The Maryland School for the Blind

ACHIEVING INDEPENDENCE

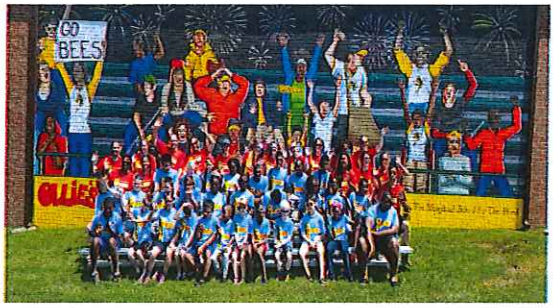
# CAMP ABILITIES

**An Overnight Sports Camp for Youth Ages 9 to 17 who are Blind or Visually Impaired.**

## July 10th to July 14th, 2017

**Located on the campus of The Maryland School for the Blind, Baltimore, MD**

**Swimming, Goalball, Beep Baseball, Soccer, Judo, Track and Field**




**Fitness Activities, Camp Fires, Meal Times, Daily Routines. Field Trip, Social Time**

**Email if you have any questions at:**
**matthewm@mdschblind.org**

# COST: $150.00

Please complete registration forms and mail with check (payable to MSB) to:

**The Maryland School for the Blind**
**Outreach Department**
**3501 Taylor Avenue**
**Baltimore, MD 21236**

**Registration due by May 26, 2017**

**Full payment or written authorization from a funding source due by June 9, 2017**

*Sports physicals and doctors clearances will be needed*

Information about the (SFSP) Summer Food Service Program meals can be found at MDsummermeals.org

www.marylandschoolfortheblind.org Like us on Facebook The Maryland School for the Blind's Camp Abilities

# Eligibility Criteria for a child to go to Camp Abilities Maryland at The Maryland School for the Blind

**Children who attend Camp Abilities Maryland must possess the following in order to participate:**

- They have a visual impairment and are eligible to receive vision services.
- Campers must be between the ages of 9-17 who are verbal and independent in self-care.
- They are predominantly independent.
- They possess verbal skills appropriate within 2 years of their age
- They display behaviors that allow them to function in a group setting that does not affect other group members.
- Must not display defiant behavior (this includes refusing to stand in a line, refusing to participate in a variety of activities, refusing to abide by the bed time curfew).
- They do not possess a medical problem that requires a 1:1 nurse for constant supervision.
- Parents must disclose ALL necessary information that will allow us to provide a safe environment for their week.

**All registration and health forms must be returned no later than May 26. Late or incomplete forms will impact your child's ability to participate.**

**Please note there is a PHYSICAL REQUIRED. Please contact your pediatrician as soon as possible to get this completed.**

**List of Health Forms required:**

1. Regular Diet Form
2. Special Diet Form (must be completed and signed by physician)
3. Emergency Transportation Form
4. Permission – over the counter medicines
5. Part 1 Health Assessment
6. Part 2 Interscholastic Athletics
7. Part 3 Health Assessment (physical must be completed and signed by physician)
8. Physical Activity

## FULL PAYMENT IS REQUIRED FOR PARTICIPATION!

**FULL PAYMENT ($150) or written authorization from a funding source must be received no later than June 9. Potential funding sources include local Lions Clubs or other community organizations and the ICAN Foundation (application attached).**

**Athletes will be ineligible, and be sent home if they display the following:**

- fleeing/run away behaviors
- biting/scratching/hitting behaviors
- defiant or conduct disorders
- medical needs that require constant nursing supervision or communicable diseases
- mobility limitations that prohibit them from ambulating 1/2 mile or inability to participate in the sport activities

*The Maryland School for the Blind* 3501 Taylor Ave., Baltimore, MD 21236-4499

# REGISTRATION FORM CAMP ABILITIES

***PARTICIPANT INFORMATION***

Participant's Name:_____ Nickname _____

DOB:_____ Age:_____ Sex___ M ___F

Address:_____

City:_____ County _____ State:____ Zip:_____

Parent/Guardian(s):_____ Relationship:_____

Home #:_____Cell #:_____ Work #:_____

Email: _____ **(PRINT CLEARLY)**

Parent/Guardian(s):_____ Relationship:_____

Home #:_____Cell #:_____ Work #:_____

Student Email: _____

School:_____ Grade:_____

Reading Level_____ Math Level _____ Vision Teacher: _____

***EMERGENCY CONTACTS*** ***(You must provide a minimum of 2 contacts with at least 2 phone numbers each)***

Emergency Contact #1_____Relationship:_____

Day #:_____ Night #:_____ Cell #:_____

Emergency Contact #2_____Relationship:_____

Day #:_____ Night #:_____ Cell #: _____

***VISUAL INFORMATION*** ***(Students are required to bring portable low vision or Braille devices and canes)***

Eye Condition:_____ Eye Dr.:_____

Level of Vision: ___ Totally Blind ___ Partially Sighted ___ Legally Blind ___ Wears Glasses

Field Loss: ___ Yes ___ No

Child uses the following for learning: Regular Print:___ Large Print:____ Braille:__ Auditory Skills:___

