



ALS Application Form

Deadline: May 15

Submit to: matt@leadershipmd.org

Parent/Guardian Information

Primary Parent/Guardian

Name: _____

Address: _____

Date of Birth (mm/dd/yyyy) : ____ / ____ / ____

Email Address: _____

Home Phone Number: ____ - ____ - ____

Cell Phone Number: ____ - ____ - ____

Business Phone Number: ____ - ____ - ____

Secondary Parent/Guardian

Name: _____

Address: _____

Date of Birth (mm/dd/yyyy) : ____ / ____ / ____

Email Address: _____

Home Phone Number: ____ - ____ - ____

Cell Phone Number: ____ - ____ - ____

Business Phone Number: ____ - ____ - ____

Delegate Information

Name: _____

Preferred Name: _____

Gender (circle one): M / F

Height: _____

Weight: _____

Hair Color: _____

Eye Color: _____

T-Shirt Size (circle one): Youth: Small / Medium / Large

Adult: Small / Medium / Large / XL / XXL

Grade Entering in the Fall: _____

Current School: _____

School Entering in the Fall (if applicable): _____

School Type (circle one): Public / Private / Homeschool/Other

Ethnic Origin (Circle all that apply):

- American Indian / Alaskan Native
- Asian
- Black / African American
- Hawaiian / Pacific Islander
- Hispanic / Latino
- White
- Two or more Ethnicities

Date of Birth (mm/dd/yyyy): ____ / ____ / _____

Delegate Email Address: _____

Delegate Cell Phone: _____ - _____ - _____

Please indicate any special information we should be aware of (circle all that apply):

- Medication
- Medical Condition
- Life – Threatening Allergy
- Allergy
- Asthma
- Special Needs
- Dietary Restrictions
- Other
- None

Have You Previously Attended an MLW program? Yes / No

If “Yes”, which program did you attend? _____

How did you hear about MLW? (circle one)

- School
- Friends
- MASC / Student Government
- Leadership Maryland
- Newspaper / Camp guides
- Former Delegates and/or Staff
- MLW Website
- Facebook
- Camp Fair
- Other

Interview Availability

Part of your application is a phone interview. On the lines next to the days of the week, please list the hours that you, the delegate, are typically available for a 15 to 20-minute interview each day. Weekday interviews can take place in the evenings and weekend interviews can happen during the day. Please list the window of time that you are typically available.

Monday		Saturday	
Tuesday		Sunday	
Wednesday			
Thursday			
Friday			

Sponsorship Information

Are you receiving a sponsorship (meaning your tuition is being partially or fully paid for by someone else) from your school or other organization? (circle one) Yes / No

If "Yes", please complete the information below:

Sponsored to attend MLW by: _____

Amount of sponsorship: _____

Contact Name for Sponsorship: _____

Email for Sponsorship: _____

Phone for Sponsorship: _____ - _____ - _____

Medical Questionnaire

Due to new regulations we will require all applicants to complete and submit all Medical forms (available with the rest of our supplemental forms). If any of the forms do not pertain to your child, simply mark N/A on the form before submitting.

Emergency Contacts

Please indicate two alternative people to contact if the family is not available.

Primary Emergency Contact: _____

Relation to Delegate: _____

Primary Phone: _____ - _____ - _____

Secondary Phone _____ - _____ - _____

Secondary Emergency Contact: _____

Relation to Delegate: _____

Primary Phone: _____ - _____ - _____

Secondary Phone: _____ - _____ - _____

Healthcare Provider Contact Information

Delegate's Physician: _____

Physician Phone: _____ - _____ - _____

Physician Address: _____

Name of family dentist/orthodontist: _____

Dentist/Orthodontist Phone: _____ - _____ - _____

Dentist/Orthodontist Address: _____

Health Information

Does your child have any medical conditions, psychological conditions, behavioral conditions, medications, dietary restrictions, allergies, or special needs that we need to be aware of? (circle one)

Yes / No

Please explain any medical conditions, psychological conditions, behavioral conditions, medications, dietary restrictions, allergies, or special needs that we need to be aware of:

Does your child have any medication allergies? (circle one) Yes / No

Please explain any medication allergies:

Does your child have any food or other allergies? (circle one) Yes / No

Please explain any food or other allergies:

Does your child have dietary restrictions or other needs? (circle one) Yes / No

Please explain any dietary restrictions or other needs:

Immunization Information

Does the delegate reside within the United States? (circle one) Yes / No

If “Yes”, please complete the information below:

State / Territory where the delegate resides: _____

Is the delegate exempt from immunizations? (circle one) Yes / No

If “Yes”, please list them: _____

If “No”, please provide the country in which the delegate resides: _____

Please Note: All International Delegates are required to complete and submit an International immunization form, available through this URL:

https://phpa.health.maryland.gov/OIDEOR/IMMUN/Shared%20Documents/MDH_896_form.pdf

All completed forms should be submitted to matt@leadershipmd.org

Insurance Information

Is the delegate covered by medical/hospital insurance? (circle one) Yes / No

If “Yes”, please complete the information below:

Insurance Company: _____

Insurance Phone Number: _____ - _____ - _____

Policy Number: _____

Group Number: _____

ID Number: _____

If “No”, please read and sign the section on the next page:

There is no medical insurance in effect to cover my above-named son/daughter for any illnesses, injuries, or other adverse health outcomes that he/she may experience. I, therefore, hereby agree to assume direct and complete financial responsibility for any and all medical care of any kind that my above-mentioned son/daughter receives while attending Maryland Leadership Workshops, Inc.'s 2018 summer residential leadership programs.

