



Wicomico County Recreation, Parks & Tourism

Camp Adapt- A Special Needs Camp, 2026

\*Location: Beaver Run School\*

Participant's Name: \_\_\_\_\_

Ages: 5-21

Monday – Thursday; 9am-3pm

Camp: June 25<sup>th</sup> – July 31<sup>st</sup>

Open House: June 24<sup>th</sup> 1-3 pm

Field Trips are TBD

**Folder Checklist: Program Director to Complete this Section**

- \_\_\_\_\_ Youth Camp Health History: Camper Form MDH 4768 Completed and Signed (page 16)
- \_\_\_\_\_ Immunization Certificate: Form MDH Form 896 Complete & Signed/Stamped by Doctor's Office (page 18)
- \_\_\_\_\_ Authorized Persons to Pick-Up listed (page 2)
- \_\_\_\_\_ Emergency Contacts listed (page 2)
- \_\_\_\_\_ Date of Child's Last Tetanus Shot (page 4)
- \_\_\_\_\_ BIP, 504 Plan and/or IEP Paperwork (if applicable) (page 5)
- \_\_\_\_\_ Payment Received
- \_\_\_\_\_ \* **"Additional Medical Paperwork"** (REQUIRED If Applicable Based on Questions Below)

**\*MEDICAL QUESTIONS**

**Parent/guardian** to use "MEDICAL QUESTIONS" below to determine if the additional medical paperwork is required for child to participate.

- 1) Does your child have a severe allergy (other than seasonal)?    Yes    No
  - 2) Does your child have a medical condition or health concerns?    Yes    No
  - 3) Does your child have asthma?    Yes    No
  - 4) Does your child have diabetes?    Yes    No
  - 5) Does your child have a history of seizures?    Yes    No
  - 6) Will your child require medication during program hours? This includes but is not limited to "As Needed" medications such as Inhalers, Epi Pens, Seizure meds and/or OTC meds. Also, including but not limited to "Daily Medications" such as ADHD meds and Insulin?    Yes    No
- If YES, how many medications will be required while in our care? \_\_\_\_\_

**Parent/Guardian:**

"I have reviewed, completed and signed off on ALL of the documents above and enclosed them in this registration folder. I understand that if the appropriate paperwork has not been received, my child's start date will be delayed and/or place in the program may be forfeited".

Parent/Legal Guardian's Name (Print): \_\_\_\_\_

Parent/Legal Guardian's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**Parent/Guardian Information**

1) Mother/Guardian Name: \_\_\_\_\_  
 Street Address: \_\_\_\_\_  
 City/State: \_\_\_\_\_ Zip: \_\_\_\_\_  
 Home Phone: \_\_\_\_\_ Work Phone \_\_\_\_\_ Cell: \_\_\_\_\_  
 Email: \_\_\_\_\_  
 Employer: \_\_\_\_\_

2) Father/Guardian Name: \_\_\_\_\_  
 Street Address: \_\_\_\_\_  
 City/State: \_\_\_\_\_ Zip: \_\_\_\_\_  
 Home Phone: \_\_\_\_\_ Work Phone \_\_\_\_\_ Cell: \_\_\_\_\_  
 Email: \_\_\_\_\_  
 Employer: \_\_\_\_\_

➔ Marital Status of Parents: \_\_\_\_\_ Single \_\_\_\_\_ Married \_\_\_\_\_ Separated \_\_\_\_\_ Divorced

If separated/divorced, which parent has custody? \_\_\_\_\_

Is there a problem with either parent visiting, talking with or picking up participant? \_\_\_\_\_ Yes \_\_\_\_\_ No

If yes, please explain: \_\_\_\_\_  
 \_\_\_\_\_

**AUTHORIZED PICK-UP INFORMATION**

**Your child will be released only to the following in addition to the parent/guardian:**

NAME	PHONE NUMBER(S)	RELATIONSHIP TO CHILD

**\*\*Please let those authorized to pick up (parents included) know they will need to bring their state issued identification each & every time the child is picked up. The child will not be released to anyone without it! Once staff gets to know these individuals it may not be needed. If you need to add or remove someone on this list, please contact the Site Director,**

**In the event of an Emergency and you cannot be reached, list two individuals' staff may contact:**  
**Individuals listed as emergency contacts also have permission pick up the child**

1. Name (print): \_\_\_\_\_ Cell: \_\_\_\_\_ Work: \_\_\_\_\_  
 Full Address: \_\_\_\_\_  
 Relationship to child: \_\_\_\_\_

2. Name (print) \_\_\_\_\_ Cell: \_\_\_\_\_ Work: \_\_\_\_\_  
 Full Address: \_\_\_\_\_  
 Relationship to child: \_\_\_\_\_

**EMERGENCY CARE CONSENT FORM**

In case of illness or accident while my child is under the care and supervision of the Wicomico County, Maryland, I the undersigned, hereby consent to Wicomico County, Maryland authorized staff to provide emergency first aid and/or administer emergency care and/or treatment through a clinic, a doctor and/or hospital should they feel it is advisable or necessary.

I also agree to pay all of the cost and fees contingent upon an emergency medical care and/or treatment for my child as secured or authorized under this consent.

This agreement shall continue as long as the participant is registered in any Wicomico County, Maryland program.

