2014 Summer Camp Mandatory Enrollment Packet
available online: www.abccareinc.com

Featuring:

Amazing Race Camp
2205 Sykesville Road Westminster, MD 21157

Cascade Water Camp
3000 Snydersburg Road Hampstead, MD 21074

Deer Park Swim Camp
2205 Sykesville Road Westminster, MD 21157

Eldersburg Adventure Camp
915 Liberty Road Sykesville, MD 21784

Northern Carroll Sports & Water Camp
3000 Snydersburg Road Hampstead, MD 21074

Piney Run Park Nature Camp
30 Martz Road Sykesville, MD 21784

Southern Carroll Adventure Camp
915 Liberty Road Sykesville, MD 21784

Lake Keowee Camp
671 High Falls Road Seneca, SC 29672

ABC Care, Inc.
2815 Patapsco Road
Finksburg, MD 21048

Phone (410) 751-3700
Fax (410) 751-3702
Web: www.abccareinc.com
Email: abccare@abccareinc.com

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PARENT MANUAL POLICY ACKNOWLEDGMENT FORM

I have read the ABC Care, Inc. Summer Camp Parent Manual and agree to abide by the requirements and policies as set forth by ABC Care, Inc. and give permission for my child/ren to participate in all activities. A mediator will settle all disputes.

Please list your child/ren’s names below:

________________________________  ___________________________________

__________________________________  ___________________________________

________________________________  ___________________________________

Parent Signature  Date
TRANSPORTATION AUTHORIZATION

I, _____________________________, give ABC Care, Inc. permission to transport my child/ren __________________________________________________________ by certified school bus service and/or ABC Care, Inc. van to and from all field trips, and between all ABC Care, Inc. summer camps.

Your signature on this blanket permission slip allows your child/ren to attend scheduled field trips and/or ABC Care, Inc. summer camp locations for the weeks registered.

In case of emergency such as a natural disaster or national emergency, your signature on this blanket permission slip allows your child/ren to be transported by a Maryland certified bus company or ABC Care, Inc. staffer vehicle to the nearest disaster relief shelter. ABC Care, Inc. will notify parents/guardians of children’s emergency location via telephone call. The emergency telephone number (s) we use to contact parents/guardians are listed on the child’s emergency form.

I understand that all necessary precautions will be taken by ABC Care, Inc. for the safety of my child/ren

_____________________________    ______________________________
Parent Signature                        Date

Reminder: Children are required to wear their camp T-shirt on field trip days. Also, ensure your child/ren have a disposable lunch in a plastic bag with two box drinks and wear appropriate clothing as well as appropriate shoes. Thank you.
PUBLICITY/PHOTOGRAPHY/VIDEO RECORDING RELEASE

From time to time our program may involve photographing, video recording, interviewing by an outside source, and other publicity pictures of the children in our program.

It is required by our licensing agent, Maryland State Department of Education and Maryland Department of Health and Mental Hygiene, that parents/guardians grant permission for this type of publicity.

Please complete the portion below and return it to your Site Director.

.................................................................................................................................

Please circle your choice:

My child/ren ________________________________

________________________________________________________________________

may be photographed, video recorded, or interviewed for: (please check your choices)

Yes     No

☐     ☐ Yearbook page
☐     ☐ ABC Care Internet Site
☐     ☐ Newspaper/Magazine
☐     ☐ Inhouse speakers/field trips
☐     ☐ Scrapbooks for center

_____________________________ ____________________
Parent/Guardian Signature   Date
EMERGENCY FORM

INSTRUCTIONS TO PARENTS:
(1) Complete all items on this side of the form. Sign and date where indicated.
(2) If your child has a medical condition which might require emergency medical care, complete the back side of the form. If necessary, have your child’s health practitioner review that information.

NOTE: THIS ENTIRE FORM MUST BE UPDATED ANNUALLY.

