2019 SUMMER CAMPS
HEALTH/RELEASE FORM

Triple Threat: ___1: 6/17-6/28 __2: 8/5-8/16 ___3: 8/19-8/30
Movie: ___7/15-7/19
Seussical Jr: ___7/22-8/2
JR Music: ___1: 6/24-6/28 ___2: 7/15-7/19 ___3: 7/22-7/26
Kidzrock: ___7/8-7/12

Camper_____Age as of 6/1/19_____Date of Birth_____Boy or Girl

Father/Guardian_____Contact Phone_____

Email_____

Mother/Guardian_____Contact Phone_____

Email_____

Mailing Address (street, city, zip)_____

Camper lives with: ☐Father ☐Mother ☐Both ☐If Other, who?_____Relationship_____

Email_____Contact Phone_____

Emergency Contacts Other than parents or guardians. List two names.

Name_____Relationship_____Contact Phone_____

Name_____Relationship_____Contact Phone_____

Release Authorization

I authorize the following people to pick up my child from the camp, during or at the conclusion of the camp day (name and cell phone)

1. _____ 2. _____
3. _____ 4. _____

Medical Information

IMMUNIZATION REQUIREMENT

All campers must have current immunizations that are consistent with State of Maryland school requirements.

School: Is your child enrolled in a Maryland PUBLIC or NON-PUBLIC certified school? ____YES _____NO
School Name_____

*****IF "NO", YOU MUST COMPLETE THE MARYLAND IMMUNIZATION CERTIFICATE.*****

*****Date of Child's last Tetanus shot** (part of DTP): _____ **(must be filled in)*****

Physician Name_____Phone Number:_____

Address (street, city, state, zip)_____

Allergies: Foods_____

Drugs_____

Other_____

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Training Center for the Arts
Since 1995

Chronic or Recurring Illness:

Asthma_____Diabetes_____Other_____

Physical, Psychiatric, or Behavioral Issues (If ADD/ADHD, Autistic, etc., must explain):_____

_____

_____

If your child is taking any medication, list the types/medication:_____

_____

_____

_____

Will your child need to take medication during camp hours? _____

- I**f yes,** a separate Authorization for Medication Form **must be completed by the physician** and returned to the Academy Office. Please download the form from the website.
- The **Authorization for Medication Form** must be signed by the parent/guardian and your child's physician.
- Directions for the medication must be labeled clearly.
- Medication **(IN ITS ORIGINAL, PROPERLY LABELD PHARMACEUTICAL CONTAINER)** must be delivered daily to the Academy Office.
- The staff is not equipped to administer medication, but will supervise the camper's self-administration of the labeled medication. If the camper is unable to self-administer the medication, the staff will call 911 in an emergency situation.

Photograph/Video Release

The Academy of Fine Arts reserves the right to use photos and videos taken in camps, classes, and performances for promotional use.

Release Agreement

By registering your child you agree to the following: Although every effort is made to provide a safe environment, I recognize there is always a risk of accident. By submitting a registration, I agree to be responsible for any medical bills incurred resulting from illness or injury during my child's participation at the Academy of Fine Arts Camps. Campers are expected to carry their own accident and medical insurance. I release the Academy of Fine Arts from any and all liability and/or claims or damages arising out of personal injury of any kind. If necessary, I authorize the Academy of Fine Arts to administer first aid and/or authorize medical treatment for my child.

By signing here, I HAVE READ, UNDERSTOOD AND AGREE TO ALL THE TERMS OF ENROLLMENT ABOVE, and I verify that all information on this form is correct.

PRINT PARENT/GUARDIAN NAME	**SIGNATURE OF PARENT/GUARDIAN**	**DATE**

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www.theacademyoffinearts.com
admin@theacadmyoffinearts.com
301.947.9705

Camp Sessions_____

Authorization for Medication Form

Medication is for authorized for _____

Physician Authorization for Medication

Condition_____

Medication_____

Dosage and schedule_____

Instructions_____

_____

_____

- **Asthma Inhaler:** Name of medication_____
- **Epinephrine** (must supply two Epi-pens) to be administered immediately after report of exposure to_____

_____

Physician initials below:

_____ Epi-pen (given in pre-measured dose of 0.3 mg epinephrine 1:1000 aqueous solution or 0.3 cc)

_____ Epi-pen Jr (given in pre-measured dose of 0.15 mg epinephrine 1:2000 aqueous solution or 0.3 cc)

_____ **If the RESCUE SQUAD has not arrived within 15 minutes, a SECOND EPI-PEN or EPI-PEN JR will be administered.**

For any other LIFE-THREATENING CONDITIONS: Other medication to be administered if RESCUE SQUAD has not arrived within 15 minutes (medication name/dose/submit video link or directions on how to administer)**:**

_____

_____

Authorization for Child or Teen to Carry and Self-Administer Medication

The camper named above may carry the following medication with him/her during camp hours. He/she has been trained on how and when to use this medication, and I believe he/she has the ability to safely carry and self-administer it.

Physician Name (Print)_____

Physician's Signature_____Date_____

Parent/Guardian Authorization for Medication

Medication is authorized for _____

Parent/Guardian initials below:

_____ I authorize my child to take the medication as directed by his/her physician.

_____ I authorize my child to carry and self-administer medication during program hours as directed by his/her physician.

_____ I authorize the staff at The Academy of Fine Arts to administer an Epi-pen or Epi-pen Jr. for my child as directed by his/her physician.

_____ I authorize the staff at The Academy of Fine Arts to administer other medication described above in a LIFE-THREATENING situation.

I have carefully completed the Authorization for Medication Form, and I assume the responsibilities indicated. With this authorization, I agree to release the staff of The Academy of Fine Arts from all liability.