Camper's Name (Print): \_\_\_\_\_ DOB: \_\_\_\_\_

Camper's Physician (print) \_\_\_\_\_ Physician's Phone #: \_\_\_\_\_

Physician's Address: \_\_\_\_\_  
(street address)

\_\_\_\_\_ (city) \_\_\_\_\_ (state) \_\_\_\_\_ (zip)

Are your child's medical records located at this Physician's office: Yes No

If NO, please list location of child's medical records: \_\_\_\_\_

Hospital Preference Name (MUST HAVE): \_\_\_\_\_

Hospital Preference Phone #: \_\_\_\_\_

Parent/Legal Guardian's Name (Print): \_\_\_\_\_

Parent/Legal Guardian's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**ABOUT YOUR CHILD**

Camper's Name (print) \_\_\_\_\_ DOB \_\_\_\_\_

Camper's age as of 6.25.2026: \_\_\_\_\_ Gender: \_\_\_\_\_ Male \_\_\_\_\_ Female

Camper's Primary Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Public School Currently Attending: \_\_\_\_\_

Person Completing this Form: \_\_\_\_\_

Relationship to Camper: \_\_\_\_\_

Health Insurance Company: \_\_\_\_\_

Health Insurance Company's Phone \_\_\_\_\_ Policy# \_\_\_\_\_

Language(s) Spoken at Home? \_\_\_\_\_

Preferred Recreational Activities? \_\_\_\_\_

Non-preferred Recreational Activities? \_\_\_\_\_

Motivator's? \_\_\_\_\_

**Campers Medical Information**

1) Does your child have an allergy? \_\_\_\_\_ Yes \_\_\_\_\_ No

If yes, what kind? What are the signs and symptoms? Treatment? \_\_\_\_\_

2) Is an epi-pen used to treat the allergy? \_\_\_\_\_ Yes \_\_\_\_\_ No

3) Does your child have a history of seizures? \_\_\_\_\_ Yes \_\_\_\_\_ No

Type of seizure: \_\_\_\_\_ Date of last seizure: \_\_\_\_\_

Time duration of last seizure: \_\_\_\_\_

Camper's Name: \_\_\_\_\_

4) Does your child have asthma?  Yes  No

If yes, what kind? What are the signs and symptoms? Treatment?

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5) Is an inhaler used to treat the asthma?  Yes  No

6) Will breathing treatments of any sort need to be administered while attending camp?  Yes  No

7) Is your child diabetic?  Yes  No

Is insulin taken?  Yes  No If yes, what kind? What are the signs and symptoms? Treatment?

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8) Does your child take any medication(s)?  Yes  No If yes, what are the names of the medication(s)? Dosage(s)? Reason(s) why child takes the medication(s)? \_\_\_\_\_

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9) Does your child have a special diet or any diet restrictions (pureed, tube fed, nothing by mouth, etc.)?

Yes  No If yes, what kind? What are the signs and symptoms? Treatment? \_\_\_\_\_

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10) Are there any other specific medical problems we need to be aware of?  Yes  No

If yes, please explain: \_\_\_\_\_

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11) Does your child have any diagnosis/diagnoses we should also be aware of?  Yes  No

If yes, please explain: \_\_\_\_\_

Is your child exempt from immunizations for religious or medical reasons?  Yes  No

If yes, please explain \_\_\_\_\_

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12) Is your child bothered by the heat?  Yes  No

If yes, please explain \_\_\_\_\_

13) Does your child have specific fears?  Yes  No

If yes, please explain \_\_\_\_\_

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14) Date of last tetanus shot (**MUST HAVE DATE**): \_\_\_\_\_ **Do not leave blank; Do NOT write "see shot record"!**

Camper's Name (print) \_\_\_\_\_

**Please check or fill in ANY of the following that apply?**

<input type="checkbox"/> Wears glasses	<input type="checkbox"/> Dresses self independently
<input type="checkbox"/> Wears hearing aides	<input type="checkbox"/> Needs help with dressing
<input type="checkbox"/> Wears braces on legs, arms (Circle which)	<input type="checkbox"/> Must be dressed
<input type="checkbox"/> Uses Wheelchair: manual or electric (Circle which)	<input type="checkbox"/> Follows a special diet
<input type="checkbox"/> Uses crutches or walker	<input type="checkbox"/> Feeds self independently
<input type="checkbox"/> Needs assistance with walking	<input type="checkbox"/> Needs help with feeding
<input type="checkbox"/> Has speech impediment	<input type="checkbox"/> Must be hand fed
<input type="checkbox"/> Uses sign language	<input type="checkbox"/> Requires Tube Feedings
<input type="checkbox"/> Menstruates	<input type="checkbox"/> Self - Toilets
<input type="checkbox"/> Has a one-on-one assistant during the school year	<input type="checkbox"/> Needs assistance with Toileting
<input type="checkbox"/> Uses harness on bus	<input type="checkbox"/> Wears diapers or pull-ups
<input type="checkbox"/> Elopes (leaves w/o permission)	

**Health History:** (add comments)

Vision \_\_\_\_\_

Hearing \_\_\_\_\_

Speech \_\_\_\_\_

Heart \_\_\_\_\_

Breathing \_\_\_\_\_

Digestion \_\_\_\_\_

Elimination \_\_\_\_\_

Behavioral \_\_\_\_\_

Thinking/Cognitive \_\_\_\_\_

Balance \_\_\_\_\_

Orthopedic \_\_\_\_\_

Muscular \_\_\_\_\_

Neurologic \_\_\_\_\_

Skin \_\_\_\_\_

Pain \_\_\_\_\_

**Additional Comments** \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**Behavior Management**

1) Does your child have a BIP, 504 or IEP? \_\_\_Yes\_\_\_ No

**Children enrolled in Camp Adapt MUST have an BIP, 504, or IEP plan. Without this paperwork, your child cannot attend camp!**