Child’s Name ____________________________________________________________________________ Birth Date ____________________________________________________________________________

Enrollment Date ____________________________________________________________________________ Hours & Days of Expected Attendance ____________________________________________________________________________

Child’s Home Address ____________________________________________________________________________ Street/Apt.# ____________________________________________________________________________ City ____________________________________________________________________________ State ____________________________________________________________________________ Zip Code ____________________________________________________________________________

Parent/Guardian Name(s) ____________________________________________________________________________ Relationship ____________________________________________________________________________

Place of Employment: ____________________________________________________________________________ Place of Employment: ____________________________________________________________________________

C: ____________________________________________________________________________ H: ____________________________________________________________________________

W: ____________________________________________________________________________ W: ____________________________________________________________________________

Name of Person Authorized to Pick Up Child (daily) ____________________________________________________________________________

Address ____________________________________________________________________________ Street/Apt.# ____________________________________________________________________________ City ____________________________________________________________________________ State ____________________________________________________________________________ Zip Code ____________________________________________________________________________

Any Changes/Additional Information ____________________________________________________________________________

ANNUAL UPDATES ____________________________________________________________________________

(Initials/Date) ____________________________________________________________________________ (Initials/Date) ____________________________________________________________________________

(Initials/Date) ____________________________________________________________________________ (Initials/Date) ____________________________________________________________________________

When parents/guardians cannot be reached, list at least one person who may be contacted to pick up the child in an emergency:

1. Name ____________________________________________________________________________ Telephone (H) ____________________________________________________________________________ (W) ____________________________________________________________________________

Address ____________________________________________________________________________ Street/Apt.# ____________________________________________________________________________ City ____________________________________________________________________________ State ____________________________________________________________________________ Zip Code ____________________________________________________________________________

2. Name ____________________________________________________________________________ Telephone (H) ____________________________________________________________________________ (W) ____________________________________________________________________________

Address ____________________________________________________________________________ Street/Apt.# ____________________________________________________________________________ City ____________________________________________________________________________ State ____________________________________________________________________________ Zip Code ____________________________________________________________________________

3. Name ____________________________________________________________________________ Telephone (H) ____________________________________________________________________________ (W) ____________________________________________________________________________

Address ____________________________________________________________________________ Street/Apt.# ____________________________________________________________________________ City ____________________________________________________________________________ State ____________________________________________________________________________ Zip Code ____________________________________________________________________________

Child’s Physician or Source of Health Care ____________________________________________________________________________ Telephone ____________________________________________________________________________

Address ____________________________________________________________________________ Street/Apt.# ____________________________________________________________________________ City ____________________________________________________________________________ State ____________________________________________________________________________ Zip Code ____________________________________________________________________________

In EMERGENCIES requiring immediate medical attention, your child will be taken to the NEAREST HOSPITAL EMERGENCY ROOM. Your signature authorizes the responsible person at the child care facility to have your child transported to that hospital.

Signature of Parent/Guardian ____________________________________________________________________________ Date ____________________________________________________________________________

OCC 1214 (Revised 9/12)
INSTRUCTIONS TO PARENT/GUARDIAN:
(1) Complete the following items, as appropriate, if your child has a condition(s) which might require emergency medical care.
(2) If necessary, have your child's health practitioner review the information you provide below and sign and date where indicated.

Child's Name: ___________________________________________ Date of Birth: _______________________
Medical Condition(s): ____________________________________________________

Medications currently being taken by your child: ________________________________________________

Date of your child's last tetanus shot: ____________________________________________
Allergies/Reactions: _______________________________________________________________

EMERGENCY MEDICAL INSTRUCTIONS:
(1) Signs/symptoms to look for: _________________________________________________________

(2) If signs/symptoms appear, do this: _________________________________________________

(3) To prevent incidents: _____________________________________________________________

OTHER SPECIAL MEDICAL PROCEDURES THAT MAY BE NEEDED: ____________________________
_________________________________________________________________________________
_________________________________________________________________________________