Please list technology currently used: Low Vision Devices ___(Type: _____)

___Tapes ___Digital Books/CD's ___Kurzweil ___Braille Note taker ___Jaws ___Screen Enlarger

___Computer ___Other (Please list)

_____

Travel Skills: ___Independent ___Needs Supervision ___Uses Cane ___Prefers Sighted Guide

***ADDITIONAL DISABILITIES/MEDICAL CONDITIONS** (additional medical documentation may be required):*

Check any additional diagnoses that apply:

____ Learning Disability ____ Multiple Sclerosis ____ ADD/ADHD

____ Intellectual Impairment ____ Brain Injury ____ Autism

____ Speech Impairment ____ Spina Bifida ____ Seizures

____ Hearing Impairment ____ Down Syndrome ____ Diabetes

____ Orthopedic Impairment (including Cerebral Palsy); please specify _____

____ Other _____

Emotional/Behavior Concerns

____ Anxiety ____ Depression

____ Difficulty coping with frustration (please specify below):

____ Displays aggression (i.e., hits others) ____ Tantrums ____ Uses loud or abusive language

___ Other _____

Social Skills:

____ Interacts easily with peers/sociable ____ Difficulty interacting with peers ____ Shy

Does your child take medication? ____ Yes ____No

If yes, please list medications or attach a printed list:

_____

_____

Does your child have food allergies? ____ Yes ____ No

Please list:

_____

Does your child have environmental allergies or sensitivities? ____Yes ____ No

_____

Does your child have any dietary restrictions? ____ Yes ____ No

Please list:

_____

_____

***ACTIVITIES OF DAILY LIVING SKILLS***

Indicate your child's level of independence:

____ Completely Independent _____ Needs minimal assistance/supervision in some areas

____ Needs total assistance in one or more areas listed below

Specify type and degree of assistance required in each area, if any:

Eating _____

Dressing _____

Grooming _____

Bathing _____

Toileting

_____

Has your child attended an overnight camp or program before? ____ Yes ____ No

If yes, please list previous overnight programs attended and your child's experience:

_____

_____

Please check any concerns that apply:

____Bedwetting ____ Sleepwalking ____ Difficulty sleeping through the night

Please share any additional information you would like us to know about your child:

_____

_____

_____

_____

_____

Please check the appropriate t-shirt size for your child:

_____ Youth Small _____ Youth Medium _____ Youth Large _____ Youth XL

_____ Adult Small _____ Adult Medium _____ Adult Large _____ Adult XL _____ Adult XXL

# *PARENT AUTHORIZATION SHEET*

*(Must be signed by parent/guardian)*

**Student Name:** _____

## Authorization to Release Information

I give The Maryland School for the Blind permission to release written reports from the Summer Program on my child to our local school system.

___ Yes ___ No

## Authorization to Transport

During our Summer Program there may be some opportunities for off-campus activities. We believe these activities are important to a well-rounded program. Sometimes they may be of an educational nature, such as field trips to a museum or place of business. Other activities of a recreational nature, but equally important, might involve a baseball game, trip to a theater, etc. I grant permission for my child to participate in all off-campus activities of which the School approves.

___ Yes ___ No

## Authorization to Utilize Image or Photograph

Many pictures are taken during the summer program of various activities. These pictures are sometimes used, along with press releases, to provide public relations information to television stations, newspapers and other publications. I grant permission for my son/daughter to be photographed for the above purposes.

___ Yes ___ No

## Authorization to Participate in Orientation and Mobility Experiences

During the Program your child will receive exposure to mobility concepts which will facilitate the awareness or development of skills needed to become a safe, independent traveler in the community. Training may include basic overview and instruction in crossing city streets, using public transportation, and various other activities in an attempt to reach the above-mentioned purpose. Your child will be transported in the MSB vehicles by the mobility specialist(s) or MSB staff to the various travel sites. All safety precautions will be observed during this training period to safeguard your child who will be under the direct supervision of one of the Mobility Specialist(s) or MSB staff. I grant permission for my child to receive these services.

___ Yes ___ No

## Permission to Apply Sunscreen and/or Insect Repellent

I give permission for MSB staff to apply or assist with the application of sun screen and/or insect repellent which has been provided by me or MSB while my child is participating in summer program activities at MSB. Furthermore, I attest, to the best of my knowledge, my child is not allergic to sunscreen and/or insect repellent.

___ Yes ___ No

**Legal Guardian Signature:** _____ **Date:** _____

Parent

# The Maryland School for the Blind

## *REGULAR*

## DIET ORDER FORM

## Health Center - School Year 2016-2017

**STUDENT NAME:** _____

____ Regular Diet

____ Food Allergy: _____

_____

____ Diet Restrictions: _____

_____

____ All Liquids (no restrictions on liquids)

____ Other: _____

_____ _____

Parent's Signature Date

CD/LB/cic:4/18/16

# The Maryland School for the Blind

## EMERGENCY (911) TRANSPORTATION CONSENT and STUDENT INSURANCE INFORMATION Health Center - School Year 2016-2017

STUDENT NAME: _____

PARENT/GUARDIAN: _____

ADDRESS: _____

PHONE: _____

The Maryland School for the Blind is hereby authorized to transport, or have my child transported, to the hospital in the event of an emergency.

