WECLOME TO SWEET POTATO KIDS

2024 SUMMER CAMP

"The Great Exploration!"

Please indicate the sessions your child will be in attendance, with a

"Yes," or "No," for that session. –Note 1 Session = 2 weeks

You must sign up for a minimum of 2 Sessions (4 weeks) to attend.

THERE ARE 8 WEEKS OF CAMP

Directors Signature:	Child/ren's Names:	Session 1 06/24-7/5	Session 2 7/8-7/19	Session 3 7/22-8/2	Session 4 8/5-8/16	Parent Signature:

Please put what grade your child is going to ____________

$250- Activity Fee is Required to Reserve your space

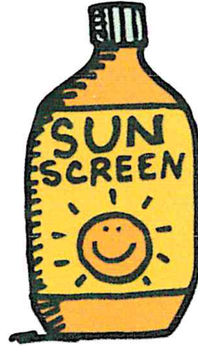
Thank you for entrusting us with the care of your children

9631 Liberty Rd, Suites CDE

Randallstown, Maryland 21133

443-405-3408

Sweet Potato Kids Summer Camp 2024
Supply List



*Water Bottle

*Book Bag (Equipped with a change of clothes.)

*Sunscreen/Insect Repellent – please fill out the topical ointment permission slip in the packet

*Swim Wear – to include water shoes (Every Wednesday) {Please be sure your child comes dressed in swim gear.} Don't forget a change of clothes to include underwear and a towel.

*Older Children – (Toiletries) {requires self-application}

*Sun Hat

*Extra Snacks if your child is a picky eater

*Mask (optional)

PLEASE BE SURE TO LABEL EVERYTHING

Permission to Administer Topical Ointment/ Lotion/ Powder

Authorization is necessary for our staff to administer over-the-counter topical ointments, insect repellents, lotions, creams, powders, and sunscreen. These products must be provided in their original containers and clearly labeled with the child's name. Our team will ensure the safekeeping of these items, keeping them out of reach of children when not in use.

Childs Name: ____

Name of Ointment/ Lotion/ Powder: ______________________________

Please ensure that your child's ointment/ Lotion/ Powder is brought to camp on their first day and given to their counselor as it will stay on-site for the duration of camp. Thank you for your cooperation in ensuring the well-being of your child during their time at camp.

Apply To:

( ) All Exposed Skin ( ) Diaper Area

( ) Face Only ( ) Other (Specify) ____________________

I hereby grant permission to Sweet Potato Kids for the application of the specified medication/ointment/powder as directed.

______________________________ ________

(Parent/Guardian Printed Name) (Date)

Parent/Guardian Signature: ______________________________

Please Note: One From must be completed per topical request

Field Trip Permission Slip – Sweet Potato Kids Summer 2024

Sweet Potato Kid's Inc. is pleased to announce our wonderful lineup of field trips for the Summer Program of 2024. In order to streamline the process for parents and guardians, we are providing this comprehensive permission slip, which grants consent for all scheduled activities throughout the duration of the program.

Some of our Field Trips Include:
The Zoo, Picnic, Jungle World, Water Wednesdays

Please note that while we have curated an exciting itinerary, the final schedule may be subject to alterations due to unforeseen circumstances or logistical adjustments. Nevertheless, we are committed to ensuring a fulfilling and enriching experience for all participants.

By affixing your signature below, you, as the parent or legal guardian of the named child, authorize their participation in **ALL** field trips organized by Sweet Potato Kid's Inc. for the Summer Program of 2024. In the unlikely event of a medical emergency during any of these activities, you hereby grant Sweet Potato Kid's Inc. permission to administer appropriate first aid and, if necessary, to seek emergency medical treatment. It is understood that every effort will be made to promptly notify you or a designated emergency contact.

It is important to note that Sweet Potato Kid's Inc. shall not be held responsible for any associated costs, expenses, claims, or liabilities arising from emergency medical treatment. To facilitate the utmost safety and care for your child, we kindly request that you provide us with any pertinent medical information or special considerations before the commencement of field trips.

Please utilize the space below to inform us of any medical conditions or allergies that may require special attention during field trip activities.

Additional Notes/Allergies: ____
____
____

Child's Name: ____________________________

Legal Guardian's Printed Name: ____________________________ Number: _______________

Emergency Contact Name: ________________________________ Number: _______________

By signing below, you acknowledge that you have carefully read and understood the terms outlined in this permission slip, and you grant permission for your child to participate in the Sweet Potato Kid's Inc. Summer Program field trips as described.

Signature ____ Date: _________________

Summer Camp Preliminary Schedule

(Schedule to change on Field trip days)

7:00 – 9:00 Breakfast and Table Toys

9:00 – 9:45 Morning Fitness/ Meditation/ Zumba

9:45 – 10:30 Morning Enrichment

10:30 – 11:00 Literacy/ Art/Creativity/Gym

11:00 – 11:45 Electives

11:45 – 12:00 Prepare for Lunch

12:00 – 1:00 Lunch

1:00 – 2:00 Games/ Enrichment

2:00 – 3:00 Free Play

3:00 – 4:00 Evening Fitness

4:00 – 5:00 Recall/ Revamp

5:00 – 5:30 Table Activities

5:30 – 6:00 Clean Up /Dismissal

IN-HOUSE FIELD TRIP PERMISSION SLIP AND WALKING SLIP

My Child ____________________________ has my ____________________________________

(Child's Name) *(Parent/Guardian Name- Printed)*

Authorization to participate in all on-site field trips at **Sweet Potato Kids** and excursions within walking distance such as **"Jungle World"** for the duration of the summer of 2024. Additionally, I acknowledge that weather permitting, my child is authorized to be transported via the 15-seat passenger vans provided by Sweet Potato Kids to **Northwest Regional Park** for recreational activities and physical exercise.

