MLW Participant Expectations/Rules

COMMITMENT:

Your application indicates your commitment to stay for the entire Journey program (1pm on June 17 through 11am on July 3). Girls will not be able to leave the program early for other commitments, vacations, etc.

EXPECTATIONS:

RESPECT

Respect for one another is of primary importance for all participants and staff members to learn and grow throughout the week. Treat others with respectful behavior so that you may expect the same in return. Respectful behavior includes:

- Respecting requests made by MLW staff members and campus employees
- Avoiding the use of profanity/obscene language
- Respecting the privacy of MLW participants and other groups who may be using the campus
- Avoiding unwanted touching of other people and their belongings (including fighting)
- Respecting all ideas and beliefs and avoiding the use of derogatory comments towards others

ATTENDANCE

It is expected that you will attend all scheduled activities. We have many fun and challenging activities for you and expect that you will be a part of each one. Eating three balanced meals a day, drinking plenty of liquids, and getting enough sleep will ensure that attending all activities will be no problem. However, if you have a legitimate reason to miss an activity, you must notify a staff member in advance. In case of an emergency, notify a staff member immediately — we are there to help!

RULES:

IN AND AROUND DORMITORIES

- No outside visitors are permitted at anytime during the week without prior permission from the program director
- Do not prop open outside doors at anytime.

CHECK-IN AND LIGHTS OUT

Check-in will occur every night at the time indicated in the guidebook you receive at registration. You must check in with a staff member from your hall by the stated time. We will give you time to get ready for bed, and we will usually schedule a hall meeting after check-in. Lights must be TURNED OFF at the time designated in your guidebook. Although you may be accustomed to staying up a bit later, remember that this week is very active and demands your full energy every day. You will need you sleep to fully participate in all activities.

Participant Expectations/Rules (continued)

EMERGENCIES
In the event of a fire, pull the fire alarm and exit the building quickly, knocking on the doors that you pass. Check in with your assigned staff member at the designated meeting location.
In the event of another type of emergency, contact the staff member who is on "dorm duty." Her name will be posted on your hall.

AROUND THE CAMPUS

- At registration, you will receive a Journey button. This button must be worn at all times unless, of course, you are in the shower or sleeping. You must also wear shoes at all times except when showering and sleeping (although you may want to wear shower shoes).
- You may NOT leave campus at any time or for any reason. If you have forgotten a necessity item that is not available at the college store, give the office staff money and a written description of the item, and they will be happy to secure it for you.
- You may NOT drive during the workshop at any time. If you think you will be tempted to drive during the week, a staff member will be happy to hold your keys for you.
- Do NOT walk alone anywhere — always take a buddy with you.
- Do not cross Route 213 outside the crosswalk or unless there is a "walk" signal.

TOBACCO, ALCOHOL, AND OTHER DRUGS
The use of all drugs, alcohol, and tobacco is absolutely forbidden at all times during the week. If you are taking prescription medication, notify your staff member at registration to make the proper arrangements.

INAPPROPRIATE BEHAVIOR AND CONSEQUENCES
The expectations outlined above are intended to allow all participants and staff members to have a safe and successful week. Any behavior that threatens or jeopardizes the safety of other persons or their enjoyment of the program will not be tolerated.

The MLW directors and staff may take any of the following actions as a consequence for participants who do not meet the expectations outlined above:

- A conference with the participant by a staff member
- A conference with the participant by a program director
- A phone call home informing a parent/guardian of the incident
- A participant-written letter of apology to the offended party
- The withholding of participation in social activities
- Removal from the program (a parent/guardian will be requested to pick up the student)

I have read and understand the expectations/rules stated above and acknowledge that I may be dismissed from MLW if I violate any of these rules.

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Printed Participant Name Signature Date

JOURNEY MEDICAL FORM B

This Form MUST BE FILLED OUT (all sections) and SIGNED by a DOCTOR.

Only physicals completed on or after February 1, 2009 will be accepted.

General Questions (If the answer is "Yes" to any of the questions, explain response below).

All boxes must be checked yes or no.