The 911 dispatcher will determine which area hospital my child will be transported to under the existing circumstances.

By signing below, I grant permission for the above-named service to be provided for my child.

_____ _____

Signature of Parent/Guardian Date

**********

**PLEASE PROVIDE A COPY OF THE FRONT AND BACK OF THE INSURANCE CARD**
**OR**
**COMPLETELY FILL IN THE STUDENT'S HEALTH INFORMATION BELOW**

Card holder's name: _____

Card holder's address: _____

Card holder's phone number: _____

Card holder's Employer: _____

Patient Relationship to card holder: _____

Insurance Carrier Name: _____

Insurance Carrier Address: _____

Policy Number: _____ Group Number: _____

Group Name: _____ Effective Date: _____

### MEDICAL ASSISTANCE/MCO INFORMATION

MDMA Number: _____

Member/Policy Number: _____

**The Maryland School for the Blind**

**PERMISSION FOR OVER-THE-COUNTER MEDICATIONS**
**Health Center - School Year 2016-2017**

Student Name _____ Date of Birth _____

Date _____ Weight _____ Height _____ Allergies _____

The Medical Director at MSB has written standard orders for common conditions students may experience while at school.

Please CHECK ALL medications that your child may receive at school.

____ A&D Ointment or Vaseline
____ Artificial Tears
____ Benadryl (generic diphenhydramine) for allergic reactions
____ Cepacol throat lozenges for sore throat discomfort
____ Coke syrup for nausea
____ Cough drops for cough
____ Diaper Cream (Barrier Cream)
____ Dulcolax for constipation
____ Hydrocortisone 1% cream for rash
____ Ibuprofen (Motrin) for discomfort, fever, pain
____ Imodium for diarrhea
____ Midol (or generic equivalent) for menstrual cramps 12 yrs. and over 95 lbs.
____ Mucinex – congestion/non-productive cough
____ OraGel – mouth pain
____ Pepto Bismol – stomach upset
____ Robitussin (generic guaifenesin) (expectorant) dry non-productive cough
____ Robitussin DM (guaifenesin dextromethorphan) disruptive cough (antitussive expectorant)
____ Sudafed (generic pseudoephedrine) for nasal congestion
____ Sunscreen – sun protection
____ Triple Antibiotic Ointment
____ Tums (or generic equivalent) for heartburn
____ Tylenol (generic acetaminophen) for headaches, fever, pain

Parent/Guardian Printed Name _____ Parent/Guardian Signature _____

Date _____

CD/LB/cic:4/18/16

Parent

# The Maryland School for the Blind
## PART I – HEALTH ASSESSMENT
## Health Center - School Year 2016-2017

To be completed by parent or guardian

| Student's Name (Last, First, Middle) | Birthdate (Mo. Day Yr.) | Sex (M/F) |
|---|---|---|
| Address (Number, Street, City, Zip) | | Phone No. |
| Parent/Guardian Names | | |
| Where do you usually take your child for routine medical care? Name: | Address: | Phone No. |
| Where do you usually take your child for dental care? Name: | Address: | Phone No. |
| What other source does your child receive health care? Name: | Address: | Phone No. |

ASSESSMENT OF STUDENT HEALTH

To the best of your knowledge has your child had any problem with the following? Please check "Yes" or "No" for each of the following.

| | Yes | No | Comments |
|---|---|---|---|
| Allergies (Food, Insects, Drugs, Latex) | | | |
| Allergies (Seasonal) | | | |
| Asthma or Breathing Problems | | | |
| Behavior or Emotional Problems | | | |
| Birth Defects | | | |
| Bleeding Problems | | | |
| Cerebral Palsy | | | |
| Dental | | | |
| Diabetes | | | |
| Ear Problems or Deafness | | | |
| Head Injury | | | |
| Heart Problems | | | |
| Hospitalization (When, Where) | | | |
| Lead Poisoning/Exposure | | | |
| Learning Problems/Disabilities | | | |
| Limits on Physical Activity | | | |
| Meningitis | | | |
| Prematurity | | | |
| Problem with Bladder | | | |
| Problem with Bowels | | | |
| Problem with Coughing | | | |
| Seizures | | | |
| Serious Allergic Reactions | | | |
| Sickle Cell Disease | | | |
| Speech Problems | | | |
| Surgery | | | |
| Other | | | |

If the answer to any of these questions is "Yes" then the physician needs to complete the order form.

Does your child take any medication?

No_____ Yes _____ Name of Medication _____

Is your child on any special treatments? (nebulizer, epi-pen, etc.)

No_____ Yes _____ Treatment _____

Does your child require any special procedures? (catheterization, etc.)

No _____ Yes _____ Please Describe _____

_____ _____

Parent/Guardian Signature Date

# The Maryland School for the Blind

## PART II – INTERSCHOLASTIC ATHLETICS
## Health Center - School Year 2016-2017

– To be completed by parent and sports candidate –
only if interested in participating in interscholastic sports at MSB.

