



2023 Winter Camp Registration Form

Please fill out a separate registration form for each child you register for camp.
PLEASE READ SECTION ON FEES AND PAYMENT TERMS CAREFULLY

Primary Parent/Legal Guardian Name Home Phone Work Phone Cell Phone

Home Address Email Address

Secondary Parent/Legal Guardian Name Home Phone Work Phone Cell Phone

Home Address Email Address

Employer: Address:

CAMP DAY SELECTION AND PAYMENT

Camper's First & Last Name: Gender: M / F Date of Birth:

Camper's Age Camper T-Shirt Size

PLEASE SELECT THE CAMP DAY(S) YOUR CHILD WILL ATTEND: Rates(Member/Non-Member)

- DAY 1 DECEMBER 26 – Winter Wonderland \$25/\$30
- DAY 2 DECEMBER 27 – Sports, Sports, Sports!! \$25/\$30
- DAY 3 DECEMBER 28 – Animal World \$25/\$30
- DAY 4 DECEMBER 29 – New Year's Challenge \$25/\$30

Member 4-Day Bundle: \$80 Non-Member 4-Day Bundle: \$100

FEES: Campers qualify for the member rate if they or their parents/legal guardians are FRCC members. We accept payment by cash, check, Discover, Master Card, or Visa. Make checks payable to FRCC.

TERMS: Payment for each child must be made in full at the time of registration. There will be no exceptions to payment terms and no refunds offered. Limited space is available for Winter Camp. In case of inclement weather, if a Winter Camp Day must be canceled, credit to each camper will be given for future FRCC activities.

FINANCIAL ASSISTANCE: A limited amount of financial assistance may be available based upon need. Please inquire at the Courtesy Desk for more information and an application.

AGES: Camp programs are age appropriate. Our Winter Camp is designed for children between the ages of 6 – 13

To register for FRCC Winter Camp you must complete and sign this and all other registration/information forms. Your child will not be registered until all forms are completed, returned, and all required payments are received.

Parent/Guardian Signature: Date:

Camper Information Form

PARTICIPANT INFORMATION

Child's Name _____ Age _____ Grade _____
 Address _____
 Home Phone _____ Date of Birth _____ Gender _____

PARENT AUTHORIZATION WAIVER

Authorization for use of Visual Likeness: On behalf of the Child named above, his/her parents, guardians, and heirs, I do hereby consent and agree that the Fort Ritchie Community Center (FRCC), its employees and agents, shall have the right to record visual images of the Child named above for purposes of promoting and publicizing FRCC programs and do hereby release and waive all rights, claims, or interests to own, control or receive compensation from the use of such visual images. I warrant that I am authorized to grant the consent and to make the release and waiver indicated herein.

 Signature of Parent/Guardian Date

Waiver of liability for injuries: On behalf of the Child named above, his/her parents, guardians, and heirs, I do hereby agree to assume the full risk of any injuries, including death, damages, or loss which may be sustained by the Child named above as a result of participating in any and all activities connected with or associated with the Summer Program and to release, hold harmless, indemnify and covenant not to sue the Fort Ritchie Community Center (FRCC), their agents, employees, and volunteers for injuries, including death, damages or loss which may be sustained by the Child named above as a result of participating in any and all activities connected with or associated with the Summer Program. In the event of any injury to the Child named above, I will notify the FRCC immediately. I warrant that I am authorized to make the release and waiver indicated herein.

 Signature of Parent/Guardian Date

PICK-UP INFORMATION

Parent/Guardian Contact #1 _____

Parent Phone # Best Daytime _____

Approved Pick-Up #2 Name _____ Phone # _____

Approved Pick-Up #3 Name _____ Phone # _____

The Fort Ritchie Community Center (FRCC) Summer Camp Program is authorized to release my child only to the individuals above. I understand that each authorized person must be at least sixteen (16) years old and that my child will NOT be permitted to leave the camp with anyone not listed above. All authorized individuals will be required to show identification and sign the child out each day. A **late fee of \$5.00** per participant for every 15 minutes will be assessed for campers not picked up by closing time (1:00 PM). Payment is due within 7 days of notification of the late fee. Your signature below indicates you have read and agree to these terms.