Has/does the participant:	Yes	No
1. Had any recent injury or illness, or infectious disease?		
2. Have a chronic or recurring illness/condition?		
3. Ever been hospitalized?		
4. Ever had surgery?		
5. Have frequent headaches?		
6. Ever had a head injury?		
7. Ever been knocked unconscious?		
8. Wear glasses, contacts or protective eye wear?		
9. Ever had frequent ear infections?		
10. Ever passed out during or after exercise?		
11. Ever been dizzy during or after exercise?		
12. Ever had seizures?		
13. Ever had chest pain during or after exercise?		
14. Ever had high blood pressure?		
15. Ever been diagnosed with a heart murmur?		
16. Ever had problems with joints (e.g. knees, ankles)?		
17. Have an orthodontic appliance being brought to camp?		
18. Have any skin problems (e.g. itching, rash, acne)?		
19. Have diabetes?		
20. Have asthma?		
21. Had mononucleosis in the past 12 months?		
22. Had problems with diarrhea/constipation?		
23. Have problems with sleepwalking?		
24. If female, have an abnormal menstrual history?		
25. Have a history of bed-wetting?		
26. Ever had an eating disorder?		
27. Ever had emotional difficulties for which professional help was sought?		
28. Ever had back problems?		

Please explain any "yes" answers, noting the number of the questions (attach additional sheets if necessary).

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Attach immunization record or complete the following:

Which of the following has the participant had? (circle)

Measles
Chicken pox
German measles
Mumps
Hepatitis A
Hepatitis B
Hepatitis C

TB Mantoux Test
Date of last test _______________
Results: ____Positive ____Negative

Please give all dates of immunization for:

Vaccine:	Dates: Mo/Yr.	Mo./Yr.	Mo./Yr.	Mo/Yr.	Mo./Yr.	Mo./Yr.
DTP	______	______	______	______	______	______
TD (tetanus/diphtheria)	______	______	______	______	______	______
Tetanus	______	______	______	______	______	______
Polio	______	______	______	______	______	
MMR	______	______				
or Measles	______	______				
or Mumps	______	______				
or Rubella	______	______				
Haemophilus influenza B	______	______	______	______		
Hepatitis B	______	______	______			
Varicella (chicken pox)	______	______				

Use this space to provide any additional information about the participant's behavior and physical, emotional, or mental health

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Complete the following information:

Name of family physician ____________________________________ Phone ___________________________

Address____

Name of family dentist/orthodontist ____

Address ____ Phone ___________________________

NAME OF PARTICIPANT: ____

Health History
The following information must be filled in. The intent of this information is to provide camp personnel the background to facilitate appropriate care. Keep a copy of the completed form for your records. **Any changes to this form should be sent to the MLW office prior to the start of the camp and a duplicate copy provided to camp personnel upon participant's arrival at camp.** Provide complete information so that the camp can be aware of your needs.

ALLERGIES List all known. Describe reaction and management of the reaction.
Medication allergies (list)

____________________________ ____

____________________________ ____

____________________________ ____

Food allergies & Other allergies (list)

____________________________ ____

____________________________ ____

Explain any restrictions to activity (e.g. what cannot be done, what adaptations or limitations are necessary)

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Has the camper been diagnosed with any of the following, or any other, chronic physical conditions that require specific medical treatment and supervision; and if untreated, can adversely affect the general health of the camper?

	Yes	No
Asthma	☐	☐
Allergies	☐	☐
Cancer	☐	☐
Diabetes	☐	☐
Epilepsy	☐	☐
Other identified medical conditions	☐	☐

(please list – this includes medical, psychological and behavioral conditions): ________________________________

If any of the boxes are checked above, please explain below (date of diagnosis, treatment, medications, etc.):

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Health Care Recommendations by Licensed Medical Personnel (MLW requires a physical exam within 18 months of attendance)

I examined this individual on _________________. BP_______________ Weight ____________ Height _______________

In my opinion, the above applicant ☐ is ☐ is not able to participate in an active camp program. (Please check box)

Signature of Licensed Medical Personnel ____ Date _____________

Printed __________________________________ Title __________________________________

Address ____ Phone ______________________________

NAME OF PARTICIPANT: ____

Participant Over-the-Counter Medication Form

According to Maryland State Law, ***the MLW camp office MAY NOT administer ANY non-prescription-over-the-counter medicine without the child's physician's signature. Parent signatures will not suffice.*** **While this has been true previously for prescription medicine, it is now a requirement for non-prescription medicine as well. ALL participants must have this form signed and returned whether or not parents want non-prescription drugs available for self-administration.**

****Please be sure to have a doctor and parent sign the bottom page of this form****

Participant Name:____ Program: ____________________

DOB: ______________ Weight: _______ Age: _________

The following order form MUST be completed and signed by the child's physician. If the child will be taking any prescription medications while at camp, the doctor must also complete the following page. The camp office is only permitted to supervise self-administration of medications of a child that is listed on this form by the child's doctor.