COMMENTS: ________________________________________________________________________
_________________________________________________________________________________
_________________________________________________________________________________
_________________________________________________________________________________

Note to Health Practitioner:
If you have reviewed the above information, please complete the following:

Name of Health Practitioner ___________________________ Date _______________________
Signature of Health Practitioner ___________________________ Telephone Number (_____) __________________
BEHAVIORAL MANAGEMENT PLAN:
PROCEDURES REGARDING INAPPROPRIATE BEHAVIOR

A child who is involved in any type of behavior that is determined by the Camp Director and Manager of ABC Care, Inc. to be conduct unacceptable for a child attending an ABC Care Summer Camp Program can be suspended or expelled. The Senior Manager or Executive Director has the authority to determine the length of the suspension or expulsion, which can range from one (1) to five (5) days.

ABC Care Inc. reserves the right to employ the following procedures in dealing with instances of inappropriate behavior:

1. The Camp Director of the camp may confiscate inappropriate and/or objectionable materials and/or objects that may be used for inappropriate behavior.
2. The Camp Director of the camp, with the Senior Manager’s guidance, reserves the right to determine the degree of punishment (i.e. Incident Reports, suspension, expulsion)
3. The Executive Director or Senior Manager has the right to request full payment for total replacement and/or monetary reimbursement for repairs and/or replacement of broken/destroyed objects resulting from a deliberate or accidental breakage. This includes and is not limited to center equipment, school items, and children/staff personal belongings.
4. Field trips are a privilege. The Camp Director of the camp reserves the right to withhold a child from attending a field trip.
5. The Camp Director of the camp reserves the right to request that a child’s parent accompany him/her while attending a field trip.
6. The Executive Director or Senior Manager reserves the right to require counseling and/or psychological testing.

OFFENSES
The following list provides examples of SOME of the offenses for which a child may receive an Incident Report, suspension, or expulsion, depending on the circumstances and severity surrounding the offense.

INCIDENT REPORTS
- Leaving the designated area that ABC Care is utilizing at that time
- Throwing rocks or snowballs
- Failure to refrain from hurting another (pinching, pushing, punching, biting, kicking, etc...)
- Using vulgar language, verbally or in written form
- Showing disrespect to another person (child or staff member)
- Improper use of equipment, materials, or furniture

SUSPENSIONS WHICH MAY RESULT IN EXPULSION
- Failure of parent(s) to attend a parent conference or adhere to its recommendations
- Theft/Robbery
- Use or possession of tobacco or firearms
- Arson/lighting matches
- Assault and battery of a staff member
- Violent behavior which creates a substantial danger to persons or property
- Possession of a real or look-a-like weapon
- Destruction and vandalism of school or personal property
- Fire alarm misuse
- Harassment
- Insubordination (disobeying a directive from a Camp Director or camp counselor)
- Gambling for money
- Lack of required immunizations or health inventories
- Sexual activity or indecent exposure

I have read and understand the behavioral management plan of ABC Care, Inc. and the procedures regarding inappropriate behavior and will agree to their implementation.

_____________________________  ______________________________
Parent’s Signature / Date         Child’s Signature / Date
PERMISSION TO TREAT FORM

I, __________________________, give ABC Care, Inc. permission to provide routine health care (first aid/CPR), procedures according to the Health Procedures List attached. I understand that all necessary precautions will be taken by ABC Care, Inc. for the safety of my child/ren and that I will be contacted in the case of an emergency.

Please list your child/ren’s names below:

________________________________ ___________________________________
________________________________ ___________________________________
__________________________________ ___________________________________

Parent Signature    Date

I, __________________________, hereby give permission for ABC Care, Inc. Camp to administer the following over-the-counter medications if the site director deems it necessary. Dosages will be administered according to directions on the bottle.

