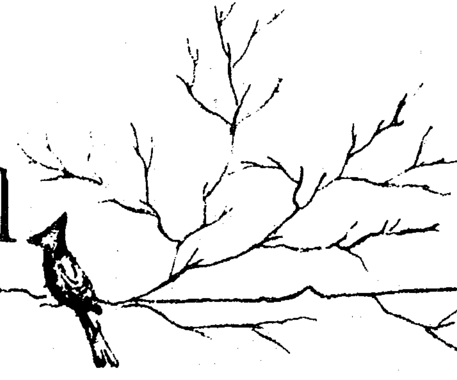
Echo Hill Outdoor School



DIRECTOR
PETER P. RICE, JR

ASSOCIATE DIRECTORS
ANDREW R. McCOWN
ELIZABETH ZELTER McCOWN

Dear Parents,

Your child will soon be embarking on a great adventure. At Echo Hill Outdoor School (EHOS) he or she will be living close to nature, experiencing and learning about our environment and our place in it. With over forty-five years of experience, we believe our curriculum of outdoor education, which emphasizes learning by doing, complements and enriches classroom learning. EHOS provides students with a unique opportunity to explore the marvels of the natural world while living closely with their peers.

Echo Hill Outdoor School, located on the Eastern Shore of Maryland, is an ideal setting for an outdoor laboratory. The school's 242 acres of forests, meadows, and freshwater shrub swamp borders a mile of sandy beach on the Chesapeake Bay, inviting a wide variety of environmental studies. A multi-faceted adventure challenge course presents individual and group initiatives aimed at building and enhancing confidence, self-esteem, and cooperation. Whether winding their way through the swamp, investigating the Bay's ecosystem on one of the 40-foot lab boats, or facing a challenge on the adventure course, the students are closely supervised by teachers fully qualified in experiential education.

During their stay, the students and teachers will be living in climate-controlled dormitories with full bathroom facilities. Bunk beds and mattresses are provided.

All the meals provide a nutritious balance of good food prepared "Eastern Shore Style." These delicious meals are served family style and facilitate healthy socialization. Some meals may be cooked outdoors by the students and teachers.

Echo Hill Outdoor School's safety record is excellent. The teachers are trained in American Red Cross First Aid and CPR. All waterfront activities are supervised by American Red Cross certified lifeguards. Should a student require additional medical attention, the school's physician, Dr. Frederick Delboy, is on call at Chestertown Family Medicine. University of Maryland Shore Medical Center of Chestertown is the nearest hospital located twelve miles away.

The attached health and registration form must be filled out with the authorization signed by you. The suggested clothing and equipment list has additional important information. Please be sure you review this list with your child.

I hope I have answered some of your questions. Please keep this sheet handy for your own reference.

Peter Rice

Dorms 2018

ECHO HILL OUTDOOR SCHOOL – 13655 BLOOMINGNECK ROAD, WORTON, MARYLAND 21678 410-348-5880
WWW.EHOS.ORG

SUGGESTED CLOTHING AND EQUIPMENT LIST (SUMMER)

All classes are conducted outdoors, and proper clothing is essential to the enjoyment of the experience. This is a basic list designed for a five-day experience during any season. **The list may require modifications based on the time of year and on your child's length of stay.** You may want to bring a twin size flat sheet to put on the mattress with your sleeping bag.

Very important items:

1 rain suit (waterproof rain coat with hat or hood, and waterproof pants if possible)
1 sweatshirt or jacket
1 hat with brim or visor
1 pair of **WATERPROOF** boots
2 pairs of comfortable shoes (sneakers, hiking boots)
1 pair of slip-on type water shoes or beach shoes (inexpensive, available at most stores)
4 short sleeve shirts or T-shirts
2 pairs long sleeve shirts
2 pairs of jeans or long pants
3-4 pairs of shorts
4 sets of underwear
4 pairs of socks
1-2 pair of pajamas
1 bathing suit
1 towel
1 sleeping bag or blanket roll
flashlight
toiletry articles (soap, toothbrush, toothpaste, hair brush or comb….)
insect repellent (cream or lotion preferred)
plastic bag for wet clothes
sunscreen
water bottle

Optional items:

laundry bag	pillow	books	$15.00 for an Echo Hill T-shirt
journal	flat twin sheet	camera	

DO NOT bring the following: (this is a MUST, for safety reasons)

