



# Washington Hebrew Congregation Child Information/Emergency Form

## Camp Keetov/In the Beginning Summer 2008



### CAMPER INFORMATION (PLEASE PRINT CLEARLY)

Full Name \_\_\_\_\_  
First Middle Last

Goes By: \_\_\_\_\_ Male/Female \_\_\_\_\_ Date of Birth \_\_\_\_\_ Current Age: \_\_\_\_\_  
month/day/year

Home Address \_\_\_\_\_  
Street address City State Zip

Home Telephone \_\_\_\_\_ Family Email Address \_\_\_\_\_

Siblings: Name(s), Age(s) \_\_\_\_\_

### PARENT/GUARDIAN INFORMATION

Relationship to camper \_\_\_\_\_

Title (Mr., Mrs., Dr., other) \_\_\_\_\_ First Name \_\_\_\_\_ Last Name \_\_\_\_\_

Street Address (if different from camper) \_\_\_\_\_

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

Home Phone (if different from camper) \_\_\_\_\_

Mobile Phone \_\_\_\_\_

Business Phone \_\_\_\_\_

Alternate Email Address \_\_\_\_\_

### PARENT/GUARDIAN INFORMATION

Relationship to camper \_\_\_\_\_

Title (Mr., Mrs., Dr., other) \_\_\_\_\_ First Name \_\_\_\_\_ Last Name \_\_\_\_\_

Street Address (if different from camper) \_\_\_\_\_

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

Home Phone (if different from camper) \_\_\_\_\_

Mobile Phone \_\_\_\_\_

Business Phone \_\_\_\_\_

Alternate Email Address \_\_\_\_\_

Applicant lives with (check any that apply)  Father  Mother  Stepfather  Stepmother  Other \_\_\_\_\_

Are you members of Washington Hebrew Congregation? (Y/N) \_\_\_\_\_ Are you affiliated with another Congregation? Which one? \_\_\_\_\_

Financial responsibility for camper will be assumed by: \_\_\_\_\_

***In case you cannot be reached, please authorize three people, other than members of your regular carpool, with whom we may consult and to whom we may release your child in the event of an emergency:***

Name \_\_\_\_\_ Relationship \_\_\_\_\_ Phone \_\_\_\_\_

Name \_\_\_\_\_ Relationship \_\_\_\_\_ Phone \_\_\_\_\_

Name \_\_\_\_\_ Relationship \_\_\_\_\_ Phone \_\_\_\_\_

Name of physician or clinic \_\_\_\_\_ Phone \_\_\_\_\_

Name of dentist \_\_\_\_\_ Phone \_\_\_\_\_

Recurring illnesses (asthma, allergies, etc.) \_\_\_\_\_

Dietary restrictions (Kashrut, allergies, etc.) \_\_\_\_\_

A staff representative has my permission to call my family physician in an emergency when I cannot be contacted and the physician may render treatment necessary for the well-being of my child.

In the event of an emergency, after an effort has been made to contact parents/guardians or those listed on this or any emergency form provided by WHC, I hereby give permission to the physician selected by the WHC, or the WHC teachers, administrators, staff members, agents or other representatives (collectively, "WHC representatives") to summon an ambulance, hospitalize, secure proper treatment for and/or order injection, anesthesia or surgery for my child; I authorize WHC and WHC representatives to take any other action a physician deems necessary or appropriate in the particular circumstances. I hereby release WHC and all WHC officers, directors, and other WHC representatives from all liability or responsibility or responsibility in connection therewith. I hereby agree to indemnify any and all of the WHC representatives from and against any and all claims, demands, losses, obligations, actions, causes of action, judgments and liabilities of every kind or nature whatsoever, including, but not limited to, reasonable attorney's fees, that any of the WHC representatives may incur or sustain by reason of or in connection with any WHC representatives' good faith effort to obtain medical assistance for my child.

Parent/Guardian (print name) \_\_\_\_\_ Date \_\_\_\_\_

Parent/Guardian signature \_\_\_\_\_



Washington Hebrew Congregation

## **Camp Keetov/In the Beginning**

### **Enrollment Agreement 2008**

Please read the following items carefully. **Two copies are provided so that you may keep one for your records.** This copy should be signed and returned to the camp office.