**Student Name:** _____
**Last** **First** **Middle**

FOR STUDENTS PARTICIPATION IN INTERSCHOLASTIC ATHLETICS

Please check yes or no for each of the following questions. Explain all yes answers in the "Comments" column. Include names and dates where appropriate.

| | Yes | No | Comments |
|---|---|---|---|
| Do you know of any reason why this individual should not participate in all sports? | | | |
| Has the individual been advised by a physician during the past year to restrict activity? | | | |
| Has the student ever had surgery? | | | |
| Has the student ever: | | | |
| been hospitalized? | | | |
| been unconscious? | | | |
| fainted? | | | |
| had frequent headaches? | | | |
| had convulsions? | | | |
| had numbness or tingling of face, arms, hands, legs, or feet? | | | |
| had chest pain? | | | |
| had shortness of breath? | | | |
| had enlarged liver or spleen? | | | |
| become weak or ill when exposed to high temperatures? | | | |
| Has the student ever had: | | | |
| head injury? | | | |
| neck injury? | | | |
| back pain? | | | |
| shoulder separation or dislocation? | | | |
| ankle sprain? | | | |
| knee trouble (including torn cartilage)? | | | |
| knee cap dislocation? | | | |
| broken bone or fracture? | | | |
| pulled ligament or ruptured tendon? | | | |
| swollen, dislocated, or painful joint? | | | |
| serious muscle injury or rupture? | | | |
| Does the student have loss or seriously impaired function of any paired organ? | | | |
| eye | | | |
| ear | | | |
| lung | | | |
| kidney | | | |
| testicle/ovary | | | |
| Does the student wear: | | | |
| glasses? | | | |
| contact lenses? | | | |
| dental braces? | | | |
| other? | | | |

_____ _____ _____ _____
**Parent/Guardian Signature** **Date** **Sports Candidate Signature** **Date**

# The Maryland School for the Blind

M.D. & Parent

## PART III – SCHOOL HEALTH ASSESSMENT
## Health Center - School Year 2016-2017

To be completed ONLY by Physician/Nurse Practitioner

| Student's Name (Last, First, Middle) | Birthdate (Mo. Day Yr.) | Sex ☐ M ☐ F |
|---|---|---|

1. Does the child have a diagnosed medication condition?

☐ No ☐ Yes _____

2. Does the child have a health condition which may require EMERGENCY ACTION while he/she is at school? (e.g. seizure, insect sting allergy, asthma, bleeding problem, diabetes, heart problem, or other problem) if yes, please DESCRIBE. Additionally, please "work with your school nurse to develop an emergency plan."

☐ No ☐ Yes _____

3. Evaluation Findings/CONCERNS

| Physical Exam | WNL | ABNL | COMMENTS | Health Area of Concern | YES | NO |
|---|---|---|---|---|---|---|
| Head | | | | Attention Deficit/Hyperactivity | | |
| Eyes | | | | Behavior/Adjustment | | |
| ENT | | | | Development | | |
| Dental | | | | Hearing | | |
| Respiratory | | | | Immunodeficiency | | |
| Cardiac | | | | Lead Exposure/Elevated Lead | | |
| GI | | | | Learning Disabilities/Problems | | |
| GU | | | | Mobility | | |
| Musculoskeletal/Orthopedic | | | | Nutrition | | |
| Neurological | | | | Physical Illness/Impairment | | |
| Skin | | | | Psychosocial | | |
| Endocrine | | | | Speech/Language | | |
| Psychosocial | | | | Vision | | |
| | | | | Other | | |

REMARKS: (Please explain any abnormal findings.)

| 4. Screenings | Results | Date Taken |
|---|---|---|
| Tuberculin Test | | |
| Blood Pressure | | |
| Height | | |
| Weight | | |
| BMI % tile | | |
| Lead Test | Optional | |
| | | |

5. Medical evaluation of students for participation in interscholastic athletics. May this student participate in the supervised activities listed?

| | Yes | No | Comments |
|---|---|---|---|
| Wrestling | | | |
| Swimming | | | |
| Goalball | | | |
| Cheerleading | | | |
| Track | | | |

6. Contact Sports

| | Yes | No | Comments |
|---|---|---|---|
| Risk of Retinal Detachment | | | |
| Long Duration of Intense Cardiovascular Activity | | | |
| Any Weight Bearing Restrictions: i.e., Lifting Weights | | | |
| Special Requirements for Sun Exposure | | | |
| Tumbling Activities | | | |
| Must Wear Eye Protection During Physical Activity | | | |

Student has had a complete history and physical examination at our office and has no evident health problem except as noted above.

_____ _____

**Physician/Nurse Practitioner Signature** **Date**

_____ _____ _____

**Physician/Nurse Practitioner (Print)** **Office Phone Number** **Office Fax Number**

CD/LB/MM/cic:4/11/16

MARYLAND STATE
SCHOOL MEDICATION ADMINISTRATION AUTHORIZATION FORM

M.D. & Parent

This order is valid only for school year (current) _____ including the summer session.

