This is what your child needs for Horizons Summer Program this year:
(The attachments are all labelled 1, 2, 3 and 4- Explanation for each attachment provided below)

1. **Youth Health History for Horizons Summer Program Students**
   We realize that you answered most of these questions on the enrollment application, but this form is required by the state of Maryland to be in each student's file.

2. **Medication Administration Authorization Form**
   -There are (3) forms that are in this section. All (3) forms will need to be filled in by your child's doctor. This will inform the staff at the program the medical issues your child is diagnosed with and the treatment prescribed by the child's doctor. This will also inform staff if your child can take the medication themselves or staff need to administer the medication to them.
   Examples of a few Medical issues that would need these (3) forms filled out:
   - ADHD requiring daily medication
   - Asthma requiring an inhaler
   - Allergies that require medication or an epi pen
   - Migraine headaches

   These are just a few examples. We are not permitted at Horizons to medicate children unless there is a doctor's order to do so, that includes Tylenol, Advil, etc.

3. **Asthma Action Plan**
   -There are (2) more additional forms that will need to be filled out by your child's doctor if your child is diagnosed with Asthma.

4. **Permission for use of Sunscreen**
   -We will need a parent's signature on form #4. We have a children's **SPF 50 Sunscreen spray** that we will be using daily on each child attending camp unless you have a particular sunscreen you would like to provide and keep at camp for your child. Just let us know your preference.

***Some of your children will only need #1 The Youth Camp Health History and #4 The Sunscreen Permission slip. Other children may need forms #2 and/ or #3. If you have any questions regarding any of these forms please feel free to contact us. We will be happy to help you and want to make this process as simple as possible.**

Sincerely,
Teresa Dellamura

Program Coordinator
Horizons of Kent & Queen Anne's
116B S. Lynchburg St
Chestertown, MD. 21620
410-778-9903
tdellamurahorizons@gmail.com

1.

YOUTH CAMP HEALTH HISTORY
CAMPER

Child's Name: _____

Current residence: _____

EMERGENCY CONTACT INFORMATION:

Emergency Contact
(Parent or Legal Guardian): _____ Phone: _____

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

Primary Care Physician or
other provider of medical care: _____ Phone: _____

HEALTH INFORMATION:

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

☐ YES, and youth camp participation was discussed with the camper's healthcare provider including considerations related to risk of COVID-19

Explain health problems and any considerations: _____

_____

_____

_____

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:
Must list current residence above.

For campers who currently reside **within** the United States, a United States territory, or the District of Columbia: Does the camper have any immunization exemptions because of a parental or guardian objection or medical contraindication? ☐ NO

☐ YES, List: _____

For campers who reside **outside** the United States, a United States territory, or the District of Columbia: Attach record of vaccination or immunity on Department form MDH-896.

_____

Parent or Legal Guardian's Signature Date

2.

MEDICATION ADMINISTRATION AUTHORIZATION FORM

for Youth Camps in Maryland

Maryland Department of Health (MDH)
Center for Healthy Homes and Community Services (CHHCS)
(410) 767-8417 Toll Free 1-877-4MD-MDH 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.

- **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 authorized individual 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 member or volunteer to administer the medication or 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, as listed in 15c below, 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.

15a. PARENT/GUARDIAN SIGNATURE	15b. DATE	15C. INDIVIDUAL(S) AUTHORIZED TO PICK UP MEDICATION
15d. HOME PHONE #	15e. CELL PHONE #	15f. 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 authorize self-administration of the above listed medication for the child named above under the supervision of the youth camp operator, a designated staff member or volunteer. 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

MEDICATION ADMINISTRATION AUTHORIZATION FORM for Youth Camps in Maryland

Maryland Department of Health (MDH)
Office of Healthy Homes and Communities
(410) 767-8417 or 1-877-4MD-DHMH ext. 8417
Draft Revision Date: 4/4/2018

This form must be completed fully in order for youth camp operators and staff members to adminter the required medication or for the camper to self-adminster 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. Non prescription 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.

