MARYLAND AGRICULTURAL RESOURCE COUNCIL: Farm Camp

ACKNOWLEDGEMENT, WAIVER AND RELEASE OF LIABILITY

I hereby confirm participant is in good health and able to participate in the activity. Also, I have been advised to consult with a licensed physician prior to participation in the activity. I acknowledge the activity may involve both apparent and inherent risks and dangers of bodily injury or death and damage to property. I fully accept and acknowledge the activities may involve risks, and I hereby assume all dangers and risks associated with the participant in the activity and will be responsible for the same. I further understand that concussion information is available at www.cdc.gov/concussion.

I acknowledge that Baltimore County, Maryland, the Recreation Council, and their respective employees, directors, officers, volunteers, members and any other participant, entity, party or person involved in any regard with the Activity or the Activity premises and their respective agents, personal representatives, heirs, employees, contractors, successors and assigns (each an activity representative and collectively the "activity representatives"), shall not be responsible or liable in any regard or manner for any and all property damage or bodily injury (including serious physical injury or even death) incurred by participant or any party related thereto, as a result of his/her participation in the activity.

I agree that the Maryland Agricultural Resource Council may use photographs of me with or without my name and for any lawful purpose, including for example such purposes as publicity, illustration, advertising, and Web content.

I have read, fully understand, and hereby freely sign, approve of, and agree to the terms of this Registration Form. I hereby expressly and forever unconditionally release, discharge, covenant not to sue, waive my rights and remedies, and agree to hold harmless and indemnify the activity representatives from any and all claims, costs, demands, losses, damages, or expenses, and from all acts of active or passive negligence or other fault on the part of the activity representatives associated with, in whole or in part, participant's involvement with the activity. I shall inform the Recreation Council in writing if any information provided in this Registration Form is incorrect or changes through the course of the activity. I shall present a government issued photo identification card including, but not limited to, my driver's license, passport, or United States Visa to the activity representative for review, if requested, at the time I submit this Registration Form to the recreation council.

Signature of parent/guardian:_____ Date:_____

Print Name of Signatory: _____

Name of Participant:_____

Relationship to Participant: _____

Registration/Medical Information & Liability Waiver Form

This Registration Form shall be completed by the legal authorized parent, or guardian, of minor/child participant.

Registered for week of: _____

Child's Name: Last: _____ First: _____ Date of Birth: ___/___/___ Male: ____ Female: ____

Parent/Guardian's Name: Last: _____ First: _____

Street Address: _____ City/State/Zip: _____

Home Phone: _____ Cell Phone: _____ Parent's E-Mail: _____

Activity Registering for: _____ School Attending: _____

Yes, I am interesting in helping: _____ I would like more information: _____

EMERGENCY CONTACTS/HEALTH INFORMATION:
In case of emergency, please notify (if minor/child participant, provide parent's information or Guardian, as appropriate).

Name:_____ Relationship:_____ Home Phone_____ Cell Phone_____

Name:_____ Relationship:_____ Home Phone_____ Cell Phone_____

Physician's Name: _____ Physician's Phone: _____

Name of Medical Provider: _____ Date of last tetanus immunization: _____

Any medical, psychological, or behavioral conditions we should be aware of (bee stings, food allergies, etc.)?_____

1. Are there any medical or health factors or limitations that might affect participant's performance in the activity?
   Yes ___ No ___

2. Is participant taking any medications or have a condition that may affect participant's safety or performance in the activity?
   Yes ___ No ___

3. Does the participant require any special accommodations (due to disability) to participate in the activity?
   Yes ___ No ___

If yes, please explain: _____

In case of injury or emergency, I for myself and/or participant (if participant is minor/child), and my personal representatives, heirs and assigns, (severally and collectively "I" for this registration form) give permission for an activity representative to call 911 and transport participant to a hospital. I shall inform the Recreation Council, in writing, of any medical or health conditions of participant that occurs or develops and which could affect participant's safety, performance or participation in or throughout the activity.