School: _____

This form must be completed fully in order for schools to administer the required medication. A new medication administration form must be completed at the beginning of each school year, 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.
* Non-prescription medication must be in the original container with the label intact.
* An adult must bring the medication to the school.
* The school nurse (RN) will call the prescriber, as allowed by HIPAA, if a question arises about the child and/or the child's medication.

Prescriber's Authorization

Name of Student: _____ Date of Birth: _____ Grade: _____

Condition for which medication is being administered: _____

Medication Name: _____ Dose: _____ Route: _____

Time/frequency of administration: _____ If PRN, frequency: _____

If PRN, for what symptoms: _____

Relevant side effects: ☐ None expected ☐ Specify: _____

Medication shall be administered from: _____ to _____
Month/Day/Year Month/Day/Year

Prescriber's Name/Title: _____
(Type or print)

Telephone: _____ FAX: _____

Address: _____

_____

Prescriber's Signature: _____ Date: _____
(Original signature or signature stamp only)

(Use for Prescriber's Address Stamp)

A verbal order was taken by the school RN (Name): _____ for the above medication on (Date): _____

PARENT/GUARDIAN AUTHORIZATION

I/We request designated school personnel to administer the medication as prescribed by the above prescriber. I/We certify that I/We have legal authority to consent to medical treatment for the student named above, including the administration of medication at school. I/We understand that at the end of the school year, an adult must pick up the medication, otherwise it will be discarded. I/We authorize the school nurse to communicate with the health care provider as allowed by HIPAA.

Parent/Guardian Signature: _____ Date: _____

Home Phone #: _____ Cell Phone #: _____ Work Phone #: _____

SELF CARRY/SELF ADMINISTRATION OF EMERGENCY MEDICATION AUTHORIZATION/APPROVAL

Self carry/self administration of emergency medication maybe authorized by the prescriber and must be approved by the school nurse according to the State medication policy.

Prescriber's authorization for self carry/self administration of emergency medication: _____ _____
Signature Date

School RN approval for self carry/self administration of emergency medication: _____ _____
Signature Date

Order reviewed by the school RN: _____ _____
Signature Date

2004

M.D. & Parent

# The Maryland School for the Blind

## PHYSICAL ACTIVITY FORM
## School Year 2016-2017

**Student Name:** _____ **Date of Birth:** _____

**Adapted Physical Education** - All students have Adapted Physical Education as part of their curriculum. Please indicate below if there are any medical reasons for exception.

Adapted Physical Education

(Example: Age appropriate skill development, fitness & activities) ☐ No exception

Exception: _____

Adapted Aquatics: goggles required for students with M.D. orders ☐ No exception

Exception: _____

Adapted Recreation (Example: Skiing, Bowling, Horseback Riding) ☐ No exception

Exception: _____

_____ _____ _____

Physician's Signature Date Physician Phone Number

_____ _____

Parent/Guardian Signature Date

CD/LB/cic:4/11/16

# The Maryland School for the Blind

## PHYSICAL ACTIVITY FORM
## School Year 2016-2017

**Student Name:** _____ **Date of Birth:** _____

**Adapted Physical Education** - All students have Adapted Physical Education as part of their curriculum. Please indicate below if there are any medical reasons for exception.

Adapted Physical Education
(Example: Age appropriate skill development, fitness & activities) ☐ No exception
Exception: _____

Adapted Aquatics ☐ No exception
Exception: _____

Adapted Recreation (Example: Skiing, Bowling, Horseback Riding) ☐ No exception
Exception: _____

**Extra-Curricular Activities**

MSB students compete against other visually impaired athletes in the Eastern Athletic Association for the Blind (EAAB) and occasionally other high schools from the surrounding area. Some of these activities are contact sports. A physical is required for all participation in these activities. The form for the physical exam is attached.

Cleared for participation in contact, competitive team sports (Example: Wrestling and Goalball)
_____Yes _____No

Cleared for all other non-contact, competitive team sports (Examples: Swimming, Cheerleading, Track/Field) _____Yes _____No

_____ _____ _____
Physician's Signature Date Physician Phone Number

_____ _____
Parent/Guardian Signature Date

- Swimming –Cushioned bumpers at each end of the pool to let swimmers know when they have reached the wall. Goggles required for all swimmers.
- Wrestling – Contact between both wrestlers maintained at all times.
- Cheerleading - Sequential/rhythmic movements, counting steps, forward rolls, minimal tumbling skills if/when applicable
- Track/Field – Distant runners run with a "guide runner" (sighted runner attached to the visually impaired runner by means of a tether held by both runners.) Runners competing in the dash events use "guide wires" and handles to navigate the distance. Counting steps and raised markers also aide the athlete in performing other events.
- Goalball – Goalball is a Paralympic team sport that is played exclusively by the visually impaired. All players are blindfolded during the game and use tactile markers on the floor to maintain their orientation. Goalball is a contact, fast pace game. Two teams of three players face each other on a court alternating rolling the ball and defending. The offensive team rolls the ball as hard as they can in an attempt to get the ball past the opposing players and across a goal line. The defensive team listens for the approach of the ball and attempts to block the ball with any part of their body from crossing the goal line. There are women's and men's teams, with no variations in equipment or rules.