2) Is your child enrolled in a Special Education Program? \_\_\_Yes\_\_\_ No

If yes, what is their Special Education Classification? \_\_\_\_\_

3) Does your child elope/run/leave classroom on his/her own without permission? \_\_\_Yes\_\_\_ No

If yes, how frequently? \_\_\_\_\_

\_\_\_\_\_

Camper's Name (print) \_\_\_\_\_

**Participant Modification Information (PMI)**

*If anything is "not applicable" please write "N/A" in any comments sections. Also, if at any time you need more room to comment, please use the "Recommendations for Support" sections on page 10.*

Communication Methods	Check if applicable	Comments
Spoken Voice	<input type="checkbox"/>	
Sign Language (ASL or SEE)	<input type="checkbox"/>	
Augmentative and Alternative Communication Device	<input type="checkbox"/>	
Other:	<input type="checkbox"/>	

Using preferred method of communication, he/she can:	Independently	With Partial Assistance	With Total Assistance	Comments
Communicates clearly in all domains (can be understood)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Requests help with a task	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Communicates personal needs (bathroom, hunger, pain, etc.)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	

Social	Independently	With Partial Assistance	With Total Assistance	Comments
Socially interacts with peers	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Initiates conversation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Maintains conversation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<i>Please list preferred topics of conversation:</i>
Respects personal space	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Shares with others	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Allows other(s) to take turns	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	

Behavioral Cues		
Please check any of the following types of triggers that staff should be aware of in order to provide proactive support.		
<input type="checkbox"/> Transitions	<input type="checkbox"/> Sharing	<input type="checkbox"/> Noise
<input type="checkbox"/> Being told "No"	<input type="checkbox"/> Touch	<input type="checkbox"/> Large Space
<input type="checkbox"/> Small Space	<input type="checkbox"/> Authority	<input type="checkbox"/> Not getting their way
<input type="checkbox"/> Unannounced change in schedule or routine	<input type="checkbox"/> Light	<input type="checkbox"/> Temperature
<input type="checkbox"/> Certain time of day	<input type="checkbox"/> Heights	<input type="checkbox"/> Other
Comments		
Please use the space below to share any additional information about what you have checked above.		

Camper's Name (print) \_\_\_\_\_

Behavior	Independently	With Partial Assistance	With Total Assistance	Comments
Uses appropriate language	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Keeps hands and feet to self	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Uses supplies and/or equipment properly	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Respects authority	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Helps with a task when asked	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Can cope with being told "no"	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Interacts positively with peers	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Likes to try new activities	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Can stay on task for a preferred activity for 10+ minutes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Can stay on task for a <b>NON</b> -preferred activity 10+ minutes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	

Activities of Daily Living	Independently	With Partial Assistance	N/A	Describe assistance needed (Leave blank if N/A)
Uses a wheelchair or other mobility device(s)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Ability to transfer to and from wheelchair or other mobility devices(s)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Walking	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Stairs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Uneven ground	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Eating	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Dressing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Undressing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Recognizes the need to use restroom	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Uses the restroom	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<i>If you indicated that assistance is needed, we will send you a toileting permissions form.</i>
Other				

Participant can:	Independently	With Partial Assistance	With Total Assistance	Comments
Follows 1-step directions	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Follows 2-step directions	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Follows multi-step directions	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Please let us know if your participant learns best visually, with physical prompting, etc.				

Camper's Name (print) \_\_\_\_\_

### Recreation

Please check all that can be done independently and provide any additional supports needed in comments section.

<b>Aquatics</b>	<input type="checkbox"/> walks on pool deck and once in pool water, can walk	<input type="checkbox"/> Responds to lifeguard whistle	<input type="checkbox"/> comfortable in water	<input type="checkbox"/> face in water	<input type="checkbox"/> Holds breath for 3-5 seconds	Comments:
	<input type="checkbox"/> Can float	<input type="checkbox"/> Swim	<input type="checkbox"/> Treads water	<input type="checkbox"/> Jumps from side	<input type="checkbox"/> Jumps from diving board	Comments:
<b>Movement</b>	<input type="checkbox"/> Balances when standing	<input type="checkbox"/> Balances when walking	<input type="checkbox"/> Can jump with two feet	<input type="checkbox"/> Can hop on one foot	<input type="checkbox"/> Can tumble/roll	Comments:
<b>Art</b>	<input type="checkbox"/> Holds writing utensil	<input type="checkbox"/> Uses scissors appropriately	<input type="checkbox"/> Uses glue appropriately	<input type="checkbox"/> Knows colors	<input type="checkbox"/> Comfortable being messy	Comments:
<b>Sports</b>	<input type="checkbox"/> Catch a ball	<input type="checkbox"/> Kick a ball	<input type="checkbox"/> Hit a target (aim)	<input type="checkbox"/> Run	<input type="checkbox"/> Uses sports equipment as intended	Comments:
<b>Other</b>						

Camper's Name (print) \_\_\_\_\_

Safety Awareness	Independently	With Partial Assistance	N/A	Comments
Will stay with the group during an activity	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Will stay with the group during transition	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Will stay with the group during downtime	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Recognizes danger	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Can safely cross a busy street	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Is safe with self and others	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Can communicate name and phone #	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<i>Please explain preferred method of communicating this information:</i>
<b>For participants with a Road ID, Project Lifesaver tracker or other service:</b>				
Name of tracking device:		ID#:		
Who to contact:		Other information:		

<b>Recommendations for Support</b>		
Please check <b>all</b> that apply:		
<input type="checkbox"/> Social stories	<input type="checkbox"/> Verbal prompts	<input type="checkbox"/> Physical prompts
<input type="checkbox"/> Hand over/ under hand prompting	<input type="checkbox"/> Modeling	<input type="checkbox"/> Peer buddy
<input type="checkbox"/> Visual cues	<input type="checkbox"/> Visual schedule	<input type="checkbox"/> Timer
<input type="checkbox"/> Incentives	<input type="checkbox"/> Other:	
<b>Comments</b>		
Please use the space below to make us aware of anything else that will help best support your participant such as supports being used at school and/or at home.		