Upset stomach- Pepto Bismol
Diarrhea- Imodium AD
Poison Ivy- Calamine lotion or Cortaid

Please list your child/ren’s names below:

________________________________ ___________________________________
________________________________ ___________________________________

Parent Signature    Date
MARYLAND STATE DEPARTMENT OF EDUCATION
Office of Child Care
HEALTH INVENTORY

Information and Instructions for Parents/Guardians:

REQUIRED INFORMATION

The following information is required prior to a child attending a Maryland State Department of Education licensed, registered or approved child care or nursery school:

- **A physical examination** by a physician or certified nurse practitioner completed no more than twelve months prior to attending child care. A Physical Examination form designated by the Maryland State Department of Education and the Department of Health and Mental Hygiene shall be used to meet this requirement (See COMAR 13A.15.03.02, 13A.16.03.02 and 13A.17.03.02).

- **Evidence of immunizations.** A Maryland Immunization Certification form for newly enrolling children may be obtained from the local health department or from school personnel. The immunization certification form (DHMH 896) or a printed or a computer generated immunization record form and the required immunizations must be completed before a child may attend. This form can be found at: [http://ideha.dhmh.maryland.gov/IMMUN/pdf/896_form.pdf](http://ideha.dhmh.maryland.gov/IMMUN/pdf/896_form.pdf)

- **Evidence of Blood-Lead Testing for children living in designated at risk areas.** The blood-lead testing certificate (DHMH 4620) (or another written document signed by a Health Care Practitioner) shall be used to meet this requirement. This form can be found at: [http://apps.fcps.org/dept/health/MarylandDHMHBloodLeadTestingCertificateDHMH4620.pdf](http://apps.fcps.org/dept/health/MarylandDHMHBloodLeadTestingCertificateDHMH4620.pdf)

EXEMPTIONS

Exemptions from a physical examination, immunizations and Blood-Lead testing are permitted if the family has an objection based on their religious beliefs and practices. The Blood-Lead certificate must be signed by a Health Care Practitioner stating a questionnaire was done.

Children may also be exempted from immunization requirements if a physician, nurse practitioner or health department official certifies that there is a medical reason for the child not to receive a vaccine.

The health information on this form will be available only to those health and child care provider or child care personnel who have a legitimate care responsibility for your child.

INSTRUCTIONS

Please complete Part I of this Physical Examination form. Part II must be completed by a physician or nurse practitioner, or a copy of your child's physical examination must be attached to this form.

If your child requires medication to be administered during child care hours, you must have the physician complete a Medication Authorization Form (OCC 1216) for each medication. The Medication Authorization Form can be obtained at [http://www.marylandpublicschools.org/NR/rdonlyres/B0050A99-6B3C-4396-A996-CC9405971A42/30754/1216_MedAuth_r120511.pdf](http://www.marylandpublicschools.org/NR/rdonlyres/B0050A99-6B3C-4396-A996-CC9405971A42/30754/1216_MedAuth_r120511.pdf)

If you do not have access to a physician or nurse practitioner or if your child requires an individualized health care plan, contact your local Health Department.

CC 1215 - Revised 12/11
PART I - HEALTH ASSESSMENT

Article I. TO BE COMPLETED BY PARENT OR GUARDIAN

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<th>Child's Name:</th>
<th>Birth date:</th>
<th>Sex</th>
<th>Mo / Day / Yr</th>
<th>M□F□</th>
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Address:

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<tr>
<th>Parent/Guardian Name(s)</th>
<th>Relationship</th>
<th>Phone Number(s)</th>
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<td>C:</td>
<td>H:</td>
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<tr>
<td>W:</td>
<td>C:</td>
<td>H:</td>
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</tbody>
</table>

Where do you usually take your child for routine medical care? Name:

Address: Phone Number:

When was the last time your child had a physical exam? Month: Year:

Where do you usually take your child for dental care? Name:

Address: Phone Number:

**ASSESSMENT OF CHILD’S HEALTH** - To the best of your knowledge has your child had any problem with the following? Check Yes or No and provide a comment for any YES answer.

