ☐ CALL 911 ☐ CALL PARENT ☐ OTHER: ____________________

☐Prior to all exercise/sports ☐When the child feels they need it	**Medication Name & Strength**	**Dose**	**Route**	**Time & Frequency**	**Special Instructions**

YELLOW ZONE - GETTING WORSE ☐ CALL 911 ☐ CALL PARENT ☐ OTHER:__________________

The Child has **ANY** of these	**Medication Name & Strength**	**Dose**	**Route**	**Time & Frequency**	**Special Instructions**
☐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)**					

RED ZONE - MEDICAL ALERT/DANGER ☐ CALL 911 ☐ CALL PARENT ☐ OTHER:____________________

The Child has **ANY** of these	**Medication Name & Strength**	**Dose**	**Route**	**Time & Frequency**	**Special Instructions**
☐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)**					

Maryland State Department of Education
Office of Child Care

ASTHMA ACTION PLAN AND MEDICATION ADMINISTRATION AUTHORIZATION FORM

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

Section II. PRESCRIBER'S AUTHORIZATION – MUST BE COMPLETED BY THE HEALTH CARE PROVIDER

8. PRESCRIBER'S NAME/TITLE			Place Stamp Here
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 – MUST BE COMPLETED BY THE PARENT/GUARDIAN

I authorize the childcare staff to administer the medication or to supervise the child in self-administration as prescribed above. 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 childcare staff and the authorized prescriber indicated on this form to communicate in compliance with HIPAA. I understand that per COMAR 13A.15, 13A.16, 13A.17, and 13A.18; the childcare program may revoke the child's authorization to self-carry/self-administer medication.

School Age Child Only: OK to Self-Carry/Self -Administer ☐ Yes ☐ No

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

Emergency Contact(s)	Name/Relationship	Phone Number to be used in case of Emergency
Parent/Guardian 1		
Parent/Guardian 2		
Emergency 1		
Emergency 2		

Section IV. CHILD CARE STAFF USE ONLY – MUST BE COMPLETED BY THE CHILD CARE PROGRAM

Child Care Responsibilities:		
	1. Medication named above was received Expiration date _________	☐ Yes ☐ No
	2. Medication labeled as required by COMAR	☐ Yes ☐ No
	3. OCC 1214 Emergency Form updated	☐ Yes ☐ No
	4. OCC 1215 Health Inventory updated	☐ Yes ☐ No
	5. Modified Diet/Exercise Plan	☐ Yes ☐ No ☐N/A
	6. Individualized Treatment/Care Plan: Medical/Behavioral/IEP/IFSP	☐ Yes ☐ No ☐N/A
	7. Staff approved to administer medication is available onsite, field trips	☐ Yes ☐ No

Reviewed by (printed name and signature):	DATE (mm/dd/yyyy)

CAMP REGISTRATION

Checklist

We want to make sure you're all set for Greenbelt's Summer Camps by making sure you've crossed these off your list.

CHECKLIST

- [ ] Camp Registration Form is complete
- [ ] Camp Selection and Payment Form is complete
- [ ] Participant Profile is complete
- [ ] Medication Administration Authorization Form(s) is complete for any/all medication administered at camp. Each form must be signed by your physician.
- [ ] Greenbelt Residents: Proof of Residency (Driver's license, MVA change of address card, or lease)

DATE / TIME

Early registration will NOT be accepted. Registration begins

Monday, February 12 at 10 am for Greenbelt Residents.

Tuesday, February 20 at 10 am for Non-Residents.

HOW / WHERE

Send completed forms by

EMAIL. Email all required forms to:
Spring Camp, Camp Pine Tree I & II, and Youth on the Go (YOGO): cpracht@greenbeltmd.gov
Kinder Camp, Creative Kids Camp, Camp Encore,
Spring Circus Camp, and Summer Circus Camp: rcampbell@greenbeltmd.gov

FAX. Fax your forms with a cover sheet to: **(301) 220-0561**

IN PERSON. Visit the Greenbelt Community Center at 15 Crescent Road
or visit the Youth Center Business Office at 99 Centerway

CONTACT

Contact us at

(301) 397-2200 for Youth Center Camps (Camp Pine Tree and YOGO)

(301) 397-2208 for Greenbelt Community Center Camps (Kinder, Creative Kids, Circus Camp, Camp Encore)