**For Therapeutic Recreation Office Use Only**

The information provided above will be used to create a modification plan below that will be shared with staff to help facilitate a positive recreational experience for your child.

**General Goals:**

- To develop appropriate social interactions with peers and staff.
- To positively participate in activities while remaining on task for 5-10 minutes.
- To develop effective ways to manage emotions with appropriate coping skills.
- To respond to verbal and non- verbal staff instructions the first time they are given.

To best support participant in a recreational setting staff will:

**Acknowledge and Certification**

The information provided will assist the camp staff in caring for your child. If there are any changes, please notify the Program Administrator, Megan Jones, [jonesrm@wicomicocounty.org](mailto:jonesrm@wicomicocounty.org)

We make every effort to maintain confidentiality. By signing below, you are indicating that the information provided in this registration packet is accurate and you are granting Wicomico County Recreation and Parks Permission to share the following information (electronically or verbally) with any pertinent staff. I hereby certify that I am the parent or legal guardian of (print child's name) \_\_\_\_\_ and I attest that the information provided in this registration packet is true and accurate to the best of my knowledge and belief.

Parent/Guardian's Printed Name: \_\_\_\_\_

Parent/Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_

## SOCIAL MEDIA/ PHOTO RELEASE

Wicomico County, Maryland may photograph or record your son/daughter during programs and activities. You understand and agree that these materials become the sole property of Wicomico County, Maryland.

You hereby irrevocably authorize Wicomico County, Maryland to use your son/daughter's likeness in photographs, video images, or other digital reproductions (collectively the "likenesses") for educational, informational, public relations, or other lawful purposes, including but not limited to within its publications, website, social media and print content, and further authorize Wicomico County, Maryland to edit, alter, copy, exhibit, publish or distribute the likenesses. In addition, you irrevocably waive your right to inspect or approve the finished product, including written or electronic copies, wherein your child's likeness appears.

On behalf of your son/daughter named below, you waive the right to royalties, other compensation, or other considerations arising from or related to the use of the likenesses.

You hereby hold harmless and release and forever discharge Wicomico County, Maryland from all claims, damages, demands, and causes of action which you, your son/daughter, or either of your heirs, representatives, executors, administrators or other persons acting on your behalf or on behalf of your estate, have or may have by reason of such likenesses.

By signing below, I represent that I am the lawful parent or guardian of the son/child named below, have authority to execute this agreement on your son/daughter's behalf, and I understand and agree to the terms and conditions outlined in the paragraphs above.

Camper's Name (print): \_\_\_\_\_

Parent/Legal Guardian's Name (Printed): \_\_\_\_\_ Yes \_\_\_ No \_\_\_

Parent/Legal Guardian's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

## PERMISSION FOR TRIPS, EXCURSIONS AND USE OF PUBLIC PARKS AND FACILITIES

I hereby give consent to Wicomico County, Maryland to take (print CHILD'S NAME) \_\_\_\_\_ on walking or transported field trips to places of interest, including public parks, with the understanding that such trips are under the supervision of authorized Summer Day Camp personnel and that all possible precautions are taken to ensure the health and safety of my child.

Additional permission slips will be required for specific summer camp transported field trips, which will include. Permission slips will include specifics of each trip. In order to attend, child must be registered for camp, have the additional permission slip signed and pay any additional field trip (if applicable). Trips are not guaranteed and subject to cancellation due to COVID restrictions.

Parent/Legal Guardian's Name (Printed): \_\_\_\_\_ Yes \_\_\_ No \_\_\_

Parent/Legal Guardian's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

## PERMISSION TO APPLY SUNBLOCK

I hereby give permission to Wicomico County, Maryland and the Camp Adapt staff to apply sunblock to my son/daughter (print CHILD'S NAME) \_\_\_\_\_. List sunblock preference here \_\_\_\_\_.

Parent/Legal Guardian's Name (Printed): \_\_\_\_\_ Yes \_\_\_ No \_\_\_

Parent/Legal Guardian's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

## PERMISSION TO SWIM & PARTICIPATE IN OTHER WATER ACTIVITIES

I hereby give consent to Wicomico County, Maryland to take (print CHILD'S NAME) \_\_\_\_\_ on trips to the pool. I also give Wicomico County permission for my child to participate in other activities that involve water. I have the understanding that in addition to water related field trips, my child will be participating in water related activities on a daily basis. I also have the understanding that such trips and daily water activities are under the supervision of authorized Summer Day Camp personnel and that all possible precautions are taken to ensure the health and safety of my child. Parents will be notified what day and time trips to the pool are scheduled. Trips are not guaranteed & subject to cancellation due to COVID restrictions.

Parent/Legal Guardian's Name (Printed): \_\_\_\_\_ Yes \_\_\_ No \_\_\_

Parent/Legal Guardian's Signature: \_\_\_\_\_

Date: \_\_\_\_\_

## WAIVERS

### **MEDICAL INFORMATION WAIVER:**

Please list clearly any medical conditions or medications taken that would affect participant's involvement in this program:

\_\_\_\_\_

\_\_\_\_\_

May the Program Director call to discuss this accommodation (if needed)? Yes \_\_\_\_\_ No \_\_\_\_\_

### **CONCUSSION WAIVER:**

In compliance with Maryland HB 858 and SB 771, I hereby acknowledge that I have received the information regarding concussions published by the United States Department of Health and Human Services Centers for Disease Control and Prevention (CDC).