<table>
<thead>
<tr>
<th>Yes</th>
<th>No</th>
<th>Comments (required for any Yes answer)</th>
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<tbody>
<tr>
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</table>

- Allergies (Food, Insects, Drugs, Latex, etc.)
- Allergies (Seasonal)
- Asthma or Breathing
- Behavioral or Emotional
- Birth Defect(s)
- Bladder
- Bowels
- Cerebral Palsy
- Coughing
- Developmental Delay
- Diabetes
- Ears or Deafness
- Eyes or Vision
- Head Injury
- Heart
- Hospitalization (When, Where)
- Lead Poisoning/Exposure
- Life Threatening Allergic Reactions
- Limits on Physical Activity
- Meningitis
- Prematurity
- Seizures
- Sickle Cell Disease
- Speech/Language
- Surgery
- Other

Does your child take medication (prescription or non-prescription) at any time?

☐ No  ☐ Yes, name(s) of medication(s):

Does your child receive any special treatments? (nebulizer, epi-pen, etc.)

☐ No  ☐ Yes, type of treatment:

Does your child require any special procedures? (catheterization, G-Tube, etc.)

☐ No  ☐ Yes, what procedure(s):

I GIVE MY PERMISSION FOR THE HEALTH PRACTITIONER TO COMPLETE PART II OF THIS FORM. I UNDERSTAND IT IS FOR CONFIDENTIAL USE IN MEETING MY CHILD’S HEALTH NEEDS IN CHILD CARE.

I ATTEST THAT INFORMATION PROVIDED ON THIS FORM IS TRUE AND ACCURATE TO THE BEST OF MY KNOWLEDGE AND BELIEF.

Signature of Parent/Guardian: ___________________________ Date: ______________________

OCC 1215 - Revised 12/11
PART II - CHILD HEALTH ASSESSMENT
To be completed ONLY by Physician/Nurse Practitioner

Child’s Name: ____________________________
Birth Date: ____________________________ Sex: ________ M □ F □

1. Does the child named above have a diagnosed medical condition?
   □ No □ Yes, describe:

2. Does the child have a health condition which may require EMERGENCY ACTION while he/she is in child care? (e.g., seizure, allergy, asthma, bleeding problem, diabetes, heart problem, or other problem) If yes, please DESCRIBE and describe emergency action(s) on the emergency card.
   □ No □ Yes, describe:

3. PE Findings

<table>
<thead>
<tr>
<th>Health Area</th>
<th>WNL</th>
<th>ABNL</th>
<th>Not Evaluated</th>
<th>Health Area</th>
<th>WNL</th>
<th>ABNL</th>
<th>Not Evaluated</th>
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<tr>
<td>Attention Deficit/Hyperactivity</td>
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<td>Lead Exposure/Elevated Lead</td>
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<td>Behavior/Adjustment</td>
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<td>Mobility</td>
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<td>Bowel/Bladder</td>
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<td>Musculoskeletal/orthopedic</td>
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<td>Cardiac/murmur</td>
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<td>Neurological</td>
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<td>Development</td>
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<td>Hearing</td>
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<td>Immunodeficiency</td>
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<td>Other:</td>
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REMARKS: (Please explain any abnormal findings.)

4. RECORD OF IMMUNIZATIONS – DHMH 896/or other official immunization document (e.g. military immunization record of immunizations) is required to be completed by a health care provider or a computer generated immunization record must be provided. (This form may be obtained from: http://ideha.dhmh.maryland.gov/IMMUN/pdf/896_form.pdf)

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

   Parent/Guardian Signature: ____________________________ Date: ____________________________

5. Is the child on medication?
   □ No □ Yes, indicate medication and diagnosis:
   (OCC 1216 Medication Authorization Form must be completed to administer medication in child care).