1. Campers are enrolled for the entire three-week or six-week session for which they have been registered. **In The Beginning** campers are enrolled for the full six-week program.
2. No refunds, adjustments or deductions of any kind will be made from fees, charges and tuition due to absence or withdrawal of any camper by parent or guardian prior to the beginning of camp and/or during the camp session. The camp shall not be required to mitigate damages. I understand that all camp fees, charges and tuition are non-refundable and non-transferable.
3. The camp reserves the right to exclude, withdraw or dismiss any camper from the program for any cause whatsoever including, but not limited to, violation of any rules, regulations, contagious health concerns or non-payment of fees if deemed by the camp to be in the best interest of the camp or camper.
4. If, in the judgment of a teacher, director, camp nurse or other responsible WHC employee or representative (collectively, "WHC employees"), emergency treatment is necessary for the student, a doctor, ambulance or other appropriate assistance may be summoned, as the WHC employee deems necessary. In such cases, WHC will promptly notify a parent/guardian or other designated responsible person. The undersigned hereby release WHC and any and all of its officers, directors, staff members, agents and other representatives (collectively, "WHC representatives") from, and hereby agree to indemnify any and all of the WHC representatives from and against, any and all claims, demands, losses, obligations, actions, causes of action, judgments and liabilities of every kind or nature whatsoever, including, but not limited to reasonable attorney's fees, that any of the WHC representatives may incur or sustain by reason of or in connection with any WHC representative's good faith effort to summon or administer medical assistance.
5. A recent (within 12 months of the beginning of camp) medical checkup and medical form noting current dates of all immunizations will be required prior to the time the camper begins the camp session.
6. The camp reserves the right to determine appropriate outdoor water programs for your child in keeping with Maryland State Health Department Regulations. (Only those children completely toilet trained will be permitted in the wading pools.)

***I have carefully read the above and I agree to comply with the terms expressed therein, without exception, and to be bound by camp regulations.***

Parent/Guardian (print name) \_\_\_\_\_ Date \_\_\_\_\_

Parent/Guardian signature \_\_\_\_\_

# **PLEASE SIGN AND RETURN**



Washington Hebrew Congregation  
**Camp Keetov/In the Beginning**

**Enrollment Agreement 2008**

Please read the following items carefully. **Two copies are provided so that you may keep one for your records.**

1. Campers are enrolled for the entire three-week or six-week session for which they have been registered. **In The Beginning** campers are enrolled for the full six-week program.
2. No refunds, adjustments or deductions of any kind will be made from fees, charges and tuition due to absence or withdrawal of any camper by parent or guardian prior to the beginning of camp and/or during the camp session. The camp shall not be required to mitigate damages. I understand that all camp fees, charges and tuition are non-refundable and non-transferable.
3. The camp reserves the right to exclude, withdraw or dismiss any camper from the program for any cause whatsoever including, but not limited to, violation of any rules, regulations, contagious health concerns or non-payment of fees if deemed by the camp to be in the best interest of the camp or camper.
4. If, in the judgment of a teacher, director, camp nurse or other responsible WHC employee or representative (collectively, "WHC employees"), emergency treatment is necessary for the student, a doctor, ambulance or other appropriate assistance may be summoned, as the WHC employee deems necessary. In such cases, WHC will promptly notify a parent/guardian or other designated responsible person. The undersigned hereby release WHC and any and all of its officers, directors, staff members, agents and other representatives (collectively, "WHC representatives") from, and hereby agree to indemnify any and all of the WHC representatives from and against, any and all claims, demands, losses, obligations, actions, causes of action, judgments and liabilities of every kind or nature whatsoever, including, but not limited to reasonable attorney's fees, that any of the WHC representatives may incur or sustain by reason of or in connection with any WHC representative's good faith effort to summon or administer medical assistance.
5. A recent (within 12 months of the beginning of camp) medical checkup and medical form noting current dates of all immunizations will be required prior to the time the camper begins the camp session.
6. The camp reserves the right to determine appropriate outdoor water programs for your child in keeping with Maryland State Health Department Regulations. (Only those children completely toilet trained will be permitted in the wading pools.)

I have carefully read the above and I agree to comply with the terms expressed therein, without exception, and to be bound by camp regulations.