For additional information I understand that I may call 1-800-232- 4636 or go to [www.cdc.gov/concussioninyouthsports](http://www.cdc.gov/concussioninyouthsports).

### **GENERAL WAIVER:**

In consideration of the execution of a similar contract by all persons participating in this program/league, I hereby I agree to abide by all rules, uphold the principles of sportsmanship and fair play, and abide by the County Code of Conduct. I further agree that the medical information given above is correct.

The undersigned do hereby expressly stipulate and agree to indemnify and hold forever harmless Wicomico County and the Wicomico County Department of Recreation, Parks and Tourism, its agents, officers and employees, against loss from any and all claims, demands, or actions in law or equity that may hereafter at any time be made or brought by the participant listed above, or by anyone on behalf of said participant for the purpose of enforcing a claim for damages on account of any injuries received or sustained by the participant arising out of his participation in the program.

In signing this Release and Hold Harmless Agreement, each of the undersigned hereby acknowledges and represents that they are aware of the risks and hazards inherent in participating in the program including exposure to the potential risk of concussion. No insurance covering accident or injury has been provided for participants. Arrangements for any such insurance would have to be made individually by the undersigned, and at no time will my participation in a program be contingent on divulging any confidential medical information.

### **COVID-19 WAIVER:**

COVID-19 Protocols continue to evolve. Wicomico County Recreation and Parks will follow guidance from the State of Maryland and local health officials. Initial protocols if any will be available to parents prior to the start of camp and have the potential to change over the course of camp.

### **PAYMENT ACKNOWLEDGEMENT WAIVER:**

Once you have turned in to the Civic Center Box Office your fully completed registration packet, there are three ways to secure a spot in camp:

- Pay full camp payment (\$475), OR
- Proof of a Wicomico County Recreation & Parks Scholarship and remaining balance for camp paid by deadline given. Our scholarship funds are for Wicomico County residents only, are income based, first come first served & require a fully completed scholarship application with all supporting documentation. Wicomico County Recreation & Parks Scholarship applications can be found by visiting: <https://www.wicomicorecandparks.org/programs/camp-adapt--a-special-needs-camp> OR
- A letter from an outside organization such as Wicomico County Health Department, Bay Shore Services, etc., specifying the amount they have agreed to pay on your behalf including the organizations contact information (signed & on company letterhead). This letter should be submitted together with your fully completed registration packet to the Civic Center Box Office. Any remaining camp balance must also be paid if the organizations funding doesn't cover the entire cost of camp.

*\*Failure to complete one of the 3 options above may result in the loss of your child's spot in the program.\**

Payment and registration for camp must be made in person at the Civic Center Box Office M-F 9am-6pm.

### **SNACK & NON-PERISHABLE FOOD ACKNOWLEDGEMENT WAIVER:**

Non-perishable is defined as a food item that can be consumed safely without refrigeration. Participants will not have access to refrigerators, microwaves, can openers, or any other appliances. Utensils will not be provided.

Parent/legal guardian understands and agrees to supply non-perishable food for their child (breakfast, lunch, snack if not utilizing what camp provides) and on any days Camp Adapt staff requests.

***By signing, I understand and agree with all waiver information in this registration packet.***

Participant's Name (printed): \_\_\_\_\_

Parent/Legal Guardian's Name (print): \_\_\_\_\_

Parent/Legal Guardian's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

# Behavior/Discipline Contract

PLEASE KEEP A COPY FOR YOURSELF

To our new and old participants and their families, we welcome you to our program. We are looking forward to an exciting experience! This document is a behavior and discipline agreement. You are receiving this document so that you and your child(ren) can become familiar with our rules and consequences. Once you, the Parent/Legal Guardian have signed this slip, we will then consider this a contract between you, our staff, and your child.

The following are our rules that have been established for the safety and enjoyment of our program.

## Rules:

1. Show respect to staff and students at all times.
2. Follow all directions the first time they are given.
3. Keep hands, feet and unkind words to yourself.
4. Stay with your group and ask permission to leave your area.
5. Use walking feet in all areas within the building; except when given permission to run in the gym.
6. Remain seated and quiet during snack/homework time.
7. Be honest and responsible.
8. Have fun!

## If a Participant Chooses to Break A Rule:

→ 1<sup>st</sup> and 2<sup>nd</sup> Offenses: **Verbal Warnings for MINOR OFFENSES**. (staff will be specific with student when warning)

- **Second time you verbally warn** a student, a time out should be enforced. Time out = no longer than the # of years old they are (ex: 5-year-old time out = 5 minutes or less).

→ 3<sup>rd</sup> Offense: **YELLOW WRITE UP AND REMOVAL FROM ACTIVITY**

- Repeatedly disrespecting staff and others (after multiple verbal warnings and a time out).
- Repeatedly disregarding the rules (after reviewing the rules and verbal warnings).
- Depending on the situation; hitting others (staff will get all sides of the story from all parties involved & dependable witnesses—this could potentially be a red write up).