 Signature of Parent/Guardian Date

In the event of an Emergency, I permit my child to be transported by ambulance to the hospital Yes No

Parent/Guardian Signature: _____ Date: _____

2023 Winter Camp Registration Form

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

MDH-4768 (12/2017)

Maryland Department of Health (MDH)
Office of Healthy Homes and Communities
(410) 767-8417 or 1-877-468-3464 ext. 78417
Draft Revision Date: 4/4/2018

MEDICATION ADMINISTRATION AUTHORIZATION FORM for Youth Camps in Maryland

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, 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. Non prescription medication includes vitamins, homeopathic, and herbal medicines.
- An adult must bring the medication to the camp and give the medication to an adult staff member.

Section I. PRESCRIBER'S AUTHORIZATION			
1. CHILD'S NAME (First Middle Last)	2. DATE OF BIRTH (mm/dd/yyyy)		
3. MEDICATION SHALL BE ADMINISTERED during the year in which this form is dated in 7b below unless more restrictive dates are specified in 3a and 3b. This authorization is NOT TO EXCEED 1 YEAR.	3a. FROM (mm/dd/yyyy)	3b. TO (mm/dd/yyyy)	
Medication Name	Condition Being Treated/PRN Parameters	Dose	Route
1			Frequency <input type="checkbox"/> Yes <input type="checkbox"/> No OK to Self-Carry (Emerg Meds Only) <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not emergency med
<i>Emergency Medication:</i> <input type="checkbox"/> Yes <input type="checkbox"/> No <i>Known side effects:</i>			
2			<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not emergency med
<i>Emergency Medication:</i> <input type="checkbox"/> Yes <input type="checkbox"/> No <i>Known side effects:</i>			
3			<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not emergency med
<i>Emergency Medication:</i> <input type="checkbox"/> Yes <input type="checkbox"/> No <i>Known side effects:</i>			
Section II. PARENT/GUARDIAN AUTHORIZATION			
I request the authorized youth camp operator, staff member or volunteer to administer the medication or to 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 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			
6a. PARENT/GUARDIAN SIGNATURE	6b. DATE (mm/dd/yyyy)	6c. INDIVIDUALS AUTHORIZED TO PICK UP MEDICATION	
6d. HOME PHONE #	6e. CELL PHONE #	6f. WORK PHONE #	
Section III. AUTHORIZATION FOR SELF-ADMINISTRATION / SELF-CARRY (OPTIONAL)			
THIS SECTION SHOULD ONLY BE COMPLETED IF ANY MEDICATIONS IN THE ASTHMA ACTION PLAN ABOVE ARE 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 all of the medications listed in Section I above that are checked as "OK to self-administer" or "OK to self-administer and self-carry" for the child named above under the supervision of the youth camp operator, a designated staff member or volunteer. If indicated in Section I, the child named above may self-carry emergency medications checked as "OK to self-administer and self-carry."			
7a. PRESCRIBER'S SIGNATURE	7b. DATE	8a. PARENT/GUARDIAN'S SIGNATURE	8b. DATE
<small>FOR SELF-ADMINISTRATION/SELF-CARRY</small>		<small>FOR SELF-ADMINISTRATION/SELF-CARRY</small>	

2023 Winter Camp Registration Form

MEDICATION ADMINISTRATION AUTHORIZATION FORM for Youth Camps in Maryland

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, and each time there is a change in dosage or time of administration of a medication.

Maryland Department of Health (MDH)
Office of Healthy Homes and Communities
(410) 767-8417 or 1-877-4MD-DHMH ext. 8417
Draft Revision Date: 4/4/2018

- 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. Non prescription medication includes vitamins, homeopathic, and herbal medicines.
- An adult must bring the medication to the camp and give the medication to an adult staff member.