FOOD,CANDY, GUM	LIGHTERS OR MATCHES
MIRRORS(may cause fires)	KNIVES
IPODS, IPADS, ELECTRONIC GAMES	CELL PHONES

Echo Hill Outdoor School, Inc.
13655 Bloomingneck Rd.
Worton, Md 21678
Telephone: 410-348-5880
www.ehos.org

Inspected: Kent County Health Department
Maryland State Fire Marshall
Maryland Department of Health and Mental Hygiene

ECHO HILL OUTDOOR SCHOOL

Summer Residential Health and Registration Form

To be filled out by parents - please print clearly and complete both sides

Your School/Group's Name:		**Date(s) Attending EHOS:**	
Gender:	**Grade:**	**Age:**	**Date of Birth:**

Child's Name (please print one letter per box):

Parent or Guardian #1 Name:

Parent or Guardian #2 Name:

Child's Home Address - Street:

Child's Home Address - City, State, Zip Code:

Home Phone:

Parent or Guardian's E-Mail Address:

Parent or Guardian's Cell Phone:

Parent or Guardian #1 Employer:	Work Phone:
Parent or Guardian #2 Employer:	Work Phone:
Person to Contact in Emergency (other than parent):	Phone:
Name of Child's Physician:	Phone:
Name of Family's Medical Insurance Company:	Policy Number:

Health Information Necessary for Child's Protection and Care:

Please circle Yes or No. If Yes please provide details; use separate page if necessary

1. Do you know of any health factor that makes it advisable for your child to follow a limited program of physical activity while at the Outdoor School? YES NO Provide Details:________________

- Recent surgery or illness: YES NO Date & Details: ________________
- Recent broken bones or sprains: YES NO Date & Details: ________________
- Recent childhood diseases or infectious diseases: YES NO Date & Details: ________________
- Asthma, heart condition, diabetes, seizure: YES NO Date & Details: ________________
- Other physical conditions: YES NO Date & Details: ________________
- Allergies to Medications: YES NO Details: ________________
- Allergies to Foods: YES NO Details: ________________
- Environmental allergies (bee stings, hayfever, etc.): YES NO Details: ________________

2. To help us supervise your child at the Outdoor School, the following information is necessary.

- Does your child sleepwalk? YES NO Details: ________________
- Does your child wet the bed at night? YES NO Details: ________________
- Has your child been away from home alone before? YES NO Details:________________
- Are there any mental, emotional, or social factors that may affect the care of your child while at the Outdoor School? YES NO Please Describe:________________

Please Complete Both Sides

Medical Information

ALL medication, prescription or otherwise, must be clearly labeled with child's name.
All medication must be in original container or it CANNOT be accepted by state guidelines.

Has your child had a Tetanus shot?	YES NO	Date of last Tetanus shot: ___/___/______ mm/dd/yyyy	
May have Tylenol if needed?	YES NO		
May have Benadryl for life-threatening emergency?	YES NO	May apply sunscreen?	YES NO
May have Benadryl for allergic reaction?	YES NO	Parent will provide __________ sunscreen *list brand*	

[ ] My child is not bringing medication.	[ ] My child takes medication as listed.
My child will be bringing an Epi-Pen YES NO Reason:	My child will be bringing an Albuterol Inhaler (for PRN or as needed) YES NO

Echo Hill requires Epi-Pens and PRN Inhalers to be carried at all times.
Please provide a fanny/waist pack for carrying.

Name of Medication	Approximate Time	Condition/Reason
1.		
2.		
3.		

Immunization Information

For Students Who Reside WITHIN the United States, a U.S. territory or the District of Columbia:	For Students who Reside OUTSIDE the United States, a U.S. territory, or the District of Columbia:
1. State/territory in which student resides: 2. Is this student exempt from any immunizations? [ ] No [ ] Yes If Yes, list them:	1. Country in which student resides: 2. Attach State of Maryland Form DHMH-896 (record of vaccination or immunity)

The following box must be completed and signed for your child to attend

This health history is correct so far as I know, and the person herein described has permission to engage in all activity, except as noted by me.