6. Should there be any restriction of physical activity in child care?
   □ No □ Yes, specify nature and duration of restriction:

7. Test/Measurement Results Date Taken
   Tuberculin Test
   Blood Pressure
   Height
   Weight
   BMI %tile

   Lead Test Indicated: □ Yes □ No

__________________________ (Child’s Name) has had a complete physical examination and any concerns have been noted above.

Additional Comments:

Physician/Nurse Practitioner (Type or Print): ____________________________ Phone Number: ____________________________
Physician/Nurse Practitioner Signature: ____________________________ Date: ____________________________
CHILDREN WHO ARE REQUIRED TO RECEIVE LEAD TESTING

Under Maryland law, children who reside, or have ever resided, in any of the at-risk zip codes listed below must receive a blood lead test at 12 months and 24 months of age. Two tests are required if the 1st test was done prior to 24 months of age.

If a child is enrolled in child care during the period between the 1st and 2nd tests, his/her parents are required to provide evidence from their health care provider that the child received a second test after the 24 month well child visit. If the 1st test is done after 24 months of age, one test is required.

The child's health care provider should record the test dates on page 3 of this form and certify them by signing and stamping the signature section of the form. All forms should be kept on file at the facility with the child's health records.

AT RISK AREAS BY ZIP CODE

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<th>Cecil</th>
<th>Garrett</th>
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<th>St. Mary's</th>
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OCC 1215 - Revised 12/11
CAMPER HEALTH HISTORY

The following information is required for a camper to be admitted to day camp:

CAMPER IMMUNIZATION INFORMATION

All campers must be current on all immunizations, see www.EDCP.org (Immunization).

1. Provide date (month and year) of camper’s last tetanus (or DTP) shot: _______________

2. Is the camper currently enrolled in a Maryland school, public or private?
   - [ ] YES, provide name of Maryland school: __________________________
   - [ ] NO, provide a copy of immunizations confirming that the child has received all
     immunizations as required by the Maryland DHMH Recommended Childhood
     Immunization Schedule. See www.EDCP.org (Immunization) for information.

3. Is the camper exempt from any immunization on medical or religious grounds?
   - [ ] YES, provide a signed copy of Maryland Department of Health and Mental Hygiene
     Immunization Certificate from either a licensed physician indicating that the
     immunization is medically contraindicated, or the parent or guardian indicating that they
     object to immunizations for religious reasons.
   - [ ] NO

CONTACT INFORMATION:

Parent or Legal Guardian: __________________________ Phone: __________________________

Emergency Contact Person: __________________________ Phone: __________________________

Camper’s Physician: __________________________ Phone: __________________________

HEALTH INFORMATION: Provide information on any medical conditions, psychological
conditions, behavioral conditions, medications, dietary restrictions, allergies, or special needs
that we need to be aware of to ensure that your child’s camp experience is positive:

________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________

Parent or Legal Guardian’s Signature: __________________________ Date: __________________________
SUNSCREEN PERMISSION (Revised 05/2012)

Camper’s Name_____________________________

It is the policy of ABC Care, Inc. that all children need sunscreen for their protection from the sun’s harmful rays.

1. Parents need to apply sunscreen to their child(ren) before arriving at camp.
2. Parents need to supply sunscreen for their child(ren). Sunscreen supplied should be easily used by camper with little assistance. Campers should be able to apply their own sunscreen throughout the day.
3. Staff will supervise the application of sunscreen throughout the day and record the use. Reapplication of the sunscreen should be according to directions written on the container.
4. ABC Care staff may assist in the application of sunscreen on campers if necessary. Campers are not allowed to assist other campers in applying sunscreen.