Section I. PRESCRIBER'S AUTHORIZATION							
1. CHILD'S NAME (First Middle Last)						2. DATE OF BIRTH (mm/dd/yyyy)	
3. MEDICATION SHALL BE ADMINISTERED during the year in which this form is dated to 7b below unless more restrictive dates are specified in 3a and 3b. This authorization is NOT TO EXCEED 1 YEAR.						3a. FROM (mm/dd/yyyy)	3b. TO (mm/dd/yyyy)
Medication Name	Condition Being Treated/PRN Parameters	Dose	Route	Frequency	OK to Self-Administer	OK to Self-Carry (Emerg Meds Only)	
1					<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not emergency med	
Emergency Medication: <input type="checkbox"/> Yes <input type="checkbox"/> No <i>Known side effects:</i>							
2					<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not emergency med	
Emergency Medication: <input type="checkbox"/> Yes <input type="checkbox"/> No <i>Known side effects:</i>							
3					<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not emergency med	
Emergency Medication: <input type="checkbox"/> Yes <input type="checkbox"/> No <i>Known side effects:</i>							
4					<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not emergency med	
Emergency Medication: <input type="checkbox"/> Yes <input type="checkbox"/> No <i>Known side effects:</i>							
5					<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not emergency med	
Emergency Medication: <input type="checkbox"/> Yes <input type="checkbox"/> No <i>Known side effects:</i>							
6					<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not emergency med	
Emergency Medication: <input type="checkbox"/> Yes <input type="checkbox"/> No <i>Known side effects:</i>							
7					<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not emergency med	
Emergency Medication: <input type="checkbox"/> Yes <input type="checkbox"/> No <i>Known side effects:</i>							
8					<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not emergency med	
Emergency Medication: <input type="checkbox"/> Yes <input type="checkbox"/> No <i>Known side effects:</i>							
9					<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not emergency med	
Emergency Medication: <input type="checkbox"/> Yes <input type="checkbox"/> No <i>Known side effects:</i>							
10					<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not emergency med	
Emergency Medication: <input type="checkbox"/> Yes <input type="checkbox"/> No <i>Known side effects:</i>							
11					<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not emergency med	
Emergency Medication: <input type="checkbox"/> Yes <input type="checkbox"/> No <i>Known side effects:</i>							
12					<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not emergency med	
Emergency Medication: <input type="checkbox"/> Yes <input type="checkbox"/> No <i>Known side effects:</i>							
13					<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not emergency med	
Emergency Medication: <input type="checkbox"/> Yes <input type="checkbox"/> No <i>Known side effects:</i>							
4. PRESCRIBER'S NAME/TITLE				This space may be used for the Prescriber's Address Stamp			
TELEPHONE		FAX					
ADDRESS							
CITY		STATE	ZIP CODE				
5a. PRESCRIBER'S SIGNATURE (Parent/guardian cannot sign here) <small>(original signature or signature stamp only)</small>						5b. DATE (mm/dd/yyyy)	
Section II. PARENT/GUARDIAN AUTHORIZATION							
I request the authorized youth camp operator, staff member or volunteer to administer the medication or to 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 as authorized individual 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.							
6a. PARENT/GUARDIAN SIGNATURE				6b. DATE (mm/dd/yyyy)	6c. INDIVIDUALS AUTHORIZED TO PICK UP MEDICATION		
6d. HOME PHONE #		6e. CELL PHONE #		6f. WORK PHONE #			
Section III. AUTHORIZATION FOR SELF-ADMINISTRATION / SELF-CARRY (OPTIONAL)							
THIS SECTION SHOULD ONLY BE COMPLETED IF ANY MEDICATIONS IN THE ASTHMA ACTION PLAN ABOVE ARE 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 all of the medications listed in Section I above that are checked as "OK to self-administer" or "OK to self-administer and self-carry" for the child named above under the supervision of the youth camp operator, a designated staff member or volunteer. If indicated in Section I, the child named above may self-carry emergency medications checked as "OK to self-administer and self-carry."							
7a. PRESCRIBER'S SIGNATURE <small>FOR SELF-ADMINISTRATION/SELF-CARRY</small>				7b. DATE	8a. PARENT/GUARDIAN'S SIGNATURE <small>FOR SELF-ADMINISTRATION/SELF-CARRY</small>		8b. DATE

ASTHMA ACTION PLAN AND MEDICATION ADMINISTRATION AUTHORIZATION FORM

for Youth Camps in Maryland

Page 1 of 2

Please complete both pages of this form if the child has an inhaler or other asthma-related medication

Maryland Department of Health (MDH)
Office of Healthy Homes and Communities
(410) 767-8417 or 1-877-463-3464 ext. 78417