Section I. PRESCRIBER'S AUTHORIZATION

1. CHILD'S NAME (First Middle Last) | 2. DATE OF BIRTH (mm/dd/yyyy) ___/___/____

3. MEDICATION SHALL BE ADMINISTERED during the year in which this form is dated in 7b below unless more restrictive dates are specified in 3a and 3b. This authorization is NOT TO EXCEED 1 YEAR. | 3a. FROM (mm/dd/yyyy) ___/___/____ | 3b. TO (mm/dd/yyyy) ___/___/____

	Medication Name	Condition Being Treated/PRN Parameters	Dose	Route	Frequency	OK to Self-Administer	OK to Self-Carry (Emerg Meds Only)
1						☐ Yes ☐ No	☐ Yes ☐ No ☐ Not emergency med
			Emergency Medication: ☐ *Yes* ☐ *No Known side effects:*				
2						☐ Yes ☐ No	☐ Yes ☐ No ☐ Not emergency med
			Emergency Medication: ☐ *Yes* ☐ *No Known side effects:*				
3						☐ Yes ☐ No	☐ Yes ☐ No ☐ Not emergency med
			Emergency Medication: ☐ *Yes* ☐ *No Known side effects:*				

4. PRESCRIBER'S NAME/TITLE

TELEPHONE FAX

ADDRESS

CITY | STATE | ZIP CODE

This space may be used for the Prescriber's Address Stamp

5a. PRESCRIBER'S SIGNATURE (Parent/guardian cannot sign here) (original signature or signature stamp only) | 5b. DATE (mm/dd/yyyy)

Section II. PARENT/GUARDIAN AUTHORIZATION

I request the authorized youth camp operator, staff member or volunteer to administer the medication or 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 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

6a. PARENT/GUARDIAN SIGNATURE | 6b. DATE (mm/dd/yyyy) | 6c. INDIVIDUALS AUTHORIZED TO PICK UP MEDICATION

6d. HOME PHONE # | 6e. CELL PHONE # | 6f. WORK PHONE #

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

THIS SECTION SHOULD ONLY BE COMPLETED IF ANY MEDICATIONS IN THE ASTHMA ACTION PLAN ABOVE ARE 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 authorize self-administration of all of the medications listed in *Section I* above that are checked as "OK to self-administer" or "OK to self-administer and self-carry" for the child named above underthe supervision of the youth camp operator, a designated staff member or volunteer. If indicated in *Section I*, the child named above may self-carry emergency medications checked as "OK to self-administer and self-carry."

7a. PRESCRIBER'S SIGNATURE FOR SELF-ADMINISTRATION/SELF-CARRY | 7b. DATE | 8a. PARENT/GUARDIAN'S SIGNATURE FOR SELF-ADMINISTRATION/SELF-CARRY | 8b. DATE

2

2.

MEDICATION ADMINISTRATION AUTHORIZATION FORM for Youth Camps in Maryland

Maryland Department of Health (MDH)
Office of Healthy Homes and Communities
(410) 767-8417 or 1-877-4MD-DHMH ext. 8417
Draft Revision Date: 4/4/2018

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. Non prescription 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.

Section I. PRESCRIBER'S AUTHORIZATION

1. CHILD'S NAME (First Middle Last)

2. DATE OF BIRTH (mm/dd/yyyy) ___/___/____

3. MEDICATION SHALL BE ADMINISTERED

3a. FROM (mm/dd/yyyy) ___/___/____ 3b. TO (mm/dd/yyyy) ___/___/____

during the year in which this form is dated in 7b below unless more restrictive dates are specified in 3a and 3b. This authorization is NOT TO EXCEED 1 YEAR.

	Medication Name	Condition Being Treated/PRN Parameters	Dose	Route	Frequency	OK to Self-Administer	OK to Self-Carry (Emerg Meds Only)
1						☐ Yes ☐ No	☐ Yes ☐ No ☐ Not emergency med
			Emergency Medication: ☐ Yes ☐ No Known side effects:				
2						☐ Yes ☐ No	☐ Yes ☐ No ☐ Not emergency med
			Emergency Medication: ☐ Yes ☐ No Known side effects:				
3						☐ Yes ☐ No	☐ Yes ☐ No ☐ Not emergency med
			Emergency Medication: ☐ Yes ☐ No Known side effects:				
4						☐ Yes ☐ No	☐ Yes ☐ No ☐ Not emergency med
			Emergency Medication: ☐ Yes ☐ No Known side effects:				
5						☐ Yes ☐ No	☐ Yes ☐ No ☐ Not emergency med
			Emergency Medication: ☐ Yes ☐ No Known side effects:				
6						☐ Yes ☐ No	☐ Yes ☐ No ☐ Not emergency med
			Emergency Medication: ☐ Yes ☐ No Known side effects:				
7						☐ Yes ☐ No	☐ Yes ☐ No ☐ Not emergency med
			Emergency Medication: ☐ Yes ☐ No Known side effects:				
8						☐ Yes ☐ No	☐ Yes ☐ No ☐ Not emergency med
			Emergency Medication: ☐ Yes ☐ No Known side effects:				
9						☐ Yes ☐ No	☐ Yes ☐ No ☐ Not emergency med
			Emergency Medication: ☐ Yes ☐ No Known side effects:				
10						☐ Yes ☐ No	☐ Yes ☐ No ☐ Not emergency med
			Emergency Medication: ☐ Yes ☐ No Known side effects:				
11						☐ Yes ☐ No	☐ Yes ☐ No ☐ Not emergency med
			Emergency Medication: ☐ Yes ☐ No Known side effects:				
12						☐ Yes ☐ No	☐ Yes ☐ No ☐ Not emergency med
			Emergency Medication: ☐ Yes ☐ No Known side effects:				
13						☐ Yes ☐ No	☐ Yes ☐ No ☐ Not emergency med
			Emergency Medication: ☐ Yes ☐ No Known side effects:				

