TWISTERS SUMMER CAMP Registration Packet

MON-FRI
9:00-1:00 Ages 3-4 yrs
9:00-3:00 ages 5-13

$200/week

ACTIVITIES | GYMNASTICS | TUMBLING | GAMES | TRAMPOLINE | DANCE PARTIES | LASER TAG | CRAFTS | NINJA | FRIENDS

FOR KIDS 3-13 YEARS OLD
PH 410-629-0878
www.berlinactivitiesdepot.com

Enrollment Information

Camp Hours: Monday-Friday 9:00am-1:00pm Ages 3-4 years
Monday-Friday 9:00-3:00pm Ages 5-13 years

One field trip per week is included in your tuition. Full week enrollment only. *Field trip schedule will be available closer to camp start.*

Camp Rates: Circle your choice.

- Full Week $200 Monday-Friday
- Part time: $140 Monday/Wednesday or Tuesday/Thursday
- Drop-in Rate: $70/day. Field trip drop-ins $85/day and depends on space available.

Registration Fee: Circle one.
Before March 15th = $0 --- Mar 15th - Apr 30th = $50 --- May 1st or later = $85

One camp shirt is included per camper- notate below if you would like to order more than one t-shirt
_____ ***parent initial*** *Camp T-shirts must be worn on field trips. Your account will be charged for a shirt if your child is not wearing it on field trip day. *
Additional T-shirts desired ($20/shirt): _____

Grade in 2022-23 School Year_____ **School Attended:** _____

Has your child completed Kindergarten by the 1st day of camp? (circle one): **Yes** *or* **No**

Parent Initial_____ **Employee Initial**_____

Camper Information

Child Name Information		
Child's First Name:		Child's Last Name:
Child's Middle Initial:		Child's Nickname or Name Preference:
Child Personal Information		
Date of Birth:	Age:	Gender:
Child Address		
Home Street Address:		
City:	State:	ZIP Code:
Other		

What is the race/ethnicity of you/your camper?_____ ( ) Prefer not to say

*Knowing the demographic makeup of our campers/community can assist in grant writing, intentional outreach, and more—please respond if you feel comfortable.

T-Shirt Size (Please Circle One)

Youth: XS SM MED LG

Adult: SM MED LG XL XXL XXXL

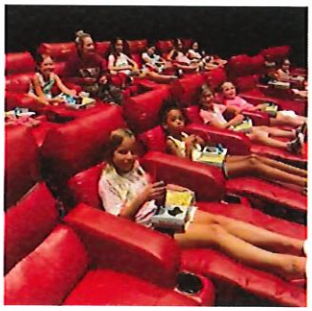
Camper Insurance Information: Primary medical insurance information that the camper is covered by:

Insurance Company: _____ Policy #: _____ Group #: _____

Picture Taking & Social Media Permission Slip

☐ I_____, parent/guardian of_____ (Child's Name), give my permission for Berlin Activities Depot to take pictures of my child during activities of B.A.D. Summer Camp. Berlin Activities Depot has permission to use these pictures for marketing, advertising, and social media.

☐ I_____, parent/guardian of_____ (Child's Name), **DO NOT** give my permission for Berlin Activities Depot to take pictures of my child during activities of B.A.D Summer Camp. Berlin Activities Depot **does not have** permission to use any pictures of my child for marketing, advertising, or social media.



Parent Initial_____ **Employee Initial**_____

Snacks and Lunches

Please note by initialing each item:

_____ Snack time will be included in the camp schedule for all ages.

_____ Lunch time will be included in the camp schedule for ages 5-13.

_____ BAD will not microwave or refrigerate any snacks or lunches. Please do not send your camper with foods that need to be heated or kept cold in a refrigerator.

_____ Campers will need to pack their own snacks/lunches and a water bottle for each day and may not share food with other campers due to potential food allergies.

Please note by initialing each line that applies:

_____ My child **MAY** purchase concession snacks from the Grub Hub.

- Their daily/weekly (please circle) allowance for snacks is: _____
- My child may order (circle all that apply)

Water/ Sports Drinks/ Soda/ Ice cream/ Chips/ Candy/ Muffins/ ANYTHING

I would like to pay for concession snacks at the Grub Hub by:

- ☐ Charging the card on file.
- ☐ I will send cash with my child. (Twisters is not responsible for lost or stolen cash).