<p>1. CHILD'S NAME (First Middle Last) _____</p>	<p>2. DATE OF BIRTH (mm/dd/yyyy) _____</p>	<p>3. PEAK FLOW PERSONAL BEST: _____</p>	
<p>4. ASTHMA SEVERITY (check one): <input type="checkbox"/> Mild Intermittent <input type="checkbox"/> Mild Persistent <input type="checkbox"/> Moderate Persistent <input type="checkbox"/> Severe Persistent <input type="checkbox"/> Exercise Induced</p>			
<p>5. ASTHMA TRIGGERS (check all that apply): <input type="checkbox"/> Colds <input type="checkbox"/> Exercise <input type="checkbox"/> Animals <input type="checkbox"/> Dust <input type="checkbox"/> Smoke <input type="checkbox"/> Food <input type="checkbox"/> Weather <input type="checkbox"/> Other _____</p>			
Section I. ASTHMA ACTION PLAN			
<p>6. THIS ASTHMA ACTION PLAN SHALL BE EFFECTIVE FOR AND MEDICATION SHALL BE ADMINISTERED during the year in which this form is dated in 9b below unless more restrictive dates are specified in 6a and 6b. This authorization is NOT TO EXCEED 1 YEAR.</p>			
GREEN ZONE - DOING WELL			
<p>You have ALL of these</p>			
Breathing is good	Dose	Route	Frequency
No cough or wheeze	OK to Self-Administer <input type="checkbox"/> Yes <input type="checkbox"/> No		
Can walk, exercise, & play	Known side effects: _____		
Can sleep all night	OK to Self-Administer <input type="checkbox"/> Yes <input type="checkbox"/> No		
If known, peak flow greater than _____ (80% personal best)	Known side effects: _____		
Exercise Zone			
<input type="checkbox"/> Prior to all exercise/sports <input type="checkbox"/> When the child feels they need it			
YELLOW ZONE - GETTING WORSE			
<p>You have ANY of these</p>			
Some problems breathing	Dose	Route	Frequency
Wheezing, noisy breathing	OK to Self-Administer <input type="checkbox"/> Yes <input type="checkbox"/> No		
Tight chest	Known side effects: _____		
Cough or cold symptoms	OK to Self-Administer <input type="checkbox"/> Yes <input type="checkbox"/> No		
Shortness of breath	Known side effects: _____		
Other: _____	OK to Self-Administer <input type="checkbox"/> Yes <input type="checkbox"/> No		
If known, peak flow between _____ and _____ (50% to 79% personal best)	Known side effects: _____		
RED ZONE - MEDICAL ALERT/DANGER			
<p>You have ANY of these</p>			
Breathing hard and fast	Dose	Route	Frequency
Lips or fingernails are blue	OK to Self-Administer <input type="checkbox"/> Yes <input type="checkbox"/> No		
Trouble walking or talking	Known side effects: _____		
Medicine is not helping (15-20 mins?)	OK to Self-Administer <input type="checkbox"/> Yes <input type="checkbox"/> No		
Other: _____	Known side effects: _____		
If known, peak flow below _____ (0% to 49% personal best)	OK to Self-Administer <input type="checkbox"/> Yes <input type="checkbox"/> No		
<p>6a. FROM (mm/dd/yyyy) _____ 6b. TO (mm/dd/yyyy) _____</p>			

MDH-4758-C (01/2019) Please turn over - this form has 2 pages with four total sections Keep for 3 Years

ASTHMA ACTION PLAN AND MEDICATION ADMINISTRATION AUTHORIZATION FORM

for Youth Camps in Maryland

Page 2 of 2

Please complete this form if the child has an inhaler or other asthma-related medication

Maryland Department of Health (MDH)
Office of Healthy Homes and Communities
(410) 767-8417 or 1-877-463-3464 ext. 78417

