

CAMP CO-OP



2025 Registration Packet

This summer camp is designed for Charles County Public School students who are receiving special education services.

TRANSPORTATION IS AVAILABLE FROM DESIGNATED PICK-UP AREAS BASED ON NEEDS.

- Activities include arts and crafts, swimming, games, sports, life skills, and special field trips.
- Enrollment is limited to 40 campers per session.
- Payment is due at time of registration.
- Sessions are filled on a first-come, first-serve basis.

Registration begins Monday, March 3!



For Campers Age 5-21

Age as of 12/31/2024. Campers must be enrolled with Charles County Public Schools.

9 a.m. – 2:30 p.m. • Monday-Friday
\$200 per week (includes field trips)

Camp Co-Op Location: La Plata H.S.

| | | |
|----------------|-----------------|------------------|
| Session 1..... | 314001-1A | June 23-27 |
| Session 2..... | 314001-1B | June 30-July 3 |
| Session 3..... | 314001-1C | July 7-11 |
| Session 4..... | 314001-1D | July 14-18 |
| Session 5..... | 314001-1E | July 21-25 |
| Session 6..... | 314001-1F | July 28-August 1 |

Annual Camp Co-Op Open House

FRIDAY, JUNE 20 • 4–6 P.M.

Tour the site and meet our staff! Take this opportunity to learn more about the exciting adventures at Camp Co-Op. This is also a great opportunity to meet the camp nurse and discuss medicine schedules.



Charles County Department of Recreation, Parks & Tourism
107 Centennial Street, Suite A, La Plata, MD 20646
301-932-3470 • www.CharlesCountyParks.com

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Camper's Name: _____ Nickname (if any) _____

Phone: _____ - _____ - _____

Address _____

Street

City

State

Zip

COUNTY

Place snapshot here.

Check any/all classifications that apply:

- | | | |
|---|---|--|
| <input type="checkbox"/> Attention Deficit Disorder | <input type="checkbox"/> Attention Deficit Hyperactive Disorder | <input type="checkbox"/> Autism |
| <input type="checkbox"/> Asperger Syndrome | <input type="checkbox"/> Behavioral Disorder | <input type="checkbox"/> Cerebral Palsy |
| <input type="checkbox"/> Emotional Disturbance | <input type="checkbox"/> Hearing Impairment | <input type="checkbox"/> Learning Disability |
| <input type="checkbox"/> Inclusion | <input type="checkbox"/> Toilet Trained | <input type="checkbox"/> Physical Disability |
| <input type="checkbox"/> Intellectually Challenged, Level _____ | <input type="checkbox"/> Visual Impairment | |
| <input type="checkbox"/> Other _____ | | |

Parent/Contact Information

Mother's Name _____

PHONE: Work _____ - _____ Home (if different than child) _____ - _____ Cell _____ - _____

Address (if different than child) _____ email _____

Street

City

State

Zip

Father's Name _____

PHONE: Work _____ - _____ Home (if different than child) _____ - _____ Cell _____ - _____

Address (if different than child) _____ email _____

Street

City

State

Zip

Emergency Contact (if Parent or Guardian is not available): Name _____

Day Phone # _____ - _____ Night Phone # _____ - _____ Other # _____ - _____

Self Care Skills (level of assistance)

| | Independent | Verbal Prompt | Limited Assist | Dependent | EXPLAIN |
|-------------------|---|--------------------------|---|---|---|
| Dressing: | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| Toileting: | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| | YES NO | | YES NO | | |
| Wears eyeglasses | <input type="checkbox"/> <input type="checkbox"/> | | <input type="checkbox"/> <input type="checkbox"/> | | |
| Wears hearing aid | | | <input type="checkbox"/> <input type="checkbox"/> | | |
| Uses wheelchair | | | | <input type="checkbox"/> <input type="checkbox"/> | |
| Can swim | | | | | <input type="checkbox"/> <input type="checkbox"/> |

Mobility (check all that apply)

Ambulatory ☐ Ambulatory with cane/walker ☐ Uses Wheelchair: Manual: ☐ Electric: ☐ Both: ☐

Can Transfer: Yes ☐ No ☐ Comments: _____

Communication (check all that apply)

Communicates verbally: Yes ☐ No ☐ If no, what means/methods are used to communicate: _____

Will ask for assistance by: _____

What types of adaptive methods/devices are used to communicate (please bring to camp): _____

