MICHAEL CLEMENT
Performing Arts

January 25, 2019

Peace of Christ be with you!

We warmly invite you to our summer musical production of ***You're A Good Man, Charlie Brown***!

Enclosed are the following items:

1) Saint Michael – Saint Clement School Summer Camp Registration Form **[COMPLETE AND RETURN]**
   - This form directs participants on how to pay, prices, other services, etc.
   - This cost for this camp this year will be $300.00 ($150.00 per week)
   → All payments will be through FACTS
   → All registration fee questions should be directed to Ms. Denise Polsinelli, (410) 668-8797 x214
   - Before-Care (*from 8 AM – 9 AM*) and After-Care (*from 4 PM – 6 PM*) is available;
   - The Summer Theatre Camp runs from 8:45 AM – 4 PM.
2) Saint Michael – Saint Clement School Performing Arts Summer Theatre Student Resume **[COMPLETE AND RETURN]**
   Information about the students and contact information of parent(s)/guardian(s)
3) Saint Michael – Saint Clement School Youth Camp Pick-Up Authorization Form **[COMPLETE AND RETURN]**
4) Camper Health History **[COMPLETE AND RETURN]**
5) Emergency Form (2 Pages) **[COMPLETE AND RETURN]**
6) Medication Authorization Form **[COMPLETE AND RETURN]**

If you have any questions please feel free to email Mr. W. Nicholas Zurowski, Director of Performing Arts, nzurowski@stmstc.org, or via telephone, (410) 668-8797 x137.

We look forward to seeing you!

W. Nicholas Zurowski
Director of Performing Arts
Saint Michael – Saint Clement School
10 Willow Avenue
Overlea, Maryland 21206

ST. MICHAEL-ST. CLEMENT SCHOOL
EST. 2017

cc. Mr. Paul Kristoff, Principal, Saint Michael – Saint Clement School, Overlea

2019 SUMMER CAMP at STMSTC

Dates: June 17 - August 9 2019

Students entering must be at least 3.5 years old – up to 12 years old.

Register early to reserve a place in our memory-making summer of FUN!

- **In addition to our Day Camp Program, we offer small group academic support in Math and Reading <u>for an additional fee per week.</u>**
- **Full Registration Packet will be sent home in June. It is necessary to have all forms filled out and returned before your child can attend camp.**
- **Please return this form to school. Your $50.00 registration fee will be taken out of your FACTS account beginning with your May 2019-2020 tuition payment.**
- **Weekly camp payments will be made through FACTS.**

Registration Fee: $50.00 per family (NON_REFUNDABLE) Paid N/A

Camp Options:

<u>Cost reflects PER CHILD / PER WEEK</u>

Camp ONLY 9:00AM - 3:00PM $150.00 per week_____# of weeks_____

Camp PLUS 8:00AM - 6:00PM $200.00 per week_____# of weeks_____
(*before-care and after-care*)

ADDITIONAL (Optional) FEES:
Academic Support Fee: $50.00 PER CHILD / PER WEEK
# of children_____
# of weeks_____

Child's Name:_____

Child's Name:_____

Child's Name:_____

Parent/Guardian Name:_____

Email Address:_____

Phone:_____

MICHAEL CLEMENT
Performing Arts

SUMMER THEATRE
STUDENT RÉSUMÉ

_____
STUDENT NAME

_____
STUDENT GRADE (AS OF CURRENT SCHOOL YEAR – 2018-2019)

_____
GUARDIAN NAME(s)

_____
EMAIL ADDRESS

_____
TELEPHONE NUMBER

PREVIOUS **THEATRE** EXPERIENCE:

_____

_____

_____

_____

PREVIOUS **MUSIC** EXPERIENCE:

_____

_____

_____

_____

ST. MICHAEL-ST. CLEMENT SCHOOL
EST. 2017

St. Michael-St. Clement School
Youth Camp
Pick – up Authorization form

To provide maximum safety for the children enrolled in Youth Camp we ask you to fill out this form stating who is authorized to pick up your child. This form will be kept on file. The person/s listed will be required to show legal identification to our staff before your child can leave with them.

Child Name: _____

1. Parent/Guardian: _____
Work Number: _____
Cell: _____

2. Authorized Pick - up
Name: _____
Work Number: _____
Cell: _____

3. Authorized Pick - up
Name: _____
Work Number: _____
Cell: _____

4. Authorized Pick - up
Name: _____
Work Number: _____
Cell: _____

ST. MICHAEL-ST. CLEMENT - 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

EMERGENCY FORM

INSTRUCTIONS TO PARENTS:
(1) Complete all items on this side of the form. Sign and date where indicated.
(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	Phone Number(s)		
		Place of Employment: _____ W:	C:	H:
		Place of Employment: _____ W:	C:	H:

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 _____

INSTRUCTIONS TO PARENT/GUARDIAN:

(1) Complete the following items, as appropriate, if your child has a condition(s) which might require emergency medical care.

(2) If necessary, have your child's health practitioner review the information you provide below and sign and date where indicated.

Child's Name: _____ Date of Birth: _____

Medical Condition(s): _____

_____

Medications currently being taken by your child: _____

_____

Date of your child's last tetanus shot: _____

Allergies/Reactions: _____

_____

EMERGENCY MEDICAL INSTRUCTIONS:

(1) Signs/symptoms to look for: _____

_____

(2) If signs/symptoms appear, do this: _____

(3) To prevent incidents: _____

_____

OTHER SPECIAL MEDICAL PROCEDURES THAT MAY BE NEEDED: _____

_____

_____

_____

COMMENTS: _____

_____

_____

_____

_____

Note to Health Practitioner:

If you have reviewed the above information, please complete the following:

_____ _____

Name of Health Practitioner Date

_____ (____)_____

Signature of Health Practitioner Telephone Number

MEDICATION ADMINISTRATION AUTHORIZATION FORM

St. Michael-St. Clement School

This form must be completed fully in order for operators and staff members to administer the required medication or for the student to self-administer medication. A new medication administration form must be completed at the beginning of each camp season/school year, for each medication, and each time there is a change in dosage or time of administration of a medication.

- **Prescription medication must be in a container labeled by the pharmacist or prescriber.**
- **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 operator, staff member or volunteer to administer the medication or supervise the student/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