2015 Medical Forms

Please read this entire packet and complete forms as necessary. It is strongly recommended that you make a copy for your files.

Forms should be sent to:
MLW, P.O. Box 1792, Germantown, MD 20875
Or to apply2015@mlw.org. Please indicate MEDICAL FORMS in subject line.

DEADLINE: May 31, 2015

To ensure the safety and well-being of all our delegates and to maintain our certification as a Youth Camp with the State of Maryland Department of Health and Mental Hygiene (DHMH), all applicants must complete all the medical information requested in this application, including obtaining a licensed health care provider signature where necessary.

Complete Medical Forms Packet includes:

- Contact Information and Parental Release and Acknowledgement
- Health History
- Prescription and Over the Counter Medication order (health care provider's signature)
- Insurance Information (photocopy of card, front and back)

Please note that in case of an emergency, these Medical Forms are used to provide information to the hospital. Therefore, please fill them out completely and legibly to ensure the safety and well-being of the delegate. Be sure to include a photocopy of the health insurance card (front and back).

MLW HEALTH PROCEDURES

Delegate medical forms are reviewed by a licensed health consultant prior to the start of the program. If any of your health information should change between now and the beginning of the program (for example, you get a new prescription that is not included in this form or you have a change in your health status), please let us know as soon as possible so our health consultant can be notified and is able to review the information in a timely manner.

The health consultant is on-site as delegates register. All prescription and non-prescription medication brought to the program must be turned in to the health consultant along with the appropriate forms and signatures. See below for more information.

MLW does not have a nurse on site during the course of the week but the health consultant is on call. Many of our staff are certified and trained in CPR and First Aid. If a delegate experiences any significant health difficulties during the program:

- his/her parent/guardian will be immediately notified;
- the health consultant will be called;
- the delegate may be taken to the Kent & Queen Anne's Hospital (located next to campus);
- campus security (which is AED and CPR trained) may be called;
- and/or 911 may be called.

MEDICATION

Delegates must turn in ALL medication (prescription AND over the counter) to the Health Consultant at registration. Per the State of Maryland Department of Health and Mental Hygiene Youth Camp regulations, MLW office staff keeps medication in the office. The exceptions to this are epi-pens and inhalers.

All medications must arrive in their **original containers.** For prescriptions, this means as prepared by pharmacy complete with **pharmacy prepared labels that are consistent with the prescriber's order** (i.e.,the medication must match the prescription order attached). Over the counter medicine should be in its original container.

If you take medicine on a regular basis:

Delegates come to the office at designated times to self-administer medication under the supervision and observation of MLW staff. Delegates are only permitted to take medication (prescription or over the counter) for which there is a health care provider's signature. Please be sure to provide one Medication Administraton Authorization Form (p. 5 of this packet) for each prescription and non prescription medication that you will be sending with the delegate, and obtain the necessary signatures on each form.

DUE TO NEW DHMH REGULATIONS, MLW STAFF IS NO LONGER ALLOWED TO PROVIDE OVER-THE-COUNTER MEDICATION. The only medication delegates will be allowed to take is what you send with him/her, and only if the enclosed Medication Administration Authorization form (p. 5 of this packet) is filled out and signed by you and your health care provider for each medication.

To clarify: you must provide one Medication Administration Authorization Form (p. 5 of this packet) for each medication, whether prescription or non-prescription. Please make copies of this form as needed, or request more copies from office@mlw.org.

MLW MEDICAL FORM – Contact and Insurance Information

If part of the application does not apply to you, please indicate that by putting a N/A (not applicable) in the appropriate section rather than leaving it blank. If you would like to include more information, please attach additional pages. Please write legibly.

Program:	ALS	MSEL	SHW	Journey	Delegate Name:

Birth date: ___/___/___

Parent Name		Parent Name	
Phone #1		Phone #1	
Phone #2		Phone #2	

EMERGENCY CONTACT: If the family is not available, please indicate two alternative people to contact.

Name		Name	
Relation to delegate		Relation to delegate	
Phone #1		Phone #1	
Phone #2		Phone #2	

HEALTH CARE PROVIDER CONTACT:

Name of delegate's **physician** _____ Phone _____
Address_____

Name of family **dentist/orthodontist** _____ Phone _____
Address _____

Name of any **specialist** delegate (eg. Endocrinologist, Orthopedist) if used _____
Address _____ Phone _____

PARENTAL RELEASE AND ACKNOWLEDGMENT:

I give permission to authorized personnel to carry out such emergency diagnostic and therapeutic procedures as may be necessary for my son/daughter, and also permit such procedures to be carried out at, and by, local hospital(s) in the event that my son/daughter is taken there for emergency care. I agree to the release of any records necessary for insurance purposes. I grant permission to Maryland Leadership Workshops, Inc. to arrange any related transportation necessary to care for my child. I understand that any medical expenses will be directly billed to my insurance company or me. **I certify that all medical and health history information provided is complete and accurate to the best of my knowledge. I hereby release and hold harmless Maryland Leadership Workshops, Inc. and its agents, servants, contractors and employees from any and all liability that may result from medical care of my son/daughter. I further certify, that unless indicated on the Delegate Medication Form, my son/daughter is capable of self administering any below-mentioned medication(s) and I assume all responsibility and liability stemming from my decision to have my child self-administer medication(s).**

_____ _____ _____

Parent/Guardian Signature Printed Name Date

MLW MEDICAL FORM – Delegate Health History

Program:	ALS	MSEL	SHW	Journey	Delegate Name:

The following information is required for a delegate/camper to be admitted to a residential camp:

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 is a positive experience (please attach additional pages, if necessary) **or indicate N/A**:

ALLERGIES List all known allergies and describe reaction and management of the reaction **or indicate N/A**.