# 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. _____

GUARDIAN 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 Mo/Yr |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 1 | | | | | | | | | 1 | | | | |
| 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

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

2. _____
Signature Title Date

3. _____
Signature Title Date

Lines 2 and 3 are for certification of vaccines given after the initial signature.

**LOST OR DESTROYED RECORDS:** **(Must be reviewed and approved by a medical provider or the local health department. See notes)**

I hereby certify that the immunization records of this child have been lost, destroyed or are unobtainable.

Signed: _____ Date: _____
Parent or Guardian

**COMPLETE THE APPROPRIATE SECTION BELOW IF THE CHILD IS EXEMPT FROM IMMUNIZATION ON MEDICAL OR RELIGIOUS GROUNDS. ANY IMMUNIZATIONS THAT HAVE BEEN RECEIVED SHOULD BE ENTERED ABOVE.**

**MEDICAL CONTRAINDICATION:**
The above child has a valid medical contraindication to being immunized at this time.

This is a ☐ permanent condition ☐ temporary condition until ____/____/____

Check appropriate box, indicate vaccine(s) and reasons: _____

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 immunizations being given to my child. This exemption does not apply during an emergency or epidemic of disease.

Signed: _____ Date: _____

# EARTH TREKS - WAIVER AND RELEASE OF LIABILITY AND ASSUMPTION OF RISKS

The individual named below desires: (a) to use or permit the use of one or more of the Earth Treks Climbing Centers (individually or collectively as the context may require, "Facility") located at - - (i) 7125-C Columbia Gateway Drive, Columbia, Maryland 21046, 725 Rockville Pike, Rockville, Maryland 20852, and/or 1930 Greenspring Drive, Timonium, Maryland 21093 (collectively, "Maryland Facilities"), and/or (ii) 700 Golden Ridge Road, Golden, Colorado 80401 ("Colorado Facility"); and/or (b) to participate in trips and/or climbing expeditions sponsored by or involving the following (individually or collectively as the context may require, "Earth Treks") - - (i) Earth Treks, Inc., Earth Treks Columbia Climbing Center, LLC, Earth Treks Timonium Climbing Center, LLC, Earth Treks Rockville Climbing Center, LLC, and/or Earth Treks Climbing Expeditions, LLC (collectively, "Maryland Entities"), and/or (ii) Earth Treks Golden LLC and/or Earth Treks Golden Climbing Center, LLC (collectively, "Colorado Entities"). In consideration for Earth Treks permitting me to use the Facility and permitting me to participate in the trips and/or climbing expeditions ("Trips"), I have agreed to execute this Waiver And Release Of Liability And Assumption Of Risks ("Release").

**WARNING BY EARTH TREKS**: There are significant elements of risk associated with climbing and any adventure, sport or activity associated with Earth Treks (individually, "Activity" and collectively, "Activities"). Although Earth Treks has taken reasonable steps to provide you with appropriate equipment and/or skilled instructors so you can enjoy each particular Activity for which you may or may not be skilled, we must remind you that each Activity is not without risk. Certain risks cannot be eliminated without destroying the unique character of the Activity. The same elements that contribute to the unique character of the Activity can be causes of accidental injury, illness, or in extreme cases, permanent trauma or death.

I acknowledge that using the Facility, participating in the Trips and participating in other Activities sponsored by Earth Treks involves certain inherent risks, including the risk of death or serious personal injury. I agree to assume all such risks, as well as any other risks involved in using the Facility, participating in the Trips or participating in any other Activity sponsored by or involving Earth Treks. I agree to release and discharge Earth Treks and all of its officers, directors, managers, members, employees, agents, and representatives, as well as all other persons or entities that may own, operate or manage each Facility, including but not limited to the respective landlord of each Facility, as well as any and all other persons or entities that might have any liability whatsoever to me (collectively, "Released Parties"), from and against any and all damages, actions, claims and liabilities, whether known or unknown, anticipated or unanticipated, suspected or unsuspected, relating to or arising from any Activity, occurrence or event involving the Facility, the Trips or Earth Treks. This Release is intended to release and discharge the Released Parties from all damages, actions, claims and liabilities of any nature, specifically including, but not limited to, damages, actions, claims and liabilities arising from or related to the negligence of the Released Parties. I further agree to indemnify, hold harmless and defend Earth Treks and each of the other Released Parties from and against any loss, damage, liability and expense, including costs and attorneys' fees, incurred by Earth Treks or any of the other Released Parties as a result of my using the Facility, participating in the Trips, or participating in any other Activity sponsored by or involving Earth Treks. In addition, I understand that wearing a helmet while climbing at the Facility or participating in a Trip is recommended. If I choose not to wear a helmet, I agree to assume all risk of personal injury and death that may occur as a result of not wearing a helmet.