4. PRESCRIBER'S NAME/TITLE

This space may be used for the Prescriber's Address Stamp

TELEPHONE FAX

ADDRESS

CITY STATE ZIP CODE

5a. PRESCRIBER'S SIGNATURE (Parent/guardian cannot sign here)
(original signature or signature stamp only)

5b. DATE (mm/dd/yyyy)

Section II. PARENT/GUARDIAN AUTHORIZATION

I request the authorized youth camp operator, staff member or volunteer to administer the medication or 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 must pick up the medications otherwise, it will be discarded. I authorize camp personnel and the authorized prescriber indicated on this form to communicate in compliance with HIPAA.

6a. PARENT/GUARDIAN SIGNATURE

6b. DATE (mm/dd/yyyy)

6c. INDIVIDUALS AUTHORIZED TO PICK UP MEDICATION

6d. HOME PHONE #

6e. CELL PHONE #

6f. WORK PHONE #

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

THIS SECTION SHOULD ONLY BE COMPLETED IF ANY MEDICATIONS IN THE ASTHMA ACTION PLAN ABOVE ARE 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 authorize self-administration of all of the medications listed in *Section I* above that are checked as "OK to self-administer" or "OK to self-administer and self-carry" for the child named above under the supervision of the youth camp operator, a designated staff member or volunteer. If indicated in *Section I*, the child named above may self-carry emergency medications checked as "OK to self-administer and self-carry."

7a. PRESCRIBER'S SIGNATURE
FOR SELF-ADMINISTRATION/SELF-CARRY

7b. DATE

8a. PARENT/GUARDIAN'S SIGNATURE
FOR SELF-ADMINISTRATION/SELF-CARRY

8b. DATE

ASTHMA ACTION PLAN AND MEDICATION ADMINISTRATION AUTHORIZATION FORM

for Youth Camps in Maryland

Please complete both pages of this form if the child has an inhaler or other asthma-related medication

Maryland Department of Health (MDH)
Office of Healthy Homes and Communities
(410) 767-8417 or 1-877-4MD-DHMH ext. 8417

1. CHILD'S NAME (First Middle Last)	2. DATE OF BIRTH (mm/dd/yyyy) ___/___/_____	3. PEAK FLOW PERSONAL BEST:

4. ASTHMA SEVERITY (check one): ☐ Mild Intermittent ☐ Mild Persistent ☐ Moderate Persistent ☐ Severe Persistent ☐ Exercise Induced

5. ASTHMA TRIGGERS (check all that apply): ☐Colds ☐Exercise ☐Animals ☐Dust ☐Smoke ☐Food ☐Weather ☐Other_____

Section I. ASTHMA ACTION PLAN

6. THIS ASTHMA ACTION PLAN SHALL BE EFFECTIVE FOR AND MEDICATION SHALL BE ADMINISTERED during the year in which this form is dated in 9b below unless more restrictive dates are specified in 6a and 6b. This authorization is NOT TO EXCEED 1 YEAR.	6a. FROM (mm/dd/yyyy) ___/___/_____	6b. TO (mm/dd/yyyy) ___/___/_____

GREEN ZONE - DOING WELL

You have **ALL** of these
- Breathing is good
- No cough or wheeze
- Can walk, exercise, & play
- Can sleep all night
- If known, peak flow greater than _____ (80% personal best)