Parent's Signature: ____ Date: _______________

Please contact us with any questions at 443-405-3408

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, 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? ☐ 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

SUMMER CAMP

FIELD TRIPS

June 25th Jungle World
Randallstown {Walking}

July 3rd
AMC Movies
Despicable Me
Owings Mills

July 26th
Video Game Truck
"In House"

ENJOY YOUR TRIP!

July 11th
"Kidzville"
Baltimore National Pike

Aug 2nd Picnic at the Park
Kona Ice Truck

July 17th
ZOO
Druid Hill Park

Aug. 9th "Players Fun Zone"

Aug. 16th
Adventure Park USA

PLEASE BE SURE TO HAVE YOUR CHILD HERE BEFORE THE TIME OF DEPARTURE. THERE IS NO ALTERNATE CARE ON FIELD TRIP DAYS

STATE OF MARYLAND

DHMH

Maryland Department of Health and Mental Hygiene

Larry Hogan, Governor - Boyd K. Rutherford, Lt. Governor - Dennis R. Schrader, Secretary

INTERPRETIVE MEMORANDUM

Date: January 25, 2017

To: MD Youth Camp Operators

From: Joseph T. McKenzie, III, LEHS, REHS/RS, MPH, Chief
Center for Healthy Homes and Community Services

Re: **REVISED POLICY: COMAR 10.16.07.14, Medications (Sunscreen)**

THIS MEMORANDUM SUPERSEDES ALL PREVIOUS INTERPRETIVE MEMORANDA REGARDING SUNSCREEN.

Appropriate sunscreen use is important to prevent skin damage and skin cancer in children. The Department encourages the appropriate use of sunscreen during summer activities. At the same time, sunscreen can cause allergic reactions in a small number of children, and parents may wish to be involved in decisions regarding sunscreen use for their children.

1. The Center for Healthy Homes and Community Services no longer considers sunscreen a medication requiring a prescriptive order.
2. Camps shall obtain authorization from the parent/guardian before applying sunscreen at camp. The authorization shall include the camper's name, the parent or guardian's signature, the date signed, the brand of sunscreen and whether staff may assist the camper in the application of the sunscreen.
3. Camps should encourage parents/guardians to provide sunscreen. Camps are also permitted to provide sunscreen with approval by parents/guardians.
4. Parents/guardians should be encouraged to apply sunscreen to their child before the child attends camp for the day.

This policy is now in effect. Questions may be directed to the Office Help Line toll-free at 1-866-703-3266.

Cc: Claire Pierson, Assistant Attorney General
Sabita Persaud, PhD, RN, APHN-BC, Maryland Board of Nursing

Environmental Health Bureau

201 W. Preston Street, Baltimore, Maryland 21201
410-767-6742 • Fax 410-333-5995

6 St. Paul Street, Suite 1301, Baltimore, Maryland 21202
410-767-8400 • Fax 410-333-8931

Toll Free 1-877-4MD-DHMH
TTY for Disabled Maryland Relay Service 1-800-735-2258
Web Site: http://phpa.dhmh.maryland.gov

ASTHMA ACTION PLAN AND MEDICATION ADMINISTRATION AUTHORIZATION FORM

for Youth Camps in Maryland

Maryland Department of Health (MDH)
Office of Healthy Homes and Communities
(410) 767-8417 or 1-877-463-3464 ext. 78417

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

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	Medication Name	Dose	Route	Frequency	OK to Self-Administer
Breathing is good					☐ Yes ☐ No
No cough or wheeze		*Known side effects:*			
Can walk, exercise, & play					☐ Yes ☐ No
Can sleep all night		*Known side effects:*			
If known, peak flow greater					☐ Yes ☐ No
than ______ (80% personal best)		*Known side effects:*			

Exercise Zone

	Rescue Medication	Dose	Route	Frequency	OK to Self-Administer	OK to Self-Carry
☐ Prior to all exercise/sports					☐ Yes ☐ No	☐ Yes ☐ No
☐ When the child feels they need it		*Known side effects:*				

YELLOW ZONE - GETTING WORSE

You have **ANY** of these	Emergency Medication	Dose	Route	Frequency	OK to Self-Administer	OK to Self-Carry
Some problems breathing Wheezing, noisy breathing					☐ Yes ☐ No	☐ Yes ☐ No
Tight chest		*Known side effects:*				
Cough or cold symptoms Shortness of breath					☐ Yes ☐ No	☐ Yes ☐ No
Other:______________		*Known side effects:*				
If known, peak flow between					☐ Yes ☐ No	☐ Yes ☐ No
____ and ____ (50% to 79% personal best)		*Known side effects:*				

RED ZONE - MEDICAL ALERT/DANGER

You have **ANY** of these	Emergency Medication	Dose	Route	Frequency	OK to Self-Administer	OK to Self-Carry
Breathing hard and fast					☐ Yes ☐ No	☐ Yes ☐ No
Lips or fingernails are blue Trouble walking or talking		*Known side effects:*				
Medicine is not helping (15-20 mins?)					☐ Yes ☐ No	☐ Yes ☐ No
Other:______________		*Known side effects:*				
If known, peak flow below ______					☐ Yes ☐ No	☐ Yes ☐ No
(0% to 49% personal best)		*Known side effects:*				

Please turn over - this form has 2 pages with four total sections

Keep for 3 Years

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 1-877-463-3464 ext. 78417

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)

Please turn over - this form has 2 pages with four total sections

Keep for 3 Years

MEDICATION ADMINISTRATION AUTHORIZATION FORM for Youth Camps in Maryland

Maryland Department of Health (MDH)
Office of Healthy Homes and Communities
(410) 767-8417 or 1-877-463-3464 ext. 78417
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-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, homeophathic, 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 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