**PLEASE RETAIN FOR YOUR FILES**



**Camper Medical Checklist**  
 To be completed by parent or guardian

Name of camper \_\_\_\_\_

*To the best of your knowledge, does your child have any problems that may affect his/her participation in camp, cause any concern, and/or be important for camp staff to know?*

Please check "Yes" or "No" for each of the following:

	<u>Yes</u>	<u>No</u>	<b>Comments</b>
Allergies (drugs, food, insects)	_____	_____	
Asthma	_____	_____	
Behavioral or emotional problems	_____	_____	
Birth defects	_____	_____	
Bleeding problems	_____	_____	
Chronic diseases	_____	_____	
Chronic infectious diseases	_____	_____	
Diabetes	_____	_____	
Hearing problems	_____	_____	
Heart problems	_____	_____	
Hospitalizations (when/where)	_____	_____	
Limits on activity	_____	_____	
Medications	_____	_____	
Premature birth	_____	_____	
Problems with bladder	_____	_____	
Problems with bowels	_____	_____	
Seizures	_____	_____	
Speech problems	_____	_____	
Surgeries	_____	_____	
Vision problems	_____	_____	
Other medical conditions	_____	_____	
<b>Is your child toilet trained</b>	_____	_____	

Use the reverse side of this form to elaborate on any of the above or for any additional information.

*Except as noted above, this child is otherwise in good physical and mental health, is free of communicable disease, has no problems that may interfere with his/her learning, and may participate fully in all activities.*

Parent/guardian's name (please print) \_\_\_\_\_ Phone \_\_\_\_\_

Parent/guardian's signature \_\_\_\_\_ Date \_\_\_\_\_



# ALLERGY INFORMATION

## Camp Keetov/In the Beginning

### Summer 2008

Child's name (please print) \_\_\_\_\_

Group Leader (leave blank) \_\_\_\_\_

To the best of my knowledge:

\_\_\_\_\_ My child has no allergies

\_\_\_\_\_ My child is allergic to the following:

Comments, medications, and/or instructions: (If your child requires medication at camp, please see the camp nurse for the appropriate permission forms).

*Person to contact in case of an emergency (other than parent):*

Name \_\_\_\_\_ Phone # \_\_\_\_\_

(Relationship to child) \_\_\_\_\_

Please initial any of the following over-the-counter topical medications that the camp nurse may apply to your child:

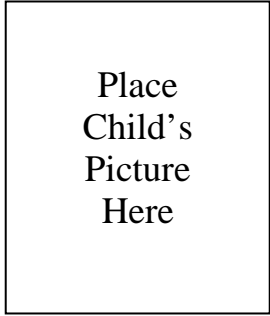
MEDICATIONS	USES	I approve the use of the following: (initial each below)
Neosporin Ointment	small cuts/rug burns/abrasions	
Benadryl Gel	bee stings/bug bites/poison ivy	
Vaseline petroleum jelly	chapped lips	
Neutrogena & Eucerin ointment/cream	dry itchy skin	

Parent/guardian name (please print) \_\_\_\_\_

Parent/guardian signature \_\_\_\_\_ Date \_\_\_\_\_

# Food Allergy Action Plan

Student's Name: \_\_\_\_\_ D.O.B: \_\_\_\_\_ Teacher: \_\_\_\_\_



ALLERGY TO: \_\_\_\_\_

Asthmatic Yes\*  No  \*Higher risk for severe reaction

## ◆ STEP 1: TREATMENT ◆

<u>Symptoms:</u>	<u>Give Checked Medication**:</u> <small>** (To be determined by physician authorizing treatment)</small>
▪ If a food allergen has been ingested, but <i>no symptoms</i> :	<input type="checkbox"/> Epinephrine <input type="checkbox"/> Antihistamine
▪ Mouth    Itching, tingling, or swelling of lips, tongue, mouth	<input type="checkbox"/> Epinephrine <input type="checkbox"/> Antihistamine
▪ Skin      Hives, itchy rash, swelling of the face or extremities	<input type="checkbox"/> Epinephrine <input type="checkbox"/> Antihistamine
▪ Gut        Nausea, abdominal cramps, vomiting, diarrhea	<input type="checkbox"/> Epinephrine <input type="checkbox"/> Antihistamine
▪ Throat†   Tightening of throat, hoarseness, hacking cough	<input type="checkbox"/> Epinephrine <input type="checkbox"/> Antihistamine
▪ Lung†     Shortness of breath, repetitive coughing, wheezing	<input type="checkbox"/> Epinephrine <input type="checkbox"/> Antihistamine
▪ Heart†    Weak or thready pulse, low blood pressure, fainting, pale, blueness	<input type="checkbox"/> Epinephrine <input type="checkbox"/> Antihistamine
▪ Other†    _____	<input type="checkbox"/> Epinephrine <input type="checkbox"/> Antihistamine
▪ If reaction is progressing (several of the above areas affected), give:	<input type="checkbox"/> Epinephrine <input type="checkbox"/> Antihistamine

†Potentially life-threatening. The severity of symptoms can quickly change.

