

Delegate Name: \_\_\_\_\_  
Last First

Program  ALS  MSEL  SHW

## MLW DELEGATE MEDICAL FORM

### IMPORTANT MEDICAL FORM INSTRUCTIONS

To ensure the safety and well being of all our participants 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.

Pages 2-7 of the medical form should be completed and returned with necessary signatures as part of a complete application. You are encouraged to make a copy of this application for your own files.

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.

### MLW HEALTH PROCEDURES

MLW has a licensed health consultant on call. 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. He/she is on site as delegates check-in at registration.

MLW does not have an onsite *nurse* during the course of the week. 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 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. 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**.

Per the State of Maryland Department of Health and Mental Hygiene Youth Camp regulations, MLW office staff keeps medication in the office. Delegates come to the office to self-administer medication under the supervision and observation of MLW staff. Delegates are only permitted to take medication for which there is a health care provider's signature.

Please see medical form pages 5 and 6.

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## MLW DELEGATE MEDICAL FORM

Delegate Name: \_\_\_\_\_ Birth date: \_\_\_\_/\_\_\_\_/\_\_\_\_  
Last First M.I.

Home Address: \_\_\_\_\_  
Street Address Apt. No  
\_\_\_\_\_  
City State Zip Code

Home Phone: (\_\_\_\_) \_\_\_\_\_

School(s): \_\_\_\_\_  
2011-2012 2012-2013

Parent Name: \_\_\_\_\_ Parent Name: \_\_\_\_\_  
Work Phone (\_\_\_\_) \_\_\_\_\_ Work Phone (\_\_\_\_) \_\_\_\_\_  
Cell Phone (\_\_\_\_) \_\_\_\_\_ Cell Phone (\_\_\_\_) \_\_\_\_\_

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

Name: \_\_\_\_\_ Relation to delegate: \_\_\_\_\_  
Home Phone: (\_\_\_\_) \_\_\_\_\_ Work Phone: (\_\_\_\_) \_\_\_\_\_ Cell Phone: (\_\_\_\_) \_\_\_\_\_

Name: \_\_\_\_\_ Relation to delegate: \_\_\_\_\_  
Home Phone: (\_\_\_\_) \_\_\_\_\_ Work Phone: (\_\_\_\_) \_\_\_\_\_ Cell 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

Delegate Name: \_\_\_\_\_ Program  ALS  MSEL  SHW  
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**MLW DELEGATE MEDICAL FORM – Contact and Insurance Information**

Name of delegate’s physician \_\_\_\_\_ Phone \_\_\_\_\_  
Address \_\_\_\_\_

Name of family dentist/orthodontist \_\_\_\_\_ Phone \_\_\_\_\_  
Address \_\_\_\_\_

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

**INSURANCE INFORMATION:** Is the delegate covered by medical/hospital insurance?

**Yes - Please attach a photocopy of the front and back of health insurance card**

Insurance Company: \_\_\_\_\_ Policy Number: \_\_\_\_\_

Group Number: \_\_\_\_\_ ID Number: \_\_\_\_\_

**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 2012 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 2012 summer programs.

\_\_\_\_\_  
Parent/Legal Guardian Signature

\_\_\_\_\_  
Printed Name

\_\_\_\_\_  
Date

Delegate Name: \_\_\_\_\_  
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### MLW DELEGATE MEDICAL FORM – Delegate Health History

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

#### CAMPER IMMUNIZATION INFORMATION

All campers must be current on all immunizations, see [www.EDCP.org](http://www.EDCP.org) (immunization).

The Maryland Department of Health and Mental Hygiene Immunization Certificate Form is attached. **Please complete OR provide a photo copy of existing records and submit to MLW** in order for the delegate to be onsite for MLW’s residential program.

If the camper is exempt from any immunization on medical or religious grounds, provide a signed copy of Maryland Department of Health and Mental Hygiene Immunization Certificate from:

- a licensed physician indicating that the immunization is medically contraindicated , or
- the parent or guardian indicating that they object to immunizations for religious reasons.

**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 (please attach additional pages, if necessary):

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

Medication allergies

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Food allergies & Other allergies

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

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Parent or Legal Guardian’s Signature: \_\_\_\_\_ Date: \_\_\_\_\_

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

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**MLW DELEGATE MEDICAL FORMS –Over the Counter Medication Form**

The following standard over the counter (OTC) medications are available in the MLW Office. If a delegate needs medication, he/she will come to the office and requests medication which will be provided at the discretion of the MLW office staff. If the delegate brings their own OTC medicines, they must be stored in the MLW Office and taken in the presence of MLW staff.

The delegate will only be allowed to have OTC medicine and self-administer medication if there is a signed Health Care Provider order in the file. Therefore, please fill this form out completely **whether or not** your child regularly takes medication and have your health care provider sign the form below.

Delegate's Age: \_\_\_\_\_ Delegate's Weight: \_\_\_\_\_

Drug Name	Route	Dosage & Schedule	Indications	Delegate Health Care Provider Order (circle one)	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	
<b>Vitamins and/or supplements</b>	PO	Per label Instructions		Yes or No	

- I, \_\_\_\_\_ (parent/guardian name), give permission for my child to take the medications listed "YES" above.
- My child has taken at home at least 1 dose of the medication(s) listed as "YES" above.
- I do NOT want my child to take the following medications: \_\_\_\_\_

**Parent or Legal Guardian's Signature** \_\_\_\_\_ **Date** \_\_\_\_\_

**REQUIRED: Health Care Provider's Signature** \_\_\_\_\_ **Date** \_\_\_\_\_

Print Name \_\_\_\_\_

Delegate Name: \_\_\_\_\_  
Last First

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**MLW DELEGATE MEDICAL FORM – Page 6 of 8**  
**Delegate Prescription Medication Form**

Does the delegate take prescription medication?

**Yes** - This form **MUST** be filled out by a physician. All questions **MUST** be answered and parents must also sign below. 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**.

**No** - Please check the box and return the form. If the delegate’s health status should change and delegate is taking prescription medication during the week long program, please submit a new form as soon as possible.

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: \_\_\_\_\_  
\_\_\_\_\_

The delegate will be expected to **SELF-ADMINISTER** the above medication under the supervision and observation of MLW staff. Please indicate whether the delegate can 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**  **NO (please check one)**

If no, list limitations here: \_\_\_\_\_

Prescribing Provider’s Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Prescribing Provider’s Address and Phone Number: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

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 or Legal Guardian’s Signature \_\_\_\_\_ Date \_\_\_\_\_