CHILD'S NAME (First Middle Last)		DATE OF BIRTH (mm/dd/yyyy)	
Section II. PRESCRIBER'S AUTHORIZATION			
This space may be used for the Prescriber's Address Stamp			
8. PRESCRIBER'S NAME/TITLE			
TELEPHONE		FAX	
ADDRESS			
CITY		STATE ZIP CODE	
9a. PRESCRIBER'S SIGNATURE (Parent/guardian cannot sign here)		9b. DATE (mm/dd/yyyy)	
<small>(original signature or signature stamp only)</small>			
Section III. PARENT/GUARDIAN AUTHORIZATION			
I request the authorized youth camp operator, staff member or volunteer to administer the medication or to 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 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			
10a. PARENT/GUARDIAN SIGNATURE		10b. DATE (mm/dd/yyyy)	10c. INDIVIDUALS AUTHORIZED TO PICK UP MEDICATION
10d. HOME PHONE #		10e. CELL PHONE #	10f. WORK PHONE #
Section IV. AUTHORIZATION FOR SELF-ADMINISTRATION / SELF-CARRY (OPTIONAL)			
THIS SECTION SHOULD ONLY BE COMPLETED IF ANY MEDICATIONS IN THE ASTHMA ACTION PLAN ABOVE ARE 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 all of the medications listed in Section I: <i>Asthma Action Plan</i> above that are checked as "OK to self-administer" or "OK to self-administer and self-carry" for the child named above under the supervision of the youth camp operator, a designated staff member or volunteer. If indicated in Section I: <i>Asthma Action Plan</i> , the child named above may self-carry emergency medications checked as "OK to self-administer and self-carry."			
11a. PRESCRIBER'S SIGNATURE FOR SELF-ADMINISTRATION/SELF-CARRY		11b. DATE (mm/dd/yyyy)	
12a. PARENT/GUARDIAN'S SIGNATURE FOR SELF-ADMINISTRATION/SELF-CARRY		12b. DATE (mm/dd/yyyy)	
Section V. CAMP MEDICAL STAFF USE ONLY			
Camp Medical Staff Notes:			
Reviewed by:		DATE (mm/dd/yyyy)	

MDH-4758-C (01/2019)

Please turn over - this form has 2 pages with four total sections

Keep for 3 Years

WINTER DAY CAMP CAMPER CODE OF CONDUCT

COPY FOR PARENT/GUARDIAN TO SIGN AND RETURN TO FRCC

As a camper, I will:

- ☺ Learn and follow the rules of the camp.
- ☺ Show respect to other campers and treat others as I would like to be treated.
- ☺ Show respect to staff and cooperate fully with their instructions.
- ☺ Respect the rights and beliefs of others and treat others with courtesy and consideration.
- ☺ Communicate in an appropriate manner, which means I must not use foul language or gestures harsh words, or tone of voice.
- ☺ Conduct myself responsibly. I understand that horseplay, teasing, bullying of campers, or other unkind behaviors are not allowed.
- ☺ Refrain from deliberately causing bodily harm to other campers or staff. I understand that pushing, kicking, hitting, and fighting are not acceptable and will not be tolerated.
- ☺ Use equipment, supplies, and facilities carefully and properly.
- ☺ Respect the property of others.
- ☺ Be fully responsible for my actions and understand that irresponsible behavior will result in disciplinary action, possibly including dismissal from camp without a refund.

Parent/Legal Guardian Signature

Your signature below indicates you have received a copy of the FRCC Summer Camp Code of Conduct, that you agree to review it with your child, and that you understand that your child will be required to abide by the code while attending camp. Poor Camp conduct will result in removal from the program.

Camper Name

_____/____/_____
Parent/Guardian Signature

Date

WINTER DAY CAMP CAMPER CODE OF CONDUCT

COPY FOR PARENT/GUARDIAN AND CAMPER TO KEEP

As a camper, I will:

- ☺ Learn and follow the rules of the camp.
- ☺ Show respect to other campers and treat others as I would like to be treated.
- ☺ Show respect to staff and cooperate fully with their instructions.
- ☺ Respect the rights and beliefs of others and treat others with courtesy and consideration.
- ☺ Communicate in an appropriate manner, which means I must not use foul language or gestures harsh words, or tone of voice.
- ☺ Conduct myself responsibly. I understand that horseplay, teasing, bullying of campers, or other unkind behaviors are not allowed.
- ☺ Refrain from deliberately causing bodily harm to other campers or staff. I understand that pushing, kicking, hitting, and fighting are not acceptable and will not be tolerated.
- ☺ Use equipment, supplies, and facilities carefully and properly.
- ☺ Respect the property of others.
- ☺ Be fully responsible for my actions and understand that irresponsible behavior will result in disciplinary action, possibly including dismissal from camp without a refund.