Swimming (check all that apply)

Can swim: Yes ☐ No ☐ Can submerge head under water: Yes ☐ No ☐ Will enter pool with assistance: Yes ☐ No ☐

Can float and get face wet: Yes ☐ No ☐ Can swim independently: Yes ☐ No ☐ Comments: _____

Parents **must send swim diapers in addition to regular pullups if camper requires disposable undergarments.*

Social/Behavioral Information

Please give brief description of behavioral, and/or emotional problems, IHP documentation, level of supervision needed and any other pertinent information:

- | | | | | |
|---|--|--|---|---|
| <input type="checkbox"/> Wanders | <input type="checkbox"/> Physically aggressive | <input type="checkbox"/> Verbally aggressive | <input type="checkbox"/> Memory deficit | <input type="checkbox"/> Fabricates stories |
| <input type="checkbox"/> Particularly vulnerable; explain how _____ | | | | |
| <input type="checkbox"/> Other _____ | | | | |

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Medical History Information

Physician's Name: _____ Phone Number: _____ - _____

Insurance: _____ Policy No: _____ Effective Date: _____ Expiration Date: _____

Medicare/Medicaid # _____

CHECK ANY OF THE FOLLOWING IF APPLICABLE

Seizures: Yes ☐ No ☐ If yes, please describe frequency: _____ Type _____

Allergies Yes ☐ No ☐ Type: _____

Life threatening allergies Yes ☐ No ☐ Explain _____

Should treatment for allergies be performed by a physician? Yes ☐ No ☐ Diet Restrictions _____

☐ Diabetes ☐ Asthma Other: _____

Medication:

It is the responsibility of the legal guardian to furnish this medication. The medication must be brought to camp in the original pharmacy container appropriately labeled. This includes the child's name, name of medication, dosage, time of administration, route, name of prescriber, date of medication order, and expiration date of drug. Medication must be brought to camp by the parent or responsible adult.

☐ Check here if no medications

| Medication Taken: | Dosage | Time Given | Reason/Condition |
|-------------------|--------|------------|------------------|
| _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ |

Has your child been exempted from any immunizations?

Yes ☐ No ☐ Explain _____

Medical Release: With my signature, I certify that I will accept emergency services offered by the Department of Recreation, Parks, and Tourism for injury and/or illness. I hereby acknowledge that the designated first aid person in charge may perform emergency care and I hereby grant permission to the Department of Recreation, Parks, and Tourism to release any medical information required by said individual and do hereby give permission for treatment. I understand that medical care will be provided to my child according to the standards of the Maryland Institute of Emergency Services and said designated first aid person is protected from liability under the Good Samaritan Act.

Legal Guardian Signature: _____ Date _____

Photo Release: I hereby give my consent to the Charles County Government and its authorized representative to use my child's likeness in any and all photographs, videos, and other forms of written or oral communication for the purpose of marketing, public relations, and publicity.

This consent is authorized without any expectation of compensation or remuneration to be paid by the Charles County Government, or any third party for the use of my child's likeness in photographs, videos or any other form of oral or written communication the Charles County Government shall deem necessary to fulfill its stated mission.

I also give consent to the Charles County Government to take a recent photograph of my child to keep on file, to be used in the event a missing person's report must be filed. I also give my consent for this photograph and other necessary information to be given to the Charles County and/or Maryland State Police and any other agency for the sole purpose of filing a missing person's report. With my signature, I certify that I have read the above and/or had the information read and explained to me.

Legal Guardian Signature: _____ Date _____

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Parent/Guardian Release Statement (This section **MUST** be completed)

I hereby state that I am the Parent/Guardian of _____. On behalf of the named child, it is agreed that in case of injury or medical emergency, Camp Co-Op may make arrangements for medical care and attention including emergency transportation to the nearest hospital; and Camp Co-Op and the undersigned Parent/Guardian agree that the person whose name and number appear on this application will be notified at the earliest possible opportunity. It is further agreed that the person and/or the appropriate Parent/Guardian specifically gives Camp Co-Op the consent and authority to allow personnel at said hospital to take such medical steps and provide such care and attention as the medical personnel deem necessary to preserve and protect the life and limb of the above named camper. Such consent shall apply when the Parent/Guardian cannot be reached in due time at the numbers listed. It is further agreed and understood that the child has no physical or other handicaps, other than those listed on this application.

