

**NEW HORIZONS** OR  **CAMP INSPIRE**  
**REGISTRATION FORM**

Please check the camp that you are registering for.

**A. PARENT OR GUARDIAN INFORMATION:**

Name: \_\_\_\_\_ Relation to Child: \_\_\_\_\_  
 Home Address: \_\_\_\_\_  
 \_\_\_\_\_ Home Phone: \_\_\_\_\_  
 Employer: \_\_\_\_\_ Work Phone: \_\_\_\_\_  
 Cell Phone: \_\_\_\_\_ Email: \_\_\_\_\_  
**Emergency Contact:** \_\_\_\_\_ Phone No: \_\_\_\_\_  
**Emergency Contact:** \_\_\_\_\_ Phone No: \_\_\_\_\_  
 School Child Attends: \_\_\_\_\_  
 Parent Signature: \_\_\_\_\_

**B. PARTICIPANTS INFORMATION: (ONE FORM PER CHILD)**

Childs Name	Birthday	Age	Grade	Diagnosis
				1. 2. 3.

**C. IDEMNIFICATION STATEMENT**

Recreation and Parks does NOT provide insurance. I and my child hereby waive and release all rights and claims for damages I may have against the Camp Staff and Recreation and Parks for any injury suffered by my child as a participant in the Summer Camp Programs.

I do \_\_\_\_\_ I do not \_\_\_\_\_ give permission to have my child appear in any media coverage approved by Recreation and Parks. I understand the Camp Director in conjunction with the Coordinators has been given the authority by Recreation and Parks to determine appropriate request.



\_\_\_\_\_ Date \_\_\_\_\_  
 Parent/Guardian Signature

**D. PAYMENT INFORMATION**

***NOTE: The below Agency Sponsorship section MUST be completed by the sponsoring agency with signature for this application to be accepted without full payment.***

**AGENCY SPONSORSHIP**

Agency Name: \_\_\_\_\_  
 Amount: \$ \_\_\_\_\_  
 Responsible Representative Signature:  
 \_\_\_\_\_

**E. EMERGENCY PICK UP**

The person or persons who are authorized to pick up the above camper at end of camp activities, in emergencies, or by special request are as follows (please print name or names):

1. Name \_\_\_\_\_ Relationship \_\_\_\_\_  
Phone numbers \_\_\_\_\_

2. Name \_\_\_\_\_ Relationship \_\_\_\_\_  
Phone numbers \_\_\_\_\_

**F. PEER ASSISTANT – (CAMP INSPIRE ONLY) MUST ALSO FILL OUT PEER ASSISTANT AIDE APPLICATION**

Name: \_\_\_\_\_

Relationship to camper: \_\_\_\_\_

Street Address: \_\_\_\_\_

City/State/Zip: \_\_\_\_\_

Home phone: (\_\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ Cell phone: (\_\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

Work phone: (\_\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ E-mail \_\_\_\_\_

**G. INFORMATION FOR BUS DRIVERS**

**FOR CAMPS THAT PROVIDE TRANSPORTATION:** Please provide the following information for the bus drivers. This form will be given to the driver in order to provide them with emergency information and directions for each child. They will contact you the week prior to camp with tentative pick up and drop off times.

Street Address of pick up/drop off location

\_\_\_\_\_

Directions to Residence or Daycare:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Daycare information (Please fill out if your child will be picked up from a daycare provider)

Name of Daycare: \_\_\_\_\_

Name of Contact person \_\_\_\_\_

Daycare Phone Number \_\_\_\_\_

## G. AUTHORIZATION FOR MEDICAL CARE AND INFORMATION

### MEDICAL CARE

I hereby authorize emergency medical care for my child(ren) during attendance at any Recreation and Parks camp, if, in the judgment of the staff, treatment is required for an injury or illness. I hereby also authorize the administering of anesthetics and resource to other procedures deemed necessary by the attending physician. I understand that whenever possible, I will be notified prior to medical treatment of my child. I understand that I will be notified at the earliest possible time should proper notice prove impossible.

