



Summer Program Forms Packet for

# 8-Day High School Kayak Trip 2018

## *Forms for Your Reference*

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## *Forms That Must Be Signed and Returned Fourteen Days Prior to Trip*

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Medical Form - page 5 (to be completed by parent/guardian/physician)

Medication Form - page 6 (must be completed by physician)

## *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

### Drop-Off / Check-In

Day: Monday, July 29, 2018  
Time: 11:00 am  
Location: Chesapeake College  
GPS Address: 1000 College Circle  
Wye Mills, MD

### Pick-Up / Departure

Day: Monday, Aug 5, 2018  
Time: 4:00 pm  
Location: Chesapeake College  
GPS Address: 1000 College Circle  
Wye Mills, MD

*Upon entering the circle at Chesapeake College, we'll be waiting in the first parking lot on the right (Lot B).*

## Suggested Packing List

*Eight-Day Kayak Trip*

### **Clothing**

Bathing Suit (2)  
T-Shirts (9)  
Shorts (9)  
Underwear (9)  
Socks (9)  
Long Pants (2)  
Synthetic Swim Shirt (1) (prevents lifejacket chafing)  
Sweatshirt (1)  
Light Jacket/Windbreaker (1)  
Foul Weather Gear Jacket & Pants (1)  
Long Sleeved Shirts (2)

### **Sleeping Gear**

Sleeping Bag (in stuff sack)  
Pillow

### **Accessories**

Sunscreen (in plastic bag-lotion preferred over spray)  
Head Lamp/Flashlight  
Towels (2)  
Toiletries (in separate bag)  
Hat

### **Refillable Water Bottle-IMPORTANT**

### **Footwear**

Sport Sandals or Water Shoes (important)  
Shoes/Boots

### **Recommended Optional Gear**

Books or Magazines to read at night  
Camera  
Sunglasses  
Sleepwear/PJs

### **Prohibited Items**

Candy or Snacks  
Money  
Electronics (cell phones, iPods, iPads, laptops, etc.)

### **Medicine**

All medicine of any type (prescription or over-the-counter) should be brought in a separate zip-lock bag and given to the trip leader upon arrival. **ALL MEDICINE MUST BE BROUGHT IN ORIGINAL CONTAINERS.**

**Please pack all gear into a single large duffle bag.**

*Pillow and sleeping bag may travel separately.*

## **Directions**

### **Eight-Day Kayak Trip**

#### **Driving Directions to Chesapeake College**

**From Annapolis and Points West:**

Take Route 50 East over the Chesapeake Bay Bridge. Continue through Kent Island and over the Kent Narrows Bridge. At the Route 50/301 split, veer right to stay on Route 50 East. After the split, travel for approximately 5.4 miles to the stoplight marking the entrance to Chesapeake College (there is a large wind turbine just before the light). Turn right onto Route 213 South/College Drive. *Travel approximately 1/10 mile and turn right onto College Circle. At the large traffic circle, veer right and turn into the first parking lot on the right-hand side – Lot B. We will be waiting with our 15 passenger van and kayak trailer.*

**From Points South and East:**

Take Route 50 West towards the Bay Bridge. At the intersection of Route 50 West and Route 213, turn left at the stoplight onto Route 214 South/College Drive. At this point, follow the italicized directions above.

**From Points North:**

Take Route 213 South through Centreville, over Route 301, and all the way to the intersection with Route 50. Go straight through the stoplight. At this point, follow the italicized directions above.

**If you get lost, feel free to call us:**

**Sultana Education Foundation's Main Office: 410-778-5954**

You may also call the Trip Leader. The Trip Leader will provide you with his/her cell phone number at the beginning of the week.

Name of Participant \_\_\_\_\_ Date of Birth \_\_\_\_\_

Has the child participated in a Sultana Summer Program previously?  Yes  NoIf yes, which program:  Schooner Sultana 5-day  Schooner Sultana 3-day  5-Day Kayak Trip  Kayak Camp  Canoe Camp

## Food Preferences & Restrictions

During your program we will provide you with healthy meals, snacks, and beverages. It is helpful for us to know in advance if you have special dietary considerations. Please check one of the boxes below so that our staff members can adequately provision your trip with foods that suit each participant's dietary needs.

Eating Habits (Please Check One) :  Eat Almost Anything  Vegetarian  Vegan  Kosher

Please Describe Any Food Allergies: \_\_\_\_\_

Please Describe Any Other Food Considerations We Should Be Aware Of: \_\_\_\_\_

## Permission & General Release

I hereby give permission for (child's name) \_\_\_\_\_ to participate in a residential educational Summer Program with the Sultana Education Foundation (Sultana). I understand that he/she will be directly involved in a variety of outdoor activities that may include kayaking, sailing, and swimming 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 \_\_\_\_\_

# Overnight Program Medical Form

To be completed by parent/guardian/physician. 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

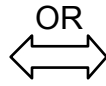
YES, Explain: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

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:



For campers who reside **outside** 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: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

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 <input type="checkbox"/> YES <b>-If yes, see Section III below.</b> <input type="checkbox"/> 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 <b>NOT TO EXCEED 1 YEAR.</b>		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		
14a. <b>PRESCRIBER'S SIGNATURE (Parent/guardian cannot sign here)</b> <small>(ORIGINAL SIGNATURE OR SIGNATURE STAMP ONLY)</small>			14b. <b>DATE</b>

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

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

PO Box 524 - Chestertown, Maryland 21620 - (p) 410-778-5954 - (fax) 410-778-4531