## DOSAGE

**Epinephrine:** inject intramuscularly (circle one) EpiPen® EpiPen® Jr. Twinject® 0.3 mg Twinject® 0.15 mg (see reverse side for instructions)

**Antihistamine:** give \_\_\_\_\_  
medication/dose/route

**Other:** give \_\_\_\_\_  
medication/dose/route

**IMPORTANT: Asthma inhalers and/or antihistamines cannot be depended on to replace epinephrine in anaphylaxis.**

## ◆ STEP 2: EMERGENCY CALLS ◆

1. Call 911 (or Rescue Squad: \_\_\_\_\_). State that an allergic reaction has been treated, and additional epinephrine may be needed.

2. Dr. \_\_\_\_\_ Phone Number: \_\_\_\_\_

3. Parent \_\_\_\_\_ Phone Number(s) \_\_\_\_\_

4. Emergency contacts:  
Name/Relationship \_\_\_\_\_ Phone Number(s) \_\_\_\_\_

a. \_\_\_\_\_ 1.) \_\_\_\_\_ 2.) \_\_\_\_\_

b. \_\_\_\_\_ 1.) \_\_\_\_\_ 2.) \_\_\_\_\_

**EVEN IF PARENT/GUARDIAN CANNOT BE REACHED, DO NOT HESITATE TO MEDICATE OR TAKE CHILD TO MEDICAL FACILITY!**

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

Doctor's Signature \_\_\_\_\_ Date \_\_\_\_\_

(Required)

11810 Falls Road  
Potomac, MD 20854



Phone (301) 279-7505  
Fax (301) 354-3200

**AUTHORIZATION AND RELEASE OF LIABILITY**  
**(For students with food and/or bee sting allergies that may result in anaphylaxis)**

I understand that Washington Hebrew Congregation (“WHC”) cannot promise or assure that an environment be created or maintained that is free of a food and/or bees that my child is allergic to, or that he/she will not suffer an allergic reaction, despite the fact that WHC has taken certain precautions and asked parental cooperation in order to minimize the risk of exposure to such food and/or bees.

I further understand that it is the policy of Washington Hebrew Congregation not to administer medicine of any kind to its students (or campers) and that WHC encourages parents and physicians to follow procedures that result in all medications being administered at home, to the extent possible. Nevertheless, in the event of a situation that a teacher, administrator, school nurse, staff member, or other WHC representative deems to be a medical emergency, I hereby authorize them to administer care and/or emergency medications in accordance with my physician’s instructions that have separately been provided to WHC. I understand that such care may not be administered by a trained professional.

I hereby release WHC and any and all of its clergy, officers, directors, staff members, school nurses or other representatives (collectively, “WHC Representatives”) from, and hereby agree to indemnify any and all of the WHC Representatives from and against, any and all lawsuits, claims, demands, losses, obligations, actions, causes of action, judgments and liabilities of every kind or nature whatsoever, including but not limited to, reasonable attorney’s fees (collectively, “liabilities”), that any of the WHC Representatives may incur or sustain, and directly or indirectly relates to, or arises from or in connection with:

1. Any allergic reaction or anaphylaxis that was or may have been caused, in whole or in part, by exposure to said allergens while at WHC or in connection with school-related activities or events; and,
2. Any WHC Representative’s effort to give (or decision to refrain from giving) treatment to my child in connection with an allergic reaction or symptoms that appear to indicate an allergic reaction.

\_\_\_\_\_ Allergic to: \_\_\_\_\_  
Student’s Name (please print)

\_\_\_\_\_ Parent/Guardian Name (please print) \_\_\_\_\_ Parent/Guardian Signature

\_\_\_\_\_ Date