Dear Parents:

The Maryland Department of Health and Mental Hygiene has adopted a policy regarding the use of sunscreen at youth camps. In order to operate a camp in the state of Maryland, we must abide by the policy as outlined below.

Please read the following regarding use and application of sunscreen at Maryland 4-H Camps. The authorization statement must be completed and submitted along with sunscreen labeled for your camper (one form and bottle per camper) on the first day of camp, at the start of each subsequent week (for long-term day camps), if the brand of sunscreen changes, or if a new bottle is supplied.

Please address questions about this policy to your Camp Coordinator.

MARYLAND 4-H CAMPS SUNSCREEN POLICY

1. Each Camper’s parent/guardian must provide written permission for use and application of sunscreen on their child.
2. Sunscreen containers must be clearly labeled with the Camper’s name and must be provided to Camp Staff at camp check-in. This signed authorization form must submitted along with the sunscreen.
3. Campers should, in most instances, apply the sunscreen on their own. If assistance is needed it will be provided by Camp Staff ONLY if specifically authorized (see below).
4. For Day Camps, Campers need to have sunscreen applied to them by the parent/guardian BEFORE arriving at camp, not when dropping off.

MARYLAND 4-H CAMPS SUNSCREEN AUTHORIZATION

(Check and sign appropriate block below)

Camper’s Name: _____________________________________  Camper’s Age: ____________

Brand of Sunscreen: ________________________________  SPF: ____________  Expiration Date: ____________

I give permission for members of the Maryland 4-H Camp Staff to assist in applying sunscreen to my child. I understand that this may require the staff member to touch my child’s face, shoulders, back, arms, and lower legs. Sunscreen will be applied in the presence of other staff members. I understand that staff will not apply sunscreen to my child’s front torso or upper legs, but will assist and/or direct the child to do so.

In the event my child does not bring sunscreen to camp and conditions warrant its use, by my signature below I authorize members of the Maryland 4-H Camp Staff to use camp supplies of sunscreen, and to apply this sunscreen to my child’s body as described above.

________________________________________  ______________________________  __________
Parent/Guardian’s Printed Name  Parent/Guardian’s Signature  Date

OR

I DO NOT give permission for Maryland 4-H Camp Staff Members to assist in applying sunscreen to my child.

________________________________________  ______________________________  __________
Parent/Guardian’s Printed Name  Parent/Guardian’s Signature  Date

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4/2015
MARYLAND 4-H EVENT
HEALTH FORM

Participant's Name: __________________________

Male ☐ Female ☐
Age: __________
Birthdate: __________ MM/DD/YYYY

Home Address: ________________________________________________________________
Street Address: ________________________________________________________________
City: __________________ State: __________ ZIP: __________

4-H Event Attending: ____________________________________________________________
Event Dates: __________________ to __________________ MM/DD/YYYY MM/DD/YYYY

PARENT/GUARDIAN or Other Person to be Notified in case of Injury or Illness:
Name: __________________________ Relationship: __________________________
E-mail: __________________________

Preferred #1: __________________________ 
Phones: #2 __________________________
Indicate mobile (M), home (H), work (W)

Home Address:
if different from participant Street Address: __________________________ City: __________________
State: __________ ZIP: __________

SECOND PARENT/GUARDIAN or Other Emergency Contact:
Name: __________________________ Relationship: __________________________
E-mail: __________________________

Preferred #1: __________________________ 
Phones: #2 __________________________
Indicate mobile (M), home (H), work (W)

ADDITIONAL CONTACT in event parent/guardian or others cannot be reached:
Name: __________________________ Relationship: __________________________
E-mail: __________________________

Preferred #1: __________________________ 
Phones: #2 __________________________
Indicate mobile (M), home (H), work (W)

HEALTH CARE PROVIDER CONTACTS:
Primary Care Physician: __________________________ Phone: __________________________
Dentist: __________________________
Other Provider (Specify): __________________________

HEALTH INSURANCE: Is participant covered by health/medical insurance? ☐ Yes ☐ No
Insurance Company: __________________________ Phone Number: __________________________
Policyholder's Name: __________________________ Policy Number: __________________________

Attach photocopy of insurance card; be sure to copy both sides of card so information is readable