Medication allergies

Food allergies & other allergies

DIETARY RESTRICTIONS OR OTHER NEEDS Please let us know if you will need accommodations during the week

IMMUNIZATION INFORMATION

For delegates who reside within the United States, a United States Territory, or the District of Columbia:	←OR→	**For delegates who reside OUTSIDE the United States, a United States Territory, or the District of Columbia:**
1. State/territory where child resides: 2. Is child exempt from any immunizations? [ ]NO [ ]YES, List them:		1. Country in which child resides: 2. Attach Department form DHMH-896 (record of vaccination or immunity)

MLW MEDICAL FORM – Medication Administration Authorization

You must complete one form for EACH medication – prescription or over the counter. Please make copies as needed.

Program:	ALS	MSEL	SHW	Journey	Delegate Name:

This form must be completed fully in order for the camper to self-administer medication. A new medication administration form must be completed at the beginning of each camp season, 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.**
- **Nonprescription medication must be in the original container with the instructions for use. Nonprescription medication includes vitamins, homeopathic, and herbal medicines.**
- **An adult must bring the medication to the camp and give the medication to an adult staff member.**

YOUTH CAMP NAME/ADDRESS: Maryland Leadership Workshops, 12900 Middlebrook Rd 3rd Floor West, Germantown, MD 20874

PRESCRIBER'S AUTHORIZATION

CHILD'S NAME		DATE OF BIRTH
CONDITION FOR WHICH MEDICATION IS BEING ADMINISTERED:		EMERGENCY MEDICATION [ ] YES [ ] NO
MEDICATION NAME	DOSE	ROUTE
TIME/FREQUENCY OF ADMINISTRATION	IF PRN, FREQUENCY	
IF PRN, FOR WHAT SYMPTOMS		
KNOWN SIDE EFFECTS SPECIFIC TO CHILD		
MEDICATION SHALL BE ADMINISTERED	FROM	TO

PRESCRIBER'S NAME/TITLE			This space may be used for the Prescriber's Address Stamp
TELEPHONE	FAX		
ADDRESS			
CITY	STATE	ZIPCODE	

PRESCRIBER'S SIGNATURE ***(Parent cannot sign here)***	DATE

PARENT/GUARDIAN AUTHORIZATION

I request the authorized youth camp operator/staff to supervise the camper in self administration if authorized as prescribed by the above 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 adult must pick up the medication, otherwise it will be discarded. I authorize camp personnel to communicate with the prescriber as allowed by HIPAA.

PARENT/GUARDIAN SIGNATURE		DATE
HOME PHONE #	CELL PHONE #	WORK PHONE #

AUTHORIZATION FOR SELF ADMINISTRATION AND SELF CARRY

I consent that the child named above is able to self-administer the medication listed. I authorize self-administration of the above listed medication for the child named above under the supervision of an authorized youth camp operator/staff member. The child named above may self-carry emergency medication if indicated below.

PRESCRIBER'S SIGNATURE	SELF CARRY EMERGENCY MEDICATION (Check One) [ ] YES [ ] NO [ ] Not emergency medication	DATE
PARENT/GUARDIAN'S SIGNATURE	SELF CARRY EMERGENCY MEDICATION (Check One) [ ] YES [ ] NO [ ] Not emergency medication	DATE

MLW MEDICAL FORM – Insurance Information

Is the delegate covered by medical/hospital insurance? YES or NO (circle one)

If YES –

Please complete the information below and attach a photocopy of the front and back of health insurance card.

Insurance Company: _____Policy Number:_____

Group Number:_____ID Number:_____

If NO –

Please read and sign below.

There is no medical insurance in effect to cover my above-named son/daughter for any illnesses, injuries, or other adverse health outcomes that he/she may experience. I, therefore, hereby agree to assume direct and complete financial responsibility for any and all medical care of any kind that my above-mentioned son/daughter receives while attending Maryland Leadership Workshops, Inc.'s 2015 summer residential leadership programs.

Further, I hereby agree to reimburse Maryland Leadership Workshops, Inc. for any and all costs, medical expenses, and other sums that Maryland Leadership Workshops, Inc. advances that relate to the medical treatment of my son/daughter while he/she is attending Maryland Leadership Workshops, Inc.'s 2015 summer programs.

_____ _____ _____

Parent/Legal Guardian Signature Printed Name Date