If a serious emergency occurs, it might be necessary for a physician to attend to your child before the Echo Hill Outdoor School staff is able to contact you or your designated physician. Such care can be provided ONLY if you will sign the following AUTHORIZATION FOR MEDICAL TREATMENT:

I hereby give permission to the physician selected by the director of Echo Hill Outdoor School to hospitalize, secure proper treatment for, and to order injection, anesthesia or surgery for my child as named above. I understand that the health insurance policy which I carry on my child is the primary policy in case of any illness or injury. Echo Hill Outdoor School carries an excess policy which covers expenses not paid by my primary family insurance, including deductibles and co-pays up to our limit.

I understand that the program my child is participating in may involve specialized activities (boating, canoeing, low and high ropes challenge course.) I give permission for my child to participate in these activities and to be transported by Echo Hill Outdoor School for these activities. I know and understand the inherent risks and dangers involved in the above named activities and I understand that although EHOS will take reasonable precautions, it is impossible to guarantee absolute safety, and that unanticipated dangers might arise. I hereby release EHOS from any responsibility for injury which might occur as a result of participation in EHOS activities.

I give Echo Hill Outdoor School permission to reproduce and publish any photo, picture, video, or likeness of my child for the purpose of enhancing enrollment and/or marketing.

Signature ____ Date ______________________

Relationship to child ____

A signed, printed copy of this form must accompany your child.

MEDICATION ADMINISTRATION AUTHORIZATION FORM
for Youth Camps in Maryland

Department of Health & Mental Hygiene (DHMH)
Center for Healthy Homes and Community Services (CHHCS)
(410) 767-8417 Toll Free 1-877-4MD-DHMH 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 adult 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 to administer the medication or supervise the camper in self administration if authorized as prescribed by the above 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 adult must pick up the medication, otherwise it will be discarded. I authorize camp personnel to communicate with the prescriber as allowed by HIPAA.

15a. PARENT/GUARDIAN SIGNATURE		15b. DATE
15c. HOME PHONE #	15d. CELL PHONE #	15e. 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, insulin 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 consent that the child named above is able to self administer the medication listed. I authorize self administration of the above listed medication for the child named above under the supervision of an authorized youth camp operator/staff member. 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

MEDICATION ADMINISTRATION FORM

Department of Health & Mental Hygiene (DHMH)
Center for Healthy Homes and Community Services (CHHCS)
6 St. Paul Street, Suite 1301
Baltimore, Maryland 21202-1608
(410) 767-8417 FAX (410) 333-8926
Toll Free 1-877-4MD-DHMH ext. 8417

I. FACILITY RECEIPT AND REVIEW

MEDICATION RECEIVED FROM		DATE
PLAN OF ACTION RECEIVED [ ] YES [ ] NO [ ] N/A	HEALTH SUPERVISOR NOTIFIED [ ] YES [ ] NO	
MEDICATION RECEIVED BY	PERSON'S SIGNATURE	DATE

II. MEDICATION ADMINISTRATION RECORD

Each administration of the listed medication shall be noted on the child's record below. Each nonprescription and prescription medication requires a separate medication authorization form and the administration of the listed medication is required to be recorded on the corresponding administration record.

Child's Name:	Date of Birth:
Medication Name:	Dosage:
Route:	Time(s) to Administer:

DATE	TIME	DOSAGE	REACTION OBSERVED (IF ANY)	STAFF OR SELF ADMINISTERED	ADMINISTERED OR SUPERVISED BY SIGNATURE

MEDICATION FINAL DISPOSITION FORM

Department of Health & Mental Hygiene (DHMH)
Center for Healthy Homes and Community Services (CHHCS)
6 St. Paul Street, Suite 1301
Baltimore, Maryland 21202-1608
(410) 767-8417 FAX (410) 333-8926
Toll Free 1-877-4MD-DHMH ext. 8417

I. FINAL DISPOSITION OF MEDICATION

Child's Name:	Date of Birth:
Medication Name:	Final Disposition: [ ] **Returned** *(Complete Section A)* [ ] **Destroyed** *(Complete Section B)*

Section A

MEDICATION RETURNED TO:	DATE
MEDICATION RETURNED BY (PERSON'S SIGNATURE)	DATE

Section B

The above indicated medication was not retrieved by the parent/guardian within 1 week of the camper leaving camp; therefore, it has been destroyed according to COMAR 10.16.06.33.

SIGNATURE OF PERSON RESPONSIBLE FOR DESTROYING MEDICATION	DATE
SIGNATURE OF PERSON WITNESSING THE DESTRUCTION OF THE MEDICATION	DATE