OR

_____ My child **May NOT** purchase snack items.

Parent Name (Print)_____

Signature: _____

Date: _____

Parent Initial_____ **Employee Initial**_____

Deposit and Tuition Worksheet

Child's Name: _____ Family Last Name: _____

Date signed up: _____ Days in Attendance: M T W TH F

# of Weeks Attending: _____ Date Deposit Received in office: _____

Week	Dates	Weekly Total	Deposit 50%	Total Weekly Balance Due	Grub Hub allowance
EXAMPLES	*June 6-10*	*$200*	*$100*	*$100*	*Grub Hub $10/wk*
Week 1 Moovin' and Groovin' into Summer Week	June 19-23				
Week 2 Barnyard Palooza Week	June 26-30				
Week 3 Stars and Stripes Week	July 3-7 *closed July 4				
Week 4 Under the Sea Week	July 10-14				
Week 5 Island Explorer Week	July 17-21				
Week 6 Color Wars Week	July 24-28				
Week 7 Ooey Gooey Science Week	July 31- Aug. 4				
Week 8 To Infinity and Beyond Week	Aug. 7-11				
Week 9 Water Water Everywhere Week	Aug. 14-18				
Week 10 Carnival Week	Aug. 21-25				
Week 11 Super Heroes and Sidekicks Week	Aug. 28- Sep. 1				

***50% weekly deposit will be subtracted from weekly tuition.**

Registration Fee due at time of registration. # of campers = _____

Total # of weeks of camp: _____ x 50% = $_____ *****This deposit is non-refundable and due in full in order to secure your child's spot and complete registration. The date in which the deposit is received will determine the registration fee*****

I agree that by signing the following I am legally liable to pay Berlin Activities Depot, Twisters Inc. the total tuition agreed upon above, and also agree to the terms, rules, and regulations that B.A.D has set forth.

Name: _____ Signature: _____ Date: _____

Parent Initial_____ Employee Initial_____

EXAMPLE OF THE DAILY CAMP SCHEDULE

TIME	GROUP A Ages 3-4	GROUP B Ages 5-7	GROUP C Ages 8-13
9:00-9:20	Welcome. Attendance. Review rules and daily schedule with campers.	Welcome. Attendance. Review rules and daily schedule with campers.	Welcome. Attendance. Review rules and daily schedule with campers.
9:20-9:40	Ninja Obstacle Course	Gymnastics Uneven Bars	Gymnastics Spring Floor
9:40-10:00	Gymnastics Spring Floor	Ninja Obstacle Course	Gymnastics Uneven Bars
10:00-10:20	Gymnastics Uneven Bars	Gymnastics Spring Floor	Ninja Obstacle Course
10:20-10:40	Snack	Themed Games	Open Gym
10:40-11:00	Open Gym	Snack	Themed Games
11:00-11:20	Themed Games	Open Gym	Snack
11:20-11:40	Laser Tag	Laser Tag	Laser Tag
12:30-1:00	Arts and Crafts	Arts and Crafts	Arts and Crafts
DISMISSAL FOR 3-4 YR OLD CAMPERS			
1:00-1:30		Lunch	Lunch
1:30-2:00		Trampoline Tricks	Sports Choice (volleyball, soccer)
2:00-2:30		Themed Games	Trampoline Tricks
2:30-3:00		Sports Choice (volleyball, soccer)	Themed Games
DISMISSAL FOR 5-13 YR OLD CAMPERS			

Parent Initial_____ Employee Initial_____

MARYLAND STATE DEPARTMENT OF EDUCATION – Office of Child Care

CACFP Enrollment: Yes:☐ No:☐

Meals your child will receive while in care:

BK☐ LN☐ SU☐ AM Snk☐ PM Snk☐ Evng Snk☐

EMERGENCY FORM

INSTRUCTIONS TO PARENTS:

(1) Complete all items on this side of the form. Sign and date where indicated. Please mark "N/A" if an item is not applicable.