→ 4<sup>th</sup> Offense: **RED WRITE UP, PHONE CALL HOME & DONE PARTICIPATING FOR THE DAY**

**A Severe Disruption:** Is an automatic **RED Write-Up**

- **A Severe Disruption** or misbehavior includes but is NOT limited to:
  - Threatening to hurt others or physical violence with another student or staff member
  - Cursing/Inappropriate language.
  - Misuse of equipment (destruction of property)
  - Blatantly disobeying rules/directions after repeated verbal warnings, a time out, and a yellow write-up with removal from activity.
  - Depending on the situation; putting hands on another student--(staff will get all sides of the story from all parties involved & dependable witnesses— this could potentially be a yellow write up).
  - Purposefully attempting to run away from the site or leave the immediate area where staff is present.
  - Bullying of ANY kind!!!

*\*Staff may change the color of a write up (Behavior/Discipline Conduct Report) or may write up a behavior not listed above depending on the situation. Write ups are subject to review by the Program Director and suspension or removal from the program may be determined. Parent/Legal Guardian must sign this Behavior/Discipline Contract prior to participant attending. Parent/Legal Guardian signature represents understanding, and agreement of our Behavior/Discipline policy.*

**\*\*When we are having behavioral issues with a camper we will discuss issues with the adults at pickup or by phone. We will work together to develop a plan to direct the camper back toward more positive behavior.**

**Bullying of ANY kind will not be tolerated!** We define bullying as (but not limited to) physically intimidating or hurting another child or staff member, repeatedly calling names or taunting others after being asked to stop, targeting with the intention of excluding students from group activities, and/or taking a student or staff's personal belongings.

**\*\* Any severe disruption or misbehavior will be written up immediately and is susceptible to suspension from the program. Depending on the severity of the behavior, the parent may be called to have the child removed for the remainder of the day.**

Any child that receives 2 or more Red Write-ups is at the risk of being suspended from the program for a day (without a refund). If behavior continues and the campers earns a 3<sup>rd</sup> Red Write-up, they will be at risk of removal from the program.

**Please review these expectations and penalties with your child. Parent & staff director signatures and dates are required below.**

**Camper's Name (print):** \_\_\_\_\_

**Parents:** "My child has discussed the discipline plan with me. We understand it and will support it."

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**Site Director:** "We will be fair and consistent in executing the discipline plan."

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

WICOMICO COUNTY DEPARTMENT OF RECREATION, PARKS AND TOURISM

**Parent Contract**

**PLEASE KEEP A COPY FOR YOURSELF**

Please review the information below to ensure you understand your responsibilities in enrolling your child in a Wicomico County Recreation, Parks and Tourism Summer Day Camp Program. Camper's Name: \_\_\_\_\_

1. **ALL PAPERWORK (registration packet, vaccination records, and Medication Administration Authorization Form if applicable) IS DUE AT THE TIME OF REGISTRATION! Having a doctor's appointment in lieu of the paperwork is not acceptable (no exceptions).**
2. Camp registration fee for all 6 weeks of camp is \$550. Registration must be received in person at the Civic Center Box Office M-F 8am-5pm.
3. Payment in full is due whether a camper chooses to attend 0-4 days per week. **Refunds will not be given once registered.**
4. **Camp Adapt 2026 will operate: June 25<sup>th</sup> – July 30<sup>th</sup> 2026 (M-Thurs 9am-3pm).** \_\_\_\_\_
5. **Open House is scheduled for: June 24<sup>rd</sup> 12-3 pm**
6. Our camps are electronic free zones. Cell phones, tablets, gaming devices & any other electronics will not be allowed (exception: communication devices and those needed for positive reinforcement). Staff reserves the right to hold on to any items brought from home that are a disruption and will be returned to parent/guardian at pickup.
7. Wicomico County Recreation and Parks is NOT responsible for lost, damaged, or stolen property. Participants should leave personal items at home.
8. If your child breaks or damages equipment that belongs to the Wicomico County Board of Education, Wicomico County Recreation, Parks and Tourism, another entity or another participant, the parent is responsible for the repair or replacement costs.
9. Camp Adapt ends promptly at 3:00pm. Pickup by parents/guardians after 3:00pm is considered LATE. If late, be prepared to pay the late pickup charge of \$1.00 per minute for every minute past 3:00pm you are late. Payment for late pickup is expected at the time of pick up that day and can be paid by exact cash, credit card or check (made out to Wicomico County).
10. Repeated late pickup may result in removal from camp. Refunds will NOT be made.
11. Parents/guardians requesting a conference with camp staff, must schedule in advance and it must be during regular camp hours (not before or after camp hours).
12. In the event camp must close early, the parent/guardian is responsible for picking the child up at the newly designated dismissal time. Staff will contact parent/guardian regarding early dismissal asap. However, an early closure could be a last-minute decision based upon the circumstances requiring the early closure.
13. In the event camp must close, staff will contact parent/guardian asap prior to the closing. However, the closing could be a last-minute decision based upon the circumstances requiring the closing.
14. Bullying and/or threats of violence from parent/guardians and/or campers will not be tolerated and are grounds for immediate suspension and/or permanent removal from camp! Refunds will NOT be made.
15. If the parent/guardian's behavior patterns threaten their own health and safety and/or that of other children,
  - a. parents and staff, you will be asked to withdraw your child from summer camp. Refunds will NOT be made.
16. Your child may be suspended and/or permanently removed from camp if their behavior patterns threaten their own health & safety or that of other children, parents & staff. Refunds will NOT be made.
17. It is the Program Directors decision to suspend and/or permanently remove campers!
18. **If your child has an illness not related to Covid-19 but that causes a fever or vomiting, your child must be symptom free for 24 hours before they can return. Other/unknown illnesses at camp will be handled based on the advice of the Health Supervisor.** Your child CANNOT attend the program if he or she has any illness that threatens the health of other children or staff. COMAR Regulations concerning periods of infection will be enforced.
19. **In order for any camper to attend camp, parents/guardians must agree to follow and abide by all COVID-19 protocols and procedures put into place.**

