Updated Nov. 6, 2015

Sultana
EDUCATION
FOUNDATION

Summer Program Forms Packet for

Kayak Camp 2017

Forms for Your Reference

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Forms That Must Be Signed and Returned Seven Days Prior to Trip

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Medical Form - page 4 (to be completed by parent/guardian)

Please return completed forms to:

Sultana Education Foundation
c/o Liza Brocker / P.O. Box 524 / Chestertown, MD 21620

If you have any questions please don't hesitate to contact us at 410-778-5954

Pick-Up / Drop-Off Information

Program Days:	Monday – Friday
Drop-Off Time:	9:00 am
Pick-Up Time:	4:00 pm
Pick-Up / Drop-Off Location:	Sultana Education Center, 200 Cross Street, Chestertown

Suggested Daily Gear List

Kayak Camp

Please arrive each day wearing/with the following items

- **Bathing Suit**
- **Synthetic Swim Shirt/Surf Shirt** *(important - helps prevent lifejacket Chafing!)*
- **Water Shoes** *(Options include Tevas, Keens, Aqua Socks & old sneakers. No flip flops!)*
- **Hat**
- **Sunglasses** *(optional but highly recommended)*
- **Sunscreen** *(please apply before arrival each day!)*
- **Bag Lunch With Child's Name** *(we will store lunches in a dry container)*
- **Re-usable Water bottle** *(pre-filled at home)*
- **Towel**
- **Dry Change of Clothes**
- **Rain Gear** *(as necessary)*

Gear may be packed in a backpack or small bag.

Lifejackets will be provided, but children may bring their own if they prefer.

Name of Participant_____Date of Birth_____

Has the child participated in a Sultana Summer Program previously? ☐ Yes ☐ No
If yes, which program: ☐ Schooner Sultana 5-day ☐ Schooner Sultana 3-day ☐ 5-Day Kayak Trip ☐ Kayak Camp ☐ Canoe Camp

Permission & General Release

I hereby give permission for (child's name)_____ to participate in an educational Summer Program with the Sultana Education Foundation (Sultana). I understand that he/she will be directly involved in a variety of outdoor activities under the direct supervision of Sultana's professionally trained educational staff. In consideration of the Sultana Education Foundation allowing my child to participate in one of its educational Summer Programs, I agree to release and discharge Sultana, its employees and agents from any injuries sustained by my child as a result of his/her participation. I agree to indemnify and hold harmless Sultana, its employees and agents against any liability incurred as a result of such injury or loss. However, I shall have no obligation to indemnify Sultana with respect to any injury or loss resulting from, arising out of, or caused by negligence on the part of Sultana.

Signature of Parent or Guardian_____Date_____

Name of Parent or Guardian (please print)_____

Photo Release

The Sultana Education Foundation regularly posts photos of its programs on its web site and includes them in newsletters and public relations materials. By signing below, you grant permission for Sultana Education Foundation to use any pictures of the applicant for these non-profit purposes. Photos will NOT be made available to any outside organizations.

Signature of Parent or Guardian:_____Date_____

Day Program Medical Form

To be completed by parent/guardian. Please attach additional information if necessary.

Contact & Insurance Information

Child Last Name: _____ First Name _____ Birth Date _____ Age _____ Male☐ Female☐

Date(s) of Trip: _____

Address: _____

City: _____ State: _____ Zip: _____

Name of Guardian/Parent #1 _____ Relationship _____

Home Phone _____ *Work Phone* _____ *Cell Phone* _____

Name of Guardian/Parent #2 _____ Relationship _____

Home Phone _____ *Work Phone* _____ *Cell Phone* _____

Additional Emergency Contact _____ Relationship _____

Home Phone _____ *Work Phone* _____ *Cell Phone* _____

Health Insurance Carrier _____ Group Number _____ ID Number _____

Name of Insured _____ Relationship to Child _____

Child's Physician: _____ Phone: _____

HEALTH INFORMATION:

2. Are there any health problems including physical, psychiatric, or behavioral problems of which we need to be aware? ☐ NO

   ☐ YES, Explain: _____

3. 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:

A. State/territory in which child resides:

_____

B. 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:

2. Country in which child resides:

_____

3. Attach Department form DHMH-896 (record of vaccination or immunity)

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

MEDICATION ADMINISTRATION AUTHORIZATION FORM

for Youth Camps in Maryland

Department of Health & Mental Hygiene (DHMH)
Center for Healthy Homes and Community Services (CHHCS)
(410) 767-8417 Toll Free 1-877-4MD-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, for each medication, and each time there is a change in dosage or time of administration of a medication.

- **I. Prescription medication must be in a container labeled by the pharmacist or prescriber.**
- **II. Nonprescription medication must be in the original container with the instructions for use. Nonprescription medication includes vitamins, homeopathic, and herbal medicines.**
- III. **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 [ ] YES ***-If yes, see Section III below.*** [ ] NO
5. MEDICATION NAME	6. DOSE	7. ROUTE
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)*** *(ORIGINAL SIGNATURE OR SIGNATURE STAMP ONLY)*		14b. DATE

II. PARENT/GUARDIAN AUTHORIZATION

I request the authorized youth camp operator/staff 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 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 EMERGENCY MEDICATION (Check One) [ ] YES [ ] NO [ ] N/A - Not emergency medication	16c. DATE
17a. PARENT/GUARDIAN'S SIGNATURE authorizing self administration	17b. SELF CARRY EMERGENCY MEDICATION (Check One) [ ] YES [ ] NO [ ] N/A - Not emergency medication	17c. DATE

This Form Must Be Completed and Returned to Sultana Fourteen Days Prior to Trip Departure Date