Signature of participant or, if minor, of parent/guardian: _____ Date: _____

Maryland Agricultural Resource Council Farm Camp
Health Assessment
To be completed by parent/guardian

Child's Name (Last, First, Middle)	Birthdate (Mo/Da/Yr)	Sex (M/F)	School and Grade

Street or Mailing Address	City	State	Zip

Parent/Guardian Names

Where do you usually take your child for medical care? Name of Provider:	Address of Provider	Phone of Provider

Date of most recent physical exam of child	Name of Provider of Physical	Phone of Provider

ASSESSMENT OF STUDENT HEALTH

To the best of your knowledge, does your child have a history of or any problems with the following: Please check "yes" or "no."

	Yes	No	Comments
Birth Defects			
Prematurity			
Hospitalization (When, Where)			
Concussion (Head Injury)			
Surgery			
Lead Poisoning			
Eye or Vision Problems			
Ear Problems or Deafness			
Speech Problems			
Cerebral Palsy			
Meningitis			
Heart Problems			
Serious Allergic Reactions			
Behavior or Emotional Problem			
Allergies (Food, Insects, Drugs, etc.) If yes, list symptoms			
Asthma			
Sickle Cell Disease			
Diabetes			
Seizures			
Bleeding Problems			
Limits on Activity			
Problem with Bladder			
Problem with Bowels			
Are all immunizations current?			
Should there be restriction of physical activity?			
Are any medications being taken?			
Special medical procedures that may be needed?			
Date of your child's last tetanus shot:			
Information that may be needed by staff:			
Comments:			

Parent/Guardian Signature: _____ Date: _____

PART II - CHILD HEALTH ASSESSMENT
To be completed *ONLY* by Physician/Nurse Practitioner

Child's Name: Last / First / Middle	Birth Date: Month / Day / Year	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

Health Area	WNL	ABNL	Not Evaluated	Health Area	WNL	ABNL	Not Evaluated
Attention Deficit/Hyperactivity	☐	☐	☐	Lead Exposure/Elevated Lead	☐	☐	☐
Behavior/Adjustment	☐	☐	☐	Mobility	☐	☐	☐
Bowel/Bladder	☐	☐	☐	Musculoskeletal/orthopedic	☐	☐	☐
Cardiac/murmur	☐	☐	☐	Neurological	☐	☐	☐
Dental	☐	☐	☐	Nutrition	☐	☐	☐
Development	☐	☐	☐	Physical Illness/Impairment	☐	☐	☐
Endocrine	☐	☐	☐	Psychosocial	☐	☐	☐
ENT	☐	☐	☐	Respiratory	☐	☐	☐
GI	☐	☐	☐	Skin	☐	☐	☐
GU	☐	☐	☐	Speech/Language	☐	☐	☐
Hearing	☐	☐	☐	Vision	☐	☐	☐
Immunodeficiency	☐	☐	☐	Other:	☐	☐	

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)

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 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:

MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE 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
1									1				Mo/Yr
2									2				
3										Td Mo/Day/Yr	Tdap Mo/Day/Yr	FLU 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

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

_____
Signature Title Date

_____
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: _____

BALTIMORE COUNTY DEPARTMENT OF RECREATION AND PARKS

DISCIPLINE
GUIDELINES AND PROCEDURES

The following is provided to inform you of examples of inappropriate behaviors and enforced step consequences. It is our intention to work with our program participants and their parents to provide a safe and orderly recreation environment and experience. Proper behavior helps to insure enjoyable participation for all the children.

Examples of Inappropriate Behavior

Hitting or scratching	Tripping	Stealing
Biting	Fighting	Vandalism
Pushing	Throwing objects at another	Acting disrespectful towards or not obeying staff
Pinching	Cursing	Under the influence of drugs and/or alcohol
Hair pulling	Lying	In possession of drugs and/or alcohol
Kicking	Name calling	In possession of guns, knives or any object fashioned to become a weapon.
Slapping	Obscene gestures	Intentional misuse of equipment

CONSEQUENCES

The following steps will be taken when inappropriate behavior is noted:

1. The child and staff will discuss the problem.
2. The parent will be notified by Program Discipline Report Form.
3. The child will be suspended for one day.
4. The child will be suspended for the remainder of the program.

THE SEVERITY OF THE INFRACTION, DETERMINES WHICH STEP WILL BE TAKEN.

I, the undersigned, have read and understand the Discipline Guidelines and Procedures.

_____

Parent/Guardian Signature Date

_____

Print Name

_____

Child's Name (Print)

Copies – 1 Parent
1 Program
Rev. 5/16/14