NOTE: Due to safety issues, if the application is misleading, contains incomplete information, and/or the child must be sent home due to behavioral issues which endanger the safety of the campers or others, the Parent/Guardian will be responsible for the full cost of picking up the child, and no refund of fees will be made.

Signature

Date

Please indicate transportation needs:

Limited transportation (made possible through a grant from the Department of Health & Mental Hygiene) is provided from two main pick-up points. **Very Limited** home pick-up and drop-off **may be** available for an additional charge of \$90 per week. (Prorated to \$72 week of June 30-July 3).

_____ My child **does not** need transportation to or from camp.

_____ My child **will** meet the bus at:

_____ Middleton Elementary/Waldorf

_____ Smallwood Middle School/Indian Head

_____ **Door-to-Door** pick up is requested (\$90 per week). Requests for door-to-door pickup must be made in writing and must include the reason for the request.

Street Address: _____

City: _____ Nearest Highway: _____

Justification (attach additional sheets if necessary): _____

I understand that checking one of the statements above **does not** guarantee bus transportation for my child.

Release of Information:

_____ I give permission for my child's teacher to release basic information to the staff of Camp Co-Op (see below).

_____ I do not give permission for my child's teacher to release basic information to the staff of Camp Co-Op.

Child's School: _____

Teacher's Name: _____



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Medication Consent Form - MUST BE SUBMITTED AT TIME OF REGISTRATION

Completion of the Medication Consent Form relieves the Charles County Government, its agents, employees, or representatives of any responsibility for ill effects resulting from the administration of the medicine.

The Camp Co-Op Nurse will administer medications and treatments to the campers as prescribed by a licensed physician. All medications must be in the original pharmacy container with a non-expired pharmacy label.

The Pharmacy label MUST include:

- Camper's Name
- Doctor's Name
- Directions for Use
- Date of Prescription
- Name of Medication/Treatment
- Prescription Number

Before administration of medicine/treatment, at least one dose of the medicine/treatment must be administered/performed at home. The date/time of last dose given at home: _____

Physician's Order for Medication/Treatment - MUST BE SUBMITTED AT TIME OF REGISTRATION

Camper's Name: _____ DOB: _____ Date of Order: _____

Diagnosis: _____

Medication/Treatment: _____

Dosage: _____ Time/Frequency of Administration: _____

Side Effects: _____

Physician's Signature: _____ Office Phone Number: _____

Parent/Guardian Permission

I _____ hereby give permission for my child _____

Print Parent/Guardian Name

Print Child's Name

to receive the medication/treatment _____

during camp. I have read and understand all the conditions in the Medication Consent form. I further give Recreation Staff permission to contact the prescriber regarding the medication/treatment.

Parent/Guardian Signature: _____ Date: _____



A new Medication Consent Form must be completed for any changes in Medication/Treatment

Charles County Department of Recreation, Parks, and Tourism • 107 Centennial Street, Suite A, La Plata, MD • 301-934-3470
MD Relay Service: 711 (Relay TDD: 1-800-735-2258) • Equal Opportunity Employer • www.CharlesCountyParks.com

Camp Co-Op Registration

ONE FORM PER PARTICIPANT
PLEASE PRINT

This section must be completed—If participant is a minor, this section should list parent or guardian information.

| | | | | | | | |
|-----------------|------|--|------|-----------------|-------|------|--------|
| Name | | | | E-Mail Address: | | | |
| Mailing Address | | | City | | State | Zip | County |
| Phone #'s | Home | | Work | | | Cell | |

| | | | |
|---------------------------|------------|---------------|--|
| Camper Information | First Name | Last Name | |
| Special Health Conditions | Age | Date of Birth | Sex M <input type="checkbox"/> F <input type="checkbox"/> |

Weekly Camp Registration

Camp runs Monday-Friday, 9 a.m.–2:30 p.m.
Program Location: La Plata High School, La Plata • Open to Age 5-21

| SESSION | CODE | DATES | CAMP COST | OFFICE USE ONLY | | |
|-------------------|-----------|--------------------|--------------------------------|-----------------|---------|--------|
| | | | | AMOUNT | INITIAL | AGENCY |
| 1 | 314001-1A | June 23-27 | <input type="checkbox"/> \$200 | | | |
| 2 | 314001-1B | June 30-July 3 | <input type="checkbox"/> \$160 | | | |
| 3 | 314001-1C | July 7-11 | <input type="checkbox"/> \$200 | | | |
| 4 | 314001-1D | July 14-18 | <input type="checkbox"/> \$200 | | | |
| 5 | 314001-1E | July 21-25 | <input type="checkbox"/> \$200 | | | |
| 6 | 314001-1F | July 28 - August 1 | <input type="checkbox"/> \$200 | | | |
| TOTAL DUE: | | | | | | |