Insofar as the Maryland Facilities and the Maryland Entities are concerned: (a) the laws of the State of Maryland shall govern the rights and obligations of the parties to this Release and the interpretation, construction and enforceability thereof; and (b) I agree that any lawsuit brought against any Released Parties shall be brought solely in the Circuit Courts for Howard County, Baltimore County or Montgomery County, Maryland. Insofar as the Colorado Facility and the Colorado Entities are concerned: (i) the laws of the State of Colorado shall govern the rights and obligations of the parties to this Release and the interpretation, construction and enforceability thereof; and (ii) I agree that any lawsuit brought against any Released Parties shall be brought solely in the District Court for the First Judicial District, Jefferson County, Colorado. This Release shall be effective upon my execution hereof and shall continue in force, unless sooner terminated pursuant to a written notice, for so long as I or (if applicable) my child or such other below-named individual use a Facility, participate in a Trip, or participate in any other Activity sponsored by or involving Earth Treks.

I acknowledge and agree that Earth Treks reserves the right to use any photograph taken at the Facility, on a Trip, or in connection with any other Activity involving Earth Treks to be used in Earth Treks' promotional materials, brochures and website.

**I HAVE READ AND I UNDERSTAND THE FOREGOING ACKNOWLEDGMENT OF RISK, ASSUMPTION OF RISK AND RESPONSIBILITY, AND RELEASE OF LIABILITY. I UNDERSTAND THAT BY SIGNING THIS FORM I MAY BE WAIVING VALUABLE LEGAL RIGHTS.**
**THIS RELEASE IS A BINDING LEGAL CONTRACT. PLEASE READ IT CAREFULLY BEFORE SIGNING** *** *Please print legibly.* ***

**Today's Date** _____ **Participant's Name** *(please print)* _____ **Participant's Date of Birth** _____

**Street Address** _____ **City** _____ **State** _____ **Zip Code** _____

**Home Telephone Number** _____ **Work Telephone Number** _____ **Cell Telephone Number** _____

**Signature of Participant** _____ **E-mail Address** _____

## TO BE SIGNED IF PARTICIPANT IS A MINOR

I represent that I am the parent or legal guardian of the above individual ("Participant") and I hereby consent to the Participant using the Facility, participating in Trips and participating in other Activities sponsored by Earth Treks. In consideration for Earth Treks allowing the Participant to use the Facility, participate in Trips and participate in the other Activities, I agree, personally and on behalf of the Participant, to be bound by the terms and conditions of this Release. I further agree to indemnify, hold harmless and defend Earth Treks and all other Released Parties from and against any loss, damage, liability and expense, including costs and attorneys' fees, incurred by Earth Treks or the other Released Parties as a result of the Participant using the Facility, participating in Trips, or participating in any other Activity involving Earth Treks.

**Today's Date** _____ **Printed name of Parent or Court-Appointed Legal Guardian** _____ **Signature of Parent or Court-Appointed Legal Guardian** _____

**Home Telephone Number** _____ **Work / Cell Telephone Number** _____

## EARTH TREKS CLIMBING CENTER (ETCC) - BOULDERING ORIENTATION

• Bouldering (un-roped climbing) is permitted at ETCC in designated bouldering areas, or no higher than 10 feet (head height) in areas designated for roped climbing.
• Bouldering involves increased inherent risks because **YOU WILL FALL**, and all falls are ground falls which could result in injury or death.
• Padded floors and crash pads (where present) mitigate risks, but do not and cannot guarantee prevention of injury or death. Improper pad placement can also cause injury or death.
• Many injuries occur when you fall near or at the top of the wall and / or when you miss the crash pad or hit an edge of a crash pad. To reduce your risk of injury:
o Down climb when possible instead of jumping off.
o Before each climb, ensure crash pads (where present) are positioned properly so that you land in the middle of the pad.
o Use a spotter to help position crash pads (where present) and ensure a clear landing zone.
• Keep Landing Zones Clear: Do not lounge on pads or walk under climbers. Remove all personal items (like water bottles) from landing zones. Be aware at all times because you could land on or be landed on by other participants.
• Proper Falling Technique Can Reduce Injuries:
o Stay relaxed – Keep your legs and arms slightly bent and ready to absorb impact. A tense body will result in more impact force throughout your body.
o Do not try to stay standing up – Trying to stay upright at all times will cause injuries. Absorb force by collapsing / rolling to the ground. Do not try to stop your fall with your hands.
• Ratings: Earth Treks rates the difficulty of boulder problems with the V-Scale (V-Intro, V1, V2, V3, etc) with V-Intro being the easiest.
• Top-Out Bouldering: Top out bouldering is permitted in designated areas only. Use designated descent paths / ladders only and descend slowly and carefully.
• New Climbers. Those who are new to bouldering should start with easier problems (V-Intro to V2) and avoid climbing the full height of the wall until they are more comfortable with the proper falling technique and how to utilize crash pads (where present).