The physician of my choice is Dr. \_\_\_\_\_  
Their Phone Number: \_\_\_\_\_

The hospital of my choice is \_\_\_\_\_

My child is allergic to the following medications and anesthetics:

\_\_\_\_\_  
\_\_\_\_\_

➔ Parent/Guardian Signature \_\_\_\_\_  
Date \_\_\_\_\_  
Child's Name: \_\_\_\_\_

### MEDICAL CARE FINACIAL RESPONSIBILITY

I understand that I am financially responsible for any expenses for medical care or transportation my child's behalf. Recreation and Parks does NOT provide accident insurance. I hereby for myself and for my child wave and release all rights and claims for damages I may have against the staff or Recreation and Parks for any injuries suffered by my child as a participant in the camp.

➔ Parent/Guardian Signature \_\_\_\_\_  
Date \_\_\_\_\_  
Child's Name: \_\_\_\_\_

### MEDICAL PAPERWORK

I hereby authorize the release of medication orders and other medical paperwork from St. Mary's County Public Schools to St. Mary's County Department of Recreation and Parks.

➔ Parent/Guardian Signature \_\_\_\_\_  
Date \_\_\_\_\_  
Child's Name: \_\_\_\_\_

## H. FOOD SERVICE ELIGIBILITY

Please indicate below if our child receives free or reduced lunch during the school year, the name of your child and the school they attend. If the camp meets eligibility requirements all children will receive breakfast and lunch free of charge to the Department. Please sign below to give your permission to share this information with St. Mary's County Public Schools AND the Maryland State Department of Education.

# **THIS MUST BE COMPLETED BY ALL FAMILIES REGARDLESS OF STATUS.**

Name of Child: \_\_\_\_\_

Name of School: \_\_\_\_\_

**1. My child is enrolled in the free and reduced lunch program.**

**YES** \_\_\_\_\_ **NO** \_\_\_\_\_

 **2. Signature of Parent or Guardian:** \_\_\_\_\_

## H. CAMPER INFORMATION

**Please remember all information on this form is confidential and will only be used to aid in the care of your child. Failure to provide all requested information may affect your child's registration status.**

Does your child have any allergies (food, medication and or environmental)? YES or NO  
If yes please indicate


Medical History: (Please include any information that would aid in understanding your child's condition  
Medical Diagnoses:


What medications will have to be administered at camp? (Camp must have Nursing orders from school or form filled out from doctor. All medications brought to camp must be in the original labeled container.)


Medical treatments to be administered while at camp. (Tube feeding, catheter etc.)


Has your child ever had a seizure? **Yes** \_\_\_ **No** \_\_\_

If **Yes**, indicate type of seizure, date of last seizure, and whether it is controlled by medication.


Is there any camp activity in which your child should not participate? **Yes** \_\_\_ **No** \_\_\_

If **Yes**, please describe: (NOTE: Recreation and Parks does NOT provide alternative care for field trips. If your child is unable to attend a field trip staff WILL NOT be available at camp until the campers return for the day. Please make alternative care arrangements on these days)


Does your child have a history of: (If any of these answers are **Yes**, elaborate below.)

1. Fainting with exercise? **Yes** \_\_\_ **No** \_\_\_
2. Undue tiredness/fatigue? **Yes** \_\_\_ **No** \_\_\_
3. Family member with sudden unexplained death under the age of 40? **Yes** \_\_\_ **No** \_\_\_
4. Tendency toward hyperthermia (over heating, elevated temperature)? **Yes** \_\_\_ **No** \_\_\_

Details:


Does your child have any dietary restrictions? **Yes** \_\_\_ **No** \_\_\_ If yes, please describe:


Will your child receive extended school years services during camp hours? **Yes** \_\_\_ **No** \_\_\_ If yes, please indicate the provider's name, times and dates of services.