| | | | | | | |
|---|---|------------------------------|--------------------------------|--------------------------------|-----------------------------|------------------------------|
| T-SHIRT ORDER T-Shirts are mandatory, must be worn for all field trips. Shirts may not be altered in any way. | Select requested size. Selecting the proper shirt size is the responsibility of the parent. SIZES MAY RUN SMALL | | | | | |
| | Child Sizes | <input type="checkbox"/> 6-8 | <input type="checkbox"/> 10-12 | <input type="checkbox"/> 14-16 | | |
| | Adult Sizes | <input type="checkbox"/> S | <input type="checkbox"/> M | <input type="checkbox"/> L | <input type="checkbox"/> XL | <input type="checkbox"/> XXL |

| | | | |
|---|--------------------|------------------|------------------|
| Requested Door-to-Door Transportation *Week of June 30-July 3 prorated to \$72 | | | |
| 314010-FB | No. of Weeks _____ | x \$90 per week: | Total Due: _____ |

Payment & Refund Information

Preregistration is required for most programs.

Payment

Payment is due at the time of registration. Checks and money orders must specify the program by code and must be for the exact amount, payable to:

CHARLES COUNTY COMMISSIONERS

Checks must include the current address and telephone number of the person making payment.

MasterCard, VISA, and Discover payments accepted only at the Department of Recreation, Parks, and Tourism registration office in Port Tobacco.

Refunds

All requests for refunds must be received, in writing, seven working days prior to the start of a program. Requests for refunds are accepted by email to Registration@CharlesCountyMD.gov.

After the program has begun, a prorated refund, based on participation, may be approved if requested in writing with medical verification received prior to the end of the program. No refunds will be considered after a program has ended. A \$15 administrative fee will be deducted from all approved refunds, regardless of circumstances, unless the program is canceled by Charles County Department of Recreation, Parks, and Tourism. Late fees and T-shirt costs are non-refundable.



No confirmations will be sent. You may assume you are registered unless otherwise contacted. Charles County Government is not responsible for program cancellations due to Charles County Public Schools programming, inclement weather, or unavoidable/extenuating circumstances. I, agree to participate or as the child's parent and/or guardian, I allow my child to participate in these programs knowing that safety precautions will be taken but realizing that the Charles County Government does not have accident insurance for participants. It is understood that activities such as the ones I will be participating in involve an element of risk and danger of accidents and knowing those risks, I hereby assume those risks. I do hereby release and hold harmless Charles County, Maryland, its officials, employees, instructors, and volunteers from any and all liabilities arising from any injuries that might occur during the supervised programs. I as a participant, or I as the child's parent and/or guardian, do hereby authorize the Charles County Government to take photographs and video of me/my child or my property for promotional and/or educational purposes. I do hereby authorize the Charles County Government to release the information for promotional purposes. I acknowledge that I have been informed that activities in which I/or my child participate may be shared through Charles County Government and Charles County Recreation, Parks and Tourism website and social media accounts, including photographs and live streaming videos, and I authorize and provide my consent for me/my child to being included in any such photographs or live streaming videos. I hereby state that this release is freely, willingly, and voluntarily made.

Forms without signatures will be returned.

Your signature acknowledges that you have read and understand the above.

Signature _____

Date _____



Registration Packets may be faxed to: 301-934-5624

Mail-in payments only accepted at:

Department of Recreation, Parks, and Tourism
Attn: Registration Office
107 Centennial Street, Suite A
La Plata, MD 20646

| | | | | | | | | | | | | | | | | |
|------------------------|------|-------|-----|-----|----------|----------|---------------|--|--------------|----|-----|-----|----|-----|----|----|
| OFFICE USE ONLY | Cash | Check | M/O | M/C | VISA | Discover | Staff Initial | | Reg #: | | W/I | M | PH | FX | | |
| Check/Card Name | | | | | Total | \$ | Date Entered | | Household ID | | HA | HE | MA | NCC | PI | SM |
| Check/Card # | | | | | Card Exp | | Security # | | SO | ST | WA | DCS | LK | NP | | |

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