Standard and Over the Counter/PRN Medications: The following medications are available in the Office and with a signed HCP order and at the discretion of the Office/Nurse, the student may self-administer.

Drug Name	Route	Dosage & Schedule	Indications	Camper Health Care Provider Order	Things to be aware of when on this medication/Comments
Tylenol (or generic)	PO (chewable, elixir, or tabs) PR (suppository)	Per label Instructions by age/weight	Pain or Fever	Yes or No	
Ibuprofen	PO (chewable tabs, suspension, or tablets)	Per label Instructions by age/weight	Pain or Fever	Yes or No	
Robitussin (or generic)	PO (syrup)	Per label Instructions by age/weight	Cough	Yes or No	
Pepto-Bismol (or generic)	PO (liquid or chewable tabs)	Per label Instructions by age/weight	Upset stomach, Diarrhea	Yes or No	
Kaopectate (or generic)	PO (liquid or tab)	Per label Instructions by age/weight	Diarrhea	Yes or No	
Children's Mylanta (or generic)	PO (chewable)	Per label Instructions by age/weight	Upset stomach	Yes or No	
Sudafed (or generic)	PO (tabs or liquid)	Per label Instructions by age/weight	Nasal congestion, Eustachian tube congestion	Yes or No	
Chlorpheniramine	PO (chewable tabs, suspension, or tabs)	Per label Instructions by age/weight	Seasonal allergy symptoms	Yes or No	
Dramamine/Bonine (or generic)	PO (chewable/regular tabs)	Per label Instructions by age/weight	Motion Sickness	Yes or No	
Dimetapp (or generic)	PO (elixir or tabs)	Per label Instructions by age/weight	Nasal congestion, Season allergy	Yes or No	
Benadryl (or generic)	PO (elixir, chewable, tab, or pills); topical ointment	Per label Instructions by age/weight	Allergic reactions (hives, insect bite, allergies)	Yes or No	
Antibiotic ointment	Topical	Per label Instructions	Superficial cuts/abrasions	Yes or No	
Hydrocortisone Cream	Topical	Per label Instructions	Allergic reactions, contact dermatitis, insect bite	Yes or No	
Calamine Lotion	Topical	Per label Instructions	Allergic reaction (insect bite, hives)	Yes or No	

Required:
Doctor's Signature ____ Date _______________________

I, ____________________________ (parent/guardian name), give permission for my child to take the medications listed above as "YES". Additionally, my child had taken at least 1 dose of the medication(s) listed above at home.

Parent's Signature ____ Date _______________________
*Parent/Guardian: Please list any medications that are marked "YES" above that you do NOT want your child to take:
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NAME OF PARTICIPANT: ____

Participant Prescription Medication Form

If the participant takes prescription medication, this form MUST be filled out by a physician.
All questions MUST be answered.

Participant's Name: ____ Date:____________________

Allergies: ____

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Dietary Limitation/Restrictions: ____

Name of Medication	Dosage	Frequency	Route/Method	Things to be aware of when on this medication	Reason for taking medication

Special Instructions regarding medication administration or storage: ______________________________

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Can the participant safely self-administer these medications without limitations (Administration of the correct medication, the correct dosage, the correct time, and the correct route without instruction or supervision from staff?) YES or NO (please circle your response)

If no, list limitations here: ____

Prescribing Provider's Signature: ____ Date: ________________

Prescribing Provider's Address and Phone Number: ____

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I, ____________________________ (parent/guardian name), give permission for my child to take the medications listed above. Additionally, my child had taken at least 1 dose of the medication(s) listed above at home.
Parent's Signature ____ Date ______________________

Note: All medications must arrive in their original containers as prepared by pharmacy complete with pharmacy prepared labels that are consistent with the prescriber's order.

Printed Participant Name Signature Date