Sunscreen Name_________________________ SPF ______________

Should my child need sunscreen in the event it ran out or was forgotten, I give ABC Care, Inc. permission to apply camp generic sunscreen on my child. (Circle One) YES       NO

__________________________________________________________
Parent’s Signature       Date
MARYLAND STATE DEPARTMENT OF EDUCATION  
Office of Child Care  
ALL ABOUT: ________________________________  
Child's First Name or Nickname

Child's Name: ____________________________  
Birthdate: ______________________________

Parent/Guardian: _________________________  
Home Phone: ____________________________

Address: ________________________________  
Zip Code: ______________________________

Provider/Center: _________________________  
Phone: __________________________________

Address: ________________________________  
Zip Code: ______________________________

The information contained herein is for CONFIDENTIAL USE ONLY.

THINGS MY CHILD DOES WELL

WHAT MY CHILD LIKES AND DISLIKES

THINGS I AM WORKING ON WITH MY CHILD

MY CHILD ENJOYS THESE PHYSICAL ACTIVITIES
<table>
<thead>
<tr>
<th>MY CHILD HAS DIFFICULTY WITH THESE ACTIVITIES</th>
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<tr>
<th>MY CHILD WILL NEED THE FOLLOWING EQUIPMENT AND/OR ROUTINES</th>
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<tr>
<th>THINGS MY CHILD MIGHT NEED HELP WITH</th>
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<tr>
<th>WHAT SPECIAL ADAPTATIONS WILL THE PROGRAM MAKE AT THIS TIME?</th>
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<td>(For the use of the Child Care Facility when needed.)</td>
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This information is intended for use by the child care provider, developed in cooperation with the parents. **THIS IS NOT INTENDED TO BE A LEGALLY BINDING CONTRACT.**

Signatures:

Parent/Guardian: 

Provider: 

Date: 

Date:

Updates:

Parent/Guardian: 

Provider: 

Date: 

Date:

Parent/Guardian: 

Provider: 

Date: 

Date:

OCC 8506 (Revised 7/05) - *All previous editions are obsolete.*
MARYLAND STATE DEPARTMENT OF EDUCATION  
OFFICE OF CHILD CARE  
MEDICATION ADMINISTRATION AUTHORIZATION FORM  

Child Care Program:  

This form must be completed fully in order for child care providers and staff to administer the required medication. A new medication administration form must be completed at the beginning of each 12 month period, 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.  
- Non-prescription medication must be in the original container with the label intact.  
- An adult must bring the medication to the facility.  

Child's Picture (Optional)  

PRESCRIBER'S AUTHORIZATION  

Child's Name: ____________________________ Date of Birth: ____________________________  

Condition for which medication is being administered: ____________________________  

Medication Name: ____________________________ Dose: ____________________________ Route: ____________________________  

Time/frequency of administration: ____________________________ If PRN, frequency: ____________________________  

If PRN, for what symptoms: ____________________________  

Possible side effects - Specify: ____________________________  

Medication shall be administered from: ____________________________ to ____________________________  

Month / Day / Year (not to exceed 1 year)  

Prescriber's Name/Title: ____________________________ (Type or print)  

Telephone: ____________________________ FAX: ____________________________  

Address: ____________________________  

Prescriber’s Signature: ____________________________ Date: ____________________________  

(Original signature or signature stamp ONLY)  

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

PARENT/GUARDIAN AUTHORIZATION  

I/we request authorized child care provider/staff to administer the medication as prescribed by the above prescriber. I/we certify that I/we have legal authority to consent to medical treatment for the child named above, including the administration of medication at the facility. I/we understand that at the end of the authorized period, an adult must pick up the medication, otherwise it will be discarded.  

Parent/Guardian Signature: ____________________________ Date: ____________________________  

Home Phone #: ____________________________ Cell Phone #: ____________________________ Work Phone #: ____________________________  

SELF CARRY/SELF ADMINISTRATION OF EMERGENCY MEDICATION AUTHORIZATION/APPROVAL  

(ONLY school-aged children may be authorized to self carry/self administer medication.)  

Self carry/self administration of emergency medication noted above may be authorized by the prescriber.  