I understand that I must collect any unused medication no later than one week after the program ends. The Academy of Fine Arts will then discard the medication.

Parent/Guardian Name (Print)_____

Parent /Guardian Signature _____Date_____

Parent/Guardian Cell Phone_____

MARYLAND DEPARTMENT OF HEALTH IMMUNIZATION CERTIFICATE

CHILD'S NAME_____
LAST FIRST MI

SEX: MALE ☐ FEMALE ☐ BIRTHDATE_____/_____/_____

COUNTY _____ SCHOOL_____ GRADE_____

PARENT OR GUARDIAN NAME _____ PHONE NO. _____

ADDRESS _____ CITY _____ ZIP_____

RECORD OF IMMUNIZATIONS (See Notes On Other Side)

Vaccines Type

Dose #	DTP-DTaP-DT Mo/Day/Yr	Polio Mo/Day/Yr	Hib Mo/Day/Yr	Hep B Mo/Day/Yr	PCV Mo/Day/Yr	Rotavirus Mo/Day/Yr	MCV Mo/Day/Yr	HPV Mo/Day/Yr	Dose #	Hep A Mo/Day/Yr	MMR Mo/Day/Yr	Varicella Mo/Day/Yr	History of Varicella Disease Mo/Yr
1									1				
2									2				
3										Td Mo/Day/Yr	Tdap Mo/Day/Yr	MenB Mo/Day/Yr	Other Mo/Day/Yr
4										_____	_____	_____	_____
5										_____	_____	_____	_____
										_____			

To the best of my knowledge, the vaccines listed above were administered as indicated.

Clinic / Office Name
Office Address/ Phone Number

1. _____
Signature Title Date
(Medical provider, local health department official, school official, or child care provider only)

2. _____
Signature Title Date

3. _____
Signature Title Date

Lines 2 and 3 are for certification of vaccines given after the initial signature.

COMPLETE THE APPROPRIATE SECTION BELOW IF THE CHILD IS EXEMPT FROM VACCINATION ON MEDICAL OR RELIGIOUS GROUNDS. ANY VACCINATION(S) THAT HAVE BEEN RECEIVED SHOULD BE ENTERED ABOVE.

MEDICAL CONTRAINDICATION:

Please check the appropriate box to describe the medical contraindication.

This is a: ☐ Permanent condition OR ☐ Temporary condition until _____/_____/_____
Date

The above child has a valid medical contraindication to being vaccinated at this time. Please indicate which vaccine(s) and the reason for the contraindication, _____

Signed: _____ Date _____
Medical Provider / LHD Official

RELIGIOUS OBJECTION:

I am the parent/guardian of the child identified above. Because of my bona fide religious beliefs and practices, I object to any vaccine(s) being given to my child. This exemption does not apply during an emergency or epidemic of disease.

Signed: _____ Date: _____

How To Use This Form

The medical provider that gave the vaccinations may record the dates (using month/day/year) directly on this form (check marks are not acceptable) and certify them by signing the signature section. Combination vaccines should be listed individually, by each component of the vaccine. A different medical provider, local health department official, school official, or child care provider may transcribe onto this form and certify vaccination dates from any other record which has the authentication of a medical provider, health department, school, or child care service.

Only a medical provider, local health department official, school official, or child care provider may sign 'Record of Immunization' section of this form. This form may not be altered, changed, or modified in any way.

Notes:

1. When immunization records have been lost or destroyed, vaccination dates may be reconstructed for all vaccines except **varicella, measles, mumps, or rubella.**

2. Reconstructed dates for all vaccines must be reviewed and approved by a medical provider or local health department no later than 20 calendar days following the date the student was temporarily admitted or retained.

3. Blood test results are NOT acceptable evidence of immunity against diphtheria, tetanus, or pertussis (DTP/DTaP/Tdap/DT/Td).

4. Blood test verification of immunity is acceptable in lieu of polio, measles, mumps, rubella, hepatitis B, or varicella vaccination dates, but **revaccination may be more expedient**.

5. History of disease is NOT acceptable in lieu of any of the required immunizations, except varicella.

Immunization Requirements

The following excerpt from the MDH Code of Maryland Regulations (COMAR) 10.06.04.03 applies to schools:

"A preschool or school principal or other person in charge of a preschool or school, public or private, may not knowingly admit a student to or retain a student in a:
(1) Preschool program unless the student's parent or guardian has furnished evidence of age appropriate immunity against Haemophilus influenzae, type b, and pneumococcal disease;
(2) Preschool program or kindergarten through the second grade of school unless the student's parent or guardian has furnished evidence of age-appropriate immunity against pertussis; and
(3) Preschool program or kindergarten through the 12th grade unless the student's parent or guardian has furnished evidence of age-appropriate immunity against: (a) Tetanus; (b) Diphtheria; (c) Poliomyelitis; (d) Measles (rubeola); (e) Mumps; (f) Rubella; (g) Hepatitis B; (h) Varicella; (i) Meningitis; and (j) Tetanus-diphtheria-acellular pertussis acquired through a Tetanus-diphtheria-acellular pertussis (Tdap) vaccine."

Please refer to the "**Minimum Vaccine Requirements for Children Enrolled in Pre-school Programs and in Schools**" to determine age-appropriate immunity for preschool through grade 12 enrollees. The minimum vaccine requirements and MDH COMAR 10.06.04.03 are available at www.health.maryland.gov. (Choose Immunization in the A-Z Index)

Age-appropriate immunization requirements for licensed childcare centers and family day care homes are based on the Department of Human Resources COMAR 13A.15.03.02 and COMAR 13A.16.03.04 G & H and the **"Age-Appropriate Immunizations Requirements for Children Enrolled in Child Care Programs"** guideline chart are available at www.health.maryland.gov. (Choose Immunization in the A-Z Index)