Medication Name	Dose	Route	Frequency	OK to Self-Administer
				☐ Yes ☐ No
	Known side effects:			
				☐ Yes ☐ No
	Known side effects:			
				☐ Yes ☐ No
	Known side effects:			

Exercise Zone

Rescue Medication	Dose	Route	Frequency	OK to Self-Administer	OK to Self-Carry
				☐ Yes ☐ No	☐ Yes ☐ No
	Known side effects:				

☐ Prior to all exercise/sports
☐ When the child feels they need it

YELLOW ZONE - GETTING WORSE

You have **ANY** of these
- 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)

Emergency Medication	Dose	Route	Frequency	OK to Self-Administer	OK to Self-Carry
				☐ Yes ☐ No	☐ Yes ☐ No
	Known side effects:				
				☐ Yes ☐ No	☐ Yes ☐ No
	Known side effects:				
				☐ Yes ☐ No	☐ Yes ☐ No
	Known side effects:				

RED ZONE - MEDICAL ALERT/DANGER

You have **ANY** of these
- 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)

Emergency Medication	Dose	Route	Frequency	OK to Self-Administer	OK to Self-Carry
				☐ Yes ☐ No	☐ Yes ☐ No
	Known side effects:				
				☐ Yes ☐ No	☐ Yes ☐ No
	Known side effects:				
				☐ Yes ☐ No	☐ Yes ☐ No
	Known side effects:				

ASTHMA ACTION PLAN AND MEDICATION ADMINISTRATION AUTHORIZATION FORM

for Youth Camps in Maryland

Please complete this form if the child has an inhaler or other asthma-related medication

Maryland Department of Health (MDH)
Office of Healthy Homes and Communities
(410) 767-8417 or 1-877-4MD-DHMH ext. 8417

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

Section II. PRESCRIBER'S AUTHORIZATION

8. PRESCRIBER'S NAME/TITLE			This space may be used for the Prescriber's Address Stamp
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

I request the authorized youth camp operator, staff member or volunteer to administer the medication or 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 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

10a. PARENT/GUARDIAN SIGNATURE	10b. DATE (mm/dd/yyyy)	10c. INDIVIDUALS AUTHORIZED TO PICK UP MEDICATION

10d. HOME PHONE #	10e. CELL PHONE #	10f. WORK PHONE #

Section IV. AUTHORIZATION FOR SELF-ADMINISTRATION / SELF-CARRY (OPTIONAL)

THIS SECTION SHOULD ONLY BE COMPLETED IF ANY MEDICATIONS IN THE ASTHMA ACTION PLAN ABOVE ARE 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 authorize self-administration of all of the medications listed in *Section I: Asthma Action Plan* above that are checked as "OK to self-administer" or "OK to self-administer and self-carry" for the child named above under the supervision of the youth camp operator, a designated staff member or volunteer. If indicated in *Section I: Asthma Action Plan*, the child named above may self-carry emergency medications checked as "OK to self-administer and self-carry."

11a. PRESCRIBER'S SIGNATURE FOR SELF-ADMINISTRATION/SELF-CARRY	11b. DATE (mm/dd/yyyy)

12a. PARENT/GUARDIAN'S SIGNATURE FOR SELF-ADMINISTRATION/SELF-CARRY	12b. DATE (mm/dd/yyyy)

Section V. CAMP MEDICAL STAFF USE ONLY

Camp Medical Staff Notes:	
Reviewed by:	DATE (mm/dd/yyyy)

4.

PERMISSION SLIP FOR USE OF SPF 50 SUNSCREEN SPRAY and INSECT REPELLANT

This year, we will be offering many outside activities. In that regard, we encourage you to apply sunscreen and insect repellant on your child before he/she arrives at the Horizons program each day. We will supply children's SPF 50 sunscreen spray and a child-friendly insect repellant for students that forgot to apply these sprays at home.

Please let us know whether you give Horizons of Kent & Queen Anne's permission to apply the sunscreen spray and insect repellant on your child during the program as needed or if you would like to supply your own items for your child's use this summer.

____ Yes. I give Horizons of Kent & Queen Anne's permission to use a child's SPF 50 sunscreen spray and insect repellant on my child_____.

(print child's name)

-Or-

____ No. Please do **NOT** use Horizons SPF 50 sunscreen spray/insect repellant spray on my child. I will provide my own sunscreen and insect repellant for my child to use during the summer program.

_____

Parent/ Guardian Name (Please Print)

_____

Parent/ Guardian Signature

_____

Date