20. **If your child becomes ill during program hours, it is the responsibility of the parent/guardian to arrange immediate pick up from the program. The Program Director will discuss protocols and when the child can return to camp.**
21. If your child is found to have lice, they will be sent home immediately. Your child will not be allowed to return until they are lice and nit free and you must supply a doctor's note or the box of the given treatment.
22. **If your child is found to have ringworm, they will be sent home immediately. In order for them to return, proof of treatment must be provided, the infected area must be dry/flaky, and the area must be covered until the rash is gone.**
23. It is the responsibility of the parent/guardian to send camper in or with the appropriate attire daily, this includes closed toe shoes. Flip flops, sandals, & crocs are not considered appropriate and are unsafe to participate in physical activity and pose an increased risk of injury. If camper doesn't have closed toe shoes, they may be asked to sit out or do an alternate activity. Foot wear concerns can be discussed with the camp site director.
24. On pool and/or water days, campers should come wearing their bathing suits with appropriate clothes over top. Please also send camper in with both flip flops & closed toe shoes, a towel, and a dry change of clothes.
25. **Parents/guardians of campers with an IEP, BIP and/or 504 Plan MUST contact the Program Director prior to registering for camp in order to discuss the child's needs. IEPs', BIP's and 504 Plans do NOT exclude campers from behavior write ups, suspensions and/or removal from camp.**
26. Wicomico Co Recreation & Parks Child Care programs do not allow participants or staff to possess or use tobacco products, vape pens, drugs, alcohol, or weapons of any kind (real or fake) on school & county grounds. Use or possession of the before mentioned is grounds for immediate removal from camp. Refunds will NOT be made.
27. Camp staff should only be contacted during regular camp hours. For assistance outside of those hours you may contact the Program Administrator during normal business hours Monday-Friday 8am-5:00pm by calling 410-548-4900 Ext. 108. And for emergencies during non-office hours call 443-944-4781. Please leave a message.
28. Photo ID's required for ALL individuals authorized to pick up campers, including parents/guardians.
29. Prior to each and every field trip, parent/guardians must sign permission slips.

**I AGREE TO ADHERE TO WICOMICO CO DEPT OF RECREATION, PARKS & TOURISM'S CHILD CARE CAMP PARENT CONTRACT.**

**I GIVE MY CHILD (*print child's name*), \_\_\_\_\_ PERMISSION TO PARTICIPATE.**

Parent/Legal Guardian's Name (Print): \_\_\_\_\_

Parent/Legal Guardian's Signature: \_\_\_\_\_ Date: \_\_\_\_\_



**YOUTH CAMP HEALTH HISTORY**  
**CAMPER**

Child's Name: \_\_\_\_\_

Current residence: \_\_\_\_\_

**EMERGENCY CONTACT INFORMATION:**

Emergency Contact  
(Parent or Legal Guardian): \_\_\_\_\_ Phone: \_\_\_\_\_

2<sup>nd</sup> Emergency Contact  
(Other than Parent Above): \_\_\_\_\_ Phone: \_\_\_\_\_

Primary Care Physician or  
other provider of medical care: \_\_\_\_\_ Phone: \_\_\_\_\_

**HEALTH INFORMATION:**

Are there any health problems including physical, psychiatric, or behavioral problems of which we need to be aware?  NO

YES, and youth camp participation was discussed with the camper's healthcare provider including considerations related to risk of COVID-19

Explain health problems and any considerations: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Are there any medications, dietary restrictions, allergies, or special needs that we need to be aware of to ensure that your child's camp experience is positive?  NO

YES, Explain: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**IMMUNIZATION INFORMATION:**  
**Must list current residence above.**

For campers who currently reside **within** the United States, a United States territory, or the District of Columbia: Does the camper have any immunization exemptions because of a parental or guardian objection or medical contraindication?  NO

YES, List: \_\_\_\_\_

For campers who reside **outside** the United States, a United States territory, or the District of Columbia: Attach record of vaccination or immunity on Department form MDH-896.

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

\_\_\_\_\_  
Date

## How To Use This Form

The medical provider that gave the vaccinations may record the dates (using month/day/year) directly on this form (check marks are not acceptable) and certify them by signing the signature section. Combination vaccines should be listed individually, by each component of the vaccine. A different medical provider, local health department official, school official, or child care provider may transcribe onto this form and certify vaccination dates from any other record which has the authentication of a medical provider, health department, school, or child care service.

**Only a medical provider, local health department official, school official, or child care provider may sign ‘Record of Immunization’ section of this form. This form may not be altered, changed, or modified in any way.**

### Notes:

1. When immunization records have been lost or destroyed, vaccination dates may be reconstructed for all vaccines except **varicella, measles, mumps, or rubella**.
2. Reconstructed dates for all vaccines must be reviewed and approved by a medical provider or local health department no later than 20 calendar days following the date the student was temporarily admitted or retained.
3. Blood test results are NOT acceptable evidence of immunity against diphtheria, tetanus, or pertussis (DTP/DTaP/Tdap/DT/Td).
4. Blood test verification of immunity is acceptable in lieu of polio, measles, mumps, rubella, hepatitis B, or varicella vaccination dates, but **revaccination may be more expedient**.
5. History of disease is NOT acceptable in lieu of any of the required immunizations, except varicella.