AUTHORIZATION FOR PARTICIPATION AND RELEASE: I certify that this health history is correct and accurately reflects the health status of the individual to whom it pertains. I hereby give permission for medical personnel selected by University of Maryland Extension (UME) to provide routine health care; to order x-rays, and routine tests; to administer medications, injections, anesthesia, surgery, and other treatment; to release records necessary for insurance purposes; and to provide or arrange necessary related transportation for me/my child. In the event I cannot be reached in an emergency, I hereby give permission for medical personnel selected by UME to select by University of Maryland Extension (UME) to provide routine health care; to order x-rays, and routine tests; to administer medications, injections, anesthesia, surgery, and other treatment; to release records necessary for insurance purposes; and to provide or arrange necessary related transportation for me/my child. In the event I cannot be reached in an emergency, I hereby give permission for medical personnel selected by UME to secure and administer treatment including hospitalization for the participant named above. I further understand that I will be responsible for medical/hospital bills. By signing this form, I give permission for the participant named above to participate in all program activities except as specified herein. This completed form may be copied for official use. This authorization shall remain in effect for the duration of the event specified above, to include the duration of any travel to/from the event. By signing this form, I release and forever discharge, agree not to sue, and to indemnify and hold harmless the State of Maryland, University of Maryland, and University of Maryland Extension and/or their officers, agents, employees, faculty, staff, and volunteers from and against any and all liabilities, costs, expenses, causes of action, claims, and/or demands in any way relating to the foregoing program activities and/or the health, illness, injury, and/or treatment of the participant named above.

Signature of Parent/Guardian: __________________________ Date: __________ Relationship to Participant: __________________________
Signature of Adult Participant: __________________________ Date: __________ (over 18 years of age)

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4/2015
### PARTICIPANT HEALTH HISTORY

If the answer is “yes” to any of the questions listed below, explain below the question. Attach additional pages or documents as necessary.

<table>
<thead>
<tr>
<th>Question</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Have you been seriously ill or had contact with anyone with an infectious disease in the last 30 days? <em>(If yes, explain)</em></td>
<td>□</td>
<td>□</td>
</tr>
<tr>
<td>Have you traveled outside the country in the last year? <em>(If yes, list countries and dates of travel)</em></td>
<td>□</td>
<td>□</td>
</tr>
<tr>
<td>Have you recently been injured, had an accident, suffered a concussion (brain injury) or had surgery? <em>(If yes, explain)</em></td>
<td>□</td>
<td>□</td>
</tr>
<tr>
<td>Do you have any <strong>allergies to medicines</strong>? <em>(If yes, list and explain reaction)</em></td>
<td>□</td>
<td>□</td>
</tr>
<tr>
<td>Do you have any <strong>food or environmental allergies</strong>? <em>(If yes, list and explain reaction)</em></td>
<td>□</td>
<td>□</td>
</tr>
<tr>
<td>Do you carry an <strong>emergency medical device or medication</strong> <em>(epi-pen, inhaler, etc)</em>? <em>(If yes, explain and state where on your body you carry the device/medication)</em></td>
<td>□</td>
<td>□</td>
</tr>
<tr>
<td>Do you have impaired <strong>sight, hearing</strong>, or chronic ear infections? <em>(If yes, explain)</em></td>
<td>□</td>
<td>□</td>
</tr>
<tr>
<td>Do you have any <strong>nervous, neurological or mental health</strong>-related issues, such as epilepsy, seizures, dizziness, loss of consciousness, migraines, emotional stress, anxiety, or attention/behavioral disorders? <em>(If yes, explain)</em></td>
<td>□</td>
<td>□</td>
</tr>
<tr>
<td>Do you have <strong>heart or respiratory</strong> issues such as asthma, breathing disorders, persistent cough, heart murmur, chest pain, abnormal blood pressure, blood diseases, etc? <em>(If yes, explain)</em></td>
<td>□</td>
<td>□</td>
</tr>
<tr>
<td>Do you have <strong>stomach or intestinal</strong> disorders such as ulcers, gall bladder, IBS, colitis, hernia, etc? <em>(If yes, explain)</em></td>
<td>□</td>
<td>□</td>
</tr>
<tr>
<td>Do you have <strong>autoimmune</strong> disorders such as diabetes, arthritis, lupus, kidney or bladder disease, etc? <em>(If yes, explain)</em></td>
<td>□</td>
<td>□</td>
</tr>
<tr>
<td>Do you have <strong>skin</strong> diseases or disorders? <em>(If yes, explain)</em></td>
<td>□</td>
<td>□</td>
</tr>
<tr>
<td>Do you take <strong>prescription medications</strong> for any chronic or long-term condition? <em>(If yes, list the medications and explain)</em></td>
<td>□</td>
<td>□</td>
</tr>
<tr>
<td>Do you have any <strong>dietary restrictions or limitations</strong>? <em>(If yes, explain)</em></td>
<td>□</td>
<td>□</td>
</tr>
<tr>
<td>Do you have any medical conditions or special needs or circumstances not addressed above? <em>(If yes, explain)</em></td>
<td>□</td>
<td>□</td>
</tr>
</tbody>
</table>

Date of most recent **Tetanus immunization:** ___________________(MM/DD/YYYY)

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4/2015__