(2) If your child has a medical condition which might require emergency medical care, complete the back side of the form. If necessary, have your child's health practitioner review that information.

NOTE: THIS ENTIRE FORM MUST BE UPDATED ANNUALLY.

Child's Name _____ Birth Date _____
Last First

Enrollment Date _____ Hours & Days of Expected Attendance _____

Child's Home Address _____
Street/Apt. # City State Zip Code

Parent/Guardian Name(s)	Relationship	Contact Information		
		Email:	C: H:	W: Employer:
		Email:	C: H:	W: Employer:

Name of Person Authorized to Pick up Child *(daily)* _____
Last First Relationship to Child

Address _____
Street/Apt. # City State Zip Code

Any Changes/Additional Information _____

ANNUAL UPDATES _____ _____ _____ _____
(Initials/Date) *(Initials/Date)* *(Initials/Date)* *(Initials/Date)*

When parents/guardians cannot be reached, list at least one person who may be contacted to pick up the child in an emergency:

1. Name _____ Telephone (H) _____ (W) _____
Last First

Address _____
Street/Apt. # City State Zip Code

2. Name _____ Telephone (H) _____ (W) _____
Last First

Address _____
Street/Apt. # City State Zip Code

3. Name _____ Telephone (H) _____ (W) _____
Last First

Address _____
Street/Apt. # City State Zip Code

Child's Physician or Source of Health Care _____ Telephone _____

Address _____
Street/Apt. # City State Zip Code

In EMERGENCIES requiring immediate medical attention, your child will be taken to the NEAREST HOSPITAL EMERGENCY ROOM. Your signature authorizes the responsible person at the child care facility to have your child transported to that hospital.

Signature of Parent/Guardian _____ Date _____

YOUTH CAMP HEALTH HISTORY
CAMPER

Child's Name: _____

Current residence: _____

_____

EMERGENCY CONTACT INFORMATION:

Emergency Contact
(Parent or Legal Guardian): _____ Phone: _____

2nd 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, Explain: _____

_____

_____

_____

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. (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. (Choose Immunization in the A-Z Index)

MARYLAND DEPARTMENT OF HEALTH IMMUNIZATION CERTIFICATE

CHILD'S NAME _____
LAST FIRST MI

SEX: MALE ☐ FEMALE ☐ BIRTHDATE ____/____/____

COUNTY _____ SCHOOL _____ GRADE _____

PARENT OR GUARDIAN NAME _____ PHONE NO. _____

ADDRESS _____ CITY _____ ZIP _____

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	Hep A Mo/Day/Yr	MMR Mo/Day/Yr	Varicella Mo/Day/Yr	Varicella Disease Mo / Yr	COVID-19 Mo/Day/Yr
1	DOSE #1	DOSE #1	DOSE #1	DOSE #1	DOSE #1	DOSE #1	DOSE #1	DOSE #1	DOSE #1	DOSE #1	DOSE #1		DOSE #1
2	DOSE #2	DOSE #2	DOSE #2	DOSE #2	DOSE #2	DOSE #2	DOSE #2	DOSE #2	DOSE #2	DOSE #2	DOSE #2		DOSE #2
3	DOSE #3	DOSE #3	DOSE #3	DOSE #3	DOSE #3	DOSE #3	DOSE #3	DOSE #3	Td Mo/Day/Yr	Tdap Mo/Day/Yr	MenB Mo/Day/Yr	Other Mo/Day/Yr	
4	DOSE #4	DOSE #4	DOSE #4	DOSE #4	DOSE #4								
5	DOSE #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.

COMPLETE THE APPROPRIATE SECTION BELOW IF THE CHILD IS EXEMPT FROM VACCINATION ON MEDICAL OR RELIGIOUS GROUNDS. ANY VACCINATION(S) THAT HAVE BEEN RECEIVED SHOULD BE ENTERED ABOVE.

MEDICAL CONTRAINDICATION:

Please check the appropriate box to describe the medical contraindication.