## EARTH TREKS CLIMBING CENTER (ETCC) – FACILITY ORIENTATION

• All climbers and observers must check in at the front desk before proceeding to the padded climbing areas or fitness room.
• Climbing is inherently dangerous. Participants must assume the risks of climbing. All climbers, course participants, and individuals operating a safety system at ETCC must sign (or their parent/guardian must sign) ETCC's Waiver And Release Of Liability And Assumption Of Risks form.
• Double check your partner's safety system (Knots / Harness / Carabiners / Belay Device) before every climb!
• ETCC staff reserve the right to check safety systems at any time.
• Individuals desiring to top rope belay, lead belay, or lead climb at ETCC must take and pass the corresponding Belay Safety Check. Those individuals who do not pass or choose to not take the Belay Safety Check may not belay or tie knots, and must wait a minimum of 24hours before taking or re-taking the Belay Safety Check. Individuals who have passed the Lead Climb Check may borrow a lead rope at the front desk, or use a personal rope provided it's a single UIAA approved rope at least 40 meters in length. ETCC staff reserve the right to revoke belay privileges at any time.
• Climbing ropes must be tied directly to the climber's harness. Clipping the rope to the harness is prohibited.
• Weight differences between the climber and the belayer can greatly impact the safety of both individuals and all belayers must take responsibility for anchoring in from their harness to the appropriate floor anchor as needed.
• All persons using ETCC are expected to respect other individuals at ETCC and conduct themselves in good order. Persons deemed by ETCC staff to be behaving in an unsafe or disorderly fashion will be asked to leave the facility.
• **Youth**: Youth climbers under the age of 13 must be supervised by an adult (18 years or older) or by an ETCC staff member. Youth under the age of 14 are not permitted in fitness areas.

## ACKNOWLEDGEMENT

I acknowledge, for myself and any minor child or children on whose behalf I have signed ETCC's Waiver And Release Of Liability And Assumption Of Risks form ("Release"), that: (a) I have read the Release and I fully understand all of the terms of the Release; (b) I agree that nothing in the Bouldering Orientation and Facility Orientation unto which this Acknowledgement is attached shall be construed to alter, modify, or extinguish any element of the Release, or any agreement made by me thereunder; (c) I understand that I or such minor child or children identified as the "Participant" on the Release require orientation and/or training before participating in climbing and bouldering activities in an ETCC facility; (d) I understand that Earth Treks may require me to pass an assessment or assessments prior to allowing me or such Participant to participate in certain activities; (e) I understand that if I or such Participant need(s) additional assistance, orientation, instruction, training or assessment during my or such Participant's participation at an ETCC climbing facility at any future time, then it is my responsibility to seek such assistance, orientation, instruction, training or assessment from the Earth Treks staff prior to participating in any activity for which I am not, or such Participant is not, trained or qualified; and (f) my signature indicates that I understand the information and acknowledgments set forth above.

_____ _____

**Signature of Participant or Participant's Parent/Guardian if Participant is under 18** **Today's Date**

# I C.A.N. Foundation

## Application for Funds Needed

**Please be sure to provide all information requested, all four sections. Incomplete applications will be returned for missing information.**

**Section I**

Name: _____ Date: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone: _____

Email: _____

School you attend: _____ School Phone #: _____

Grade: _____ Braille Reader: _____ Large Print: _____

**Section II**

Amount being requested: $_____

Funds being used for: _____

_____

_____

**Section III**

Teacher of the Visually Impaired: _____
Name

TVI email: _____

TVI Phone: _____ TVI Signature: _____

**Section IV**

The student needs to submit a written paragraph explaining what the requested funds are going to be used for. What the student hopes to gain from the purchase of technology or scholarship funds. This can be in print or Braille. Please have the student as involved with this as their age and ability allows.

Please return this to:

I C.A.N. Foundation ● 99 Crimson Ave. ● Taneytown, Md. 21787 ● 410-756-1542

Outreach Short Course Summer Program/Camp Abilities

# Packing List

**Please label all items**

- ☐ Complete set of athletic clothing for 5 days, Monday –Friday-if residential (each week)
  (per MSB school policy - No short shorts, no spaghetti strap tank tops)
- ☐ Appropriate footwear, including tennis shoes, aqua shoes, socks
  (flip-flops for beach and pool areas only)
- ☐ Sleepwear, including robe & slippers if residential
- ☐ Laundry bag
- ☐ Swim suit\ beach towel
- ☐ Sweater or light jacket and 1 pair of long pants
- ☐ Raincoat/poncho or umbrella
- ☐ Sunglasses
- ☐ High SPF Sunscreen / Bug spray or repellent
- ☐ Cane – please bring even if not regularly used every day.
- ☐ Any low vision or braille devices you may use
- ☐ Hat with a brim or visor
- ☐ Reusable Water bottle

Personal care items including:

- ☐ Toothbrush-toothpaste-plastic cup
- ☐ Soap/Body Wash
- ☐ Deodorant
- ☐ Shampoo/Conditioner/ hair dryer
- ☐ Comb/brush
- ☐ Items for feminine hygiene if needed
- ☐ Small basket to organize care items

Optional:

- ☐ Disposable camera
- ☐ Cell phone (check handbook for rules)
- ☐ Ear plugs
- ☐ Pillow
- ☐ Spending money (child will be responsible for care of own money)
- ☐ Favorite snack