Prescriber’s authorization: ____________________________ Signature: ____________________________ Date: ____________________________  

Parental approval: ____________________________ Signature: ____________________________ Date: ____________________________  

FACILITY RECEIPT AND REVIEW  

Medication was received from: ____________________________ Date: ____________________________  

Special Health Care Plan Received: □ YES □ NO  

Medication was received by: ____________________________ Signature of Person Receiving Medication and Reviewing the Form: ____________________________ Date: ____________________________  

OCC 1216 (Revised 07/30/13)  

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MEDICATION ADMINISTERED

Each administration of a medication to the child shall be noted in the child's record. Each administration of prescription or non-prescription to a child, including self-administration of a medication by a child, shall be noted in the child's record. Basic care items such as: a diaper rash product, sunscreen, or insect repellent, authorized and supplied by the child's parent, may be applied without prior approval of a licensed health practitioner. These products are not required to be recorded on this form, but should be maintained as a part of the child's overall record. Keep this form in the child’s permanent record while the child remains in the care of this provider or facility.

<table>
<thead>
<tr>
<th>Child’s Name:</th>
<th>Date of Birth:</th>
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<tbody>
<tr>
<td>Medication Name:</td>
<td>Dosage:</td>
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<tr>
<td>Route:</td>
<td>Time(s) to administer:</td>
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<tr>
<th>DATE</th>
<th>TIME</th>
<th>DOSAGE</th>
<th>REACTIONS OBSERVED (IF ANY)</th>
<th>SIGNATURE</th>
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ADDITIONAL WEEKS REQUEST FORM

Name of Child: __________________________ Age: ______
Home Address: ________________________________
City, State, Zip: __________________________________________________________
Home Phone: _________________________ Grade Entering in the Fall: _____________
Parent’s/Guardian’s Name: ______________________________________________
Mother’s Employer and Phone #: ____________________________________________
Father’s Employer and Phone #: _____________________________________________

Please mark a check next to the weeks you wish to add:

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<th>✔</th>
<th>Dates</th>
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YOU WILL BE BILLED ACCORDINGLY.

IF YOU REGISTER YOUR CHILD FOR ADDITIONAL WEEKS AFTER THE TUITION DUE DATE, TUITION AND WALK IN FEE ARE DUE WITH THIS FORM.

Parent’s/Guardian’s Signature __________________________ Date ______________

Please return to the Site Director or mail to the following address or fax to 410-751-3702:
ABC Care, Inc.
2815 Patapsco Road
Finksburg, MD 21048
Referral Program
Membership Referrals

This summer will be an exciting one at ABC Care. Why not enjoy it with your friends? If you
know of a potential new family who has never attended an ABC Care summer camp, please
submit their contact information using the form below. If the referral joins ABC Care Summer
Camp this year, you will receive a $50 credit towards camp tuition. Referred family need only
to register and attend for at least 1 week.

You must be a current registered family with your account in good standing when the referred
family joins. Upon full payment by your referral, the referring family will receive their credit.
There will be no cash refund of the referral credit.

2014 Referral Form

<table>
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<tr>
<th>Your Information</th>
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<tbody>
<tr>
<td>Your Full Name:</td>
</tr>
<tr>
<td>Your Phone Number:</td>
</tr>
<tr>
<td>Child’s Name Attending:</td>
</tr>
<tr>
<td>Camp Your Child Attends:</td>
</tr>
<tr>
<td>Date Submitted:</td>
</tr>
</tbody>
</table>

<table>
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<tr>
<th>Information for Individual/Family you are Referring:</th>
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<tbody>
<tr>
<td>First Name:</td>
</tr>
<tr>
<td>Last Name:</td>
</tr>
<tr>
<td>Phone:</td>
</tr>
<tr>
<td>This Phone # is their: Home Work Other</td>
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<td>E-Mail:</td>
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</tbody>
</table>

Notice: Referral must be turned in at time of camp registration payment.