## Immunization Requirements

The following excerpt from the MDH Code of Maryland Regulations (COMAR) 10.06.04.03 applies to schools:

“A preschool or school principal or other person in charge of a preschool or school, public or private, may not knowingly admit a student to or retain a student in a:

- (1) Preschool program unless the student's parent or guardian has furnished evidence of age appropriate immunity against Haemophilus influenzae, type b, and pneumococcal disease;
- (2) Preschool program or kindergarten through the second grade of school unless the student's parent or guardian has furnished evidence of age-appropriate immunity against pertussis; and
- (3) Preschool program or kindergarten through the 12th grade unless the student's parent or guardian has furnished evidence of age-appropriate immunity against: (a) Tetanus; (b) Diphtheria; (c) Poliomyelitis; (d) Measles (rubeola); (e) Mumps; (f) Rubella; (g) Hepatitis B; (h) Varicella; (i) Meningitis; and (j) Tetanus-diphtheria-acellular pertussis acquired through a Tetanus-diphtheria-acellular pertussis (Tdap) vaccine.”

Please refer to the “**Minimum Vaccine Requirements for Children Enrolled in Pre-school Programs and in Schools**” to determine age-appropriate immunity for preschool through grade 12 enrollees. The minimum vaccine requirements and MDH COMAR 10.06.04.03 are available at [www.health.maryland.gov](http://www.health.maryland.gov). (Choose Immunization in the A-Z Index)

Age-appropriate immunization requirements for licensed childcare centers and family day care homes are based on the Department of Human Resources COMAR 13A.15.03.02 and COMAR 13A.16.03.04 G & H and the “**Age-Appropriate Immunizations Requirements for Children Enrolled in Child Care Programs**” guideline chart are available at [www.health.maryland.gov](http://www.health.maryland.gov). (Choose Immunization in the A-Z Index)



**\*\*\*IF YOUR CHILD WILL NEED ANY KIND OF MEDICATION (INCLUDING INHALERS, EPIPENS, ADHD MEDICATION, ETC.) WHILE THEY ARE AT SUMMER CAMP, PLEASE HAVE THEIR PEDIATRICIAN COMPLETE THIS FORM FOR SAID MEDICATION ALONGSIDE THEIR VACCINATION RECORDS.\*\*\***

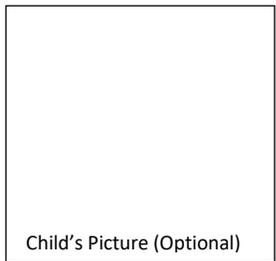
**MARYLAND STATE DEPARTMENT OF EDUCATION**

**OFFICE OF CHILD CARE  
MEDICATION ADMINISTRATION AUTHORIZATION FORM**

Child Care Program: \_\_\_\_\_

This form must be completed in order for child care providers and staff to administer the required medication. A new medication administration form must be completed at the beginning of each 12-month periods, for each medication, and each time there is a change in the dosage or the 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.
- Parent/Guardian must bring the medication to the facility.
- Must Pick up the medication at the end of the authorized period, otherwise it will be discarded



Child's Picture (Optional)

**PRESCRIBER'S AUTHORIZATION**

Child's Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Condition for which medication is being administered: \_\_\_\_\_

Medication Name: \_\_\_\_\_ Dose: \_\_\_\_\_ Route: \_\_\_\_\_

Time/frequency of administration: \_\_\_\_\_ If PRN, frequency: \_\_\_\_\_  
(PRN=as needed)

If PRN, for what symptoms: \_\_\_\_\_

Possible side effects & special Instructions: \_\_\_\_\_

Medication shall be administered from: \_\_\_\_\_ to \_\_\_\_\_

Month / Day / Year

Month / Day / Year (not to exceed 1 year)

Known Food or Drug: Allergies? Yes \_\_\_ No \_\_\_ If Yes, please explain \_\_\_\_\_

Prescriber's Name/Title: \_\_\_\_\_

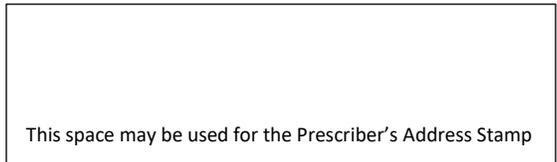
(Type or print)

Telephone: \_\_\_\_\_ FAX: \_\_\_\_\_

Address: \_\_\_\_\_

Prescriber's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

(Original signature or signature stamp ONLY)



This space may be used for the Prescriber's Address Stamp

**PARENT/GUARDIAN AUTHORIZATION**

I/We request authorized child care provider/staff to administer the medication as prescribed by the above prescriber. I attest that I have administered at least one dose of the medication to my child without adverse effects. I/We certify that I/we have legal authority, understand the risk and consent to medical treatment for the child named above, including the administration of medication. I agree to review special instruction and demonstrate medication administration procedure to the child care provider.

Parent/Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Home Phone #: \_\_\_\_\_ Cell Phone #: \_\_\_\_\_ Work Phone #: \_\_\_\_\_

**SELF CARRY/SELF ADMINISTRATION OF EMERGENCY MEDICATION AUTHORIZATION/APPROVAL  
(Only school-aged children may be authorized to self carry/self administer medication.)**

Self-carry/self-administration of **emergency** medication noted above may be authorized by the prescriber.

Prescriber's Authorization: \_\_\_\_\_ Date: \_\_\_\_\_

Parental Approval: \_\_\_\_\_ Date: \_\_\_\_\_

**FACILITY RECEIPT AND REVIEW**

Medication was received from: \_\_\_\_\_ Date: \_\_\_\_\_

Special Health Care Plan Received:  YES  NO

Medication was received by: \_\_\_\_\_ Date: \_\_\_\_\_