This is a: ☐ Permanent condition OR ☐ Temporary condition until ____/____/____
Date

The above child has a valid medical contraindication to being vaccinated at this time. Please indicate which vaccine(s) and the reason for the contraindication, _____

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 vaccine(s) being given to my child. This exemption does not apply during an emergency or epidemic of disease.

Signed: _____ Date: _____

MEDICATION ADMINISTRATION AUTHORIZATION FORM

for Youth Camps in Maryland

Maryland Department of Health (MDH)
Center for Healthy Homes and Community Services (CHHCS)
(410) 767-8417 Toll Free 1-877-4MD-MDH ext. 8417

This form must be completed fully in order for youth camp operators and staff members to administer the required medication or for the camper to self-administer medication. A new medication administration form must be completed at the beginning of each camp season, 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.**
- **Nonprescription medication must be in the original container with the instructions for use. Nonprescription medication includes vitamins, homeopathic, and herbal medicines.**
- **An authorized individual must bring the medication to the camp and give the medication to an adult staff member.**

I. PRESCRIBER'S AUTHORIZATION

1. CHILD'S NAME		2. DATE OF BIRTH ___/___/___ Month Day Year
3. CONDITION FOR WHICH MEDICATION IS BEING ADMINISTERED:		4. EMERGENCY MEDICATION [ ] YES *-If yes, see Section III below.* [ ] NO
5. MEDICATION NAME	6. DOSE	7. ROUTE
8. TIME/FREQUENCY OF ADMINISTRATION	9. IF PRN, FREQUENCY	
10. IF PRN, FOR WHAT SYMPTOMS		
11. KNOWN SIDE EFFECTS SPECIFIC TO CHILD		
12. MEDICATION SHALL BE ADMINISTERED during the year in which this form is dated in 14b below unless more restrictive dates are specified in 12a and 12b. This authorization is ***NOT TO EXCEED 1 YEAR.***	12a. FROM ___/___/___ Month Day Year	12b. TO ___/___/___ Month Day Year
13. PRESCRIBER'S NAME/TITLE		This space may be used for the Prescriber's Address Stamp
TELEPHONE	FAX	
ADDRESS		
CITY	STATE / ZIPCODE	
14a. PRESCRIBER'S SIGNATURE ***(Parent/guardian cannot sign here)*** *(ORIGINAL SIGNATURE OR SIGNATURE STAMP ONLY)*		14b. DATE

II. PARENT/GUARDIAN AUTHORIZATION

I request the authorized youth camp operator, staff member or volunteer to administer the medication or supervise the camper in self-administration as prescribed by the above authorized prescriber. I certify that I have legal authority to consent to medical treatment for the child named above, including the administration of medication at the facility. I understand that at the end of the authorized period, an authorized individual, as listed in 15c below, which may include the child, must pick up the medication, otherwise it will be discarded. I authorize camp personnel and the authorized prescriber indicated on this form to communicate in compliance with HIPAA.

15a. PARENT/GUARDIAN SIGNATURE	15b. DATE	15C. INDIVIDUAL(S) AUTHORIZED TO PICK UP MEDICATION
15d. HOME PHONE #	15e. CELL PHONE #	15f. WORK PHONE #

III. AUTHORIZATION FOR SELF-ADMINISTRATION / SELF-CARRY (OPTIONAL)

This section should only be completed if this medication is approved for self-administration. Self-carry is only permitted for emergency medications such as inhalers and epinephrine. Both the prescriber and the parent/guardian must consent to self-administration below. However, youth camp operators are not required to permit self-administration or self-carry.

I authorize self-administration of the above listed medication for the child named above under the supervision of the youth camp operator, a designated staff member or volunteer. If indicated below, the child named above may self-carry emergency medication.

16a. PRESCRIBER'S SIGNATURE authorizing self-administration	16b. SELF-CARRY EMERGENCY MEDICATION (Check One) [ ] YES [ ] NO [ ] N/A - Not emergency medication	16c. DATE
17a. PARENT/GUARDIAN'S SIGNATURE authorizing self-administration	17b. SELF-CARRY EMERGENCY MEDICATION (Check One) [ ] YES [ ] NO [ ] N/A - Not emergency medication	17c. DATE