Further, I hereby agree to reimburse Maryland Leadership Workshops, Inc. for any and all costs, medical expenses, and other sums that Maryland Leadership Workshops, Inc. advances that relate to the medical treatment of my son/daughter while he/she is attending Maryland Leadership Workshops, Inc.'s 2018 summer programs.

Parent/Legal Guardian Signature	Printed Name	Date
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Scholarship Information

If applying for a scholarship for 2018, please contact matt@leadershipmd.org to obtain a scholarship application.

Parent/Legal Guardian Employment Information

Primary Parent/Guardian employer: _____

Secondary Parent/Guardian employer: _____

Behavioral Questionnaire

The section provided on the following page asks for information that is important for us to ensure your child has a successful week at MLW. Your answers to these questions ARE NOT a factor in the acceptance of your child into our program. Please be honest and forthright so that our staff can best prepare to work with your child.

If your child has a mental or physical health diagnosis or issue, how does it affect them on a day-to-day basis? What do we need to know?

Has your child ever been hospitalized due to behavioral issues? If yes, please explain:

Has your child ever been away from home without family for a week? (circle one) Yes / No

Does your child relate easily to others, or is that often a challenge?

Does your child enjoy participating in large group activities? Or are they happier being alone/in small groups?

When your child is frustrated, angry, upset or sad, how do they handle these emotions?

What techniques are successful for handling inappropriate behaviors by your child, should those behaviors arise?

Describe your child's personality. What do they enjoy/not enjoy doing?

Custodial Information

Does anyone other than the adults listed in this application have permission to pick your child up from camp? (older siblings, extended family members, friends, etc.)

(circle one) Yes / No

If "Yes", please enter the names and phone numbers of up to 3 authorized persons below:

Authorized Person 1 Name: _____

Authorized Person 1 Phone Number: _____ - _____ - _____

Authorized Person 2 Name: _____

Authorized Person 2 Phone Number: _____ - _____ - _____

Authorized Person 3 Name: _____

Authorized Person 3 Phone Number: _____ - _____ - _____

Is there an issue over custody of the delegate? (circle one) Yes / No

If "Yes", please explain the issue over custody. Be as thorough as possible so there is no confusion while your child is in our care:

Waivers

Parents/Guardians - Please read this form and review with your child.

Attendance and Refund Policies

The following refund schedule applies for delegates who cancel their registration.

- Cancellations before May 1st, will receive a \$500 refund.
- Cancellations between May 1st and June 1st, will receive a \$300 refund.
- Cancellations after June 1st^t cannot be refunded.
- Refunds will be issued by September 30th.

All necessary items for a complete application, including signed medical forms, must be received prior to May 15th. A reserved space in the program may be forfeited in order to make room for the delegates who are on the waiting list if material is not received by the deadline.

Students participating in MLW's summer programs must participate in the entire week-long residential experience. Students will not be permitted to arrive at the program late or depart early. Unfortunately, refunds cannot be made to students who, for unexpected health or other reasons, must leave the program early. MLW reserves the right to expel without refund any student who violates MLW's Rules and Expectations, violates Maryland State law, or for other cause.

Permission to Apply and Attend

I hereby grant permission for my child to apply to and participate in this program. I accept and assume any and all risks associated with his/her attendance and participation in the program and its activities. I understand that my child should not attend the camp if he/she is not healthy. I understand that my child must abide by program policies and the instructions of program staff. I permit my child and his/her image to be involved in activities and media events that are designed to promote the benefits of Maryland Leadership Workshops, Inc., including but not limited to photographs, videotapes, posting images on the MLW website, facebook page, Twitter, Instagram and othersocial media, newsletters and press releases. Additionally, I hereby grant permission for MLW to share the school name and email address of my child with other participants in MLW programs, local school system personnel, Leadership Maryland, and local community leadership associations. Knowing these facts, I, for myself, my child at tending the program, and anyone else who might claim on my or my child's behalf, hereby agree that MLW is not responsible for lost or stolen items, accidents, injuries, and/or medical or dental expenses arising from my child's participation in the program and, accordingly, I covenant not to sue, and waive, release and discharge MLW and anyone working on their behalf from any and all claims of liability or expenses of any kind or nature whatsoever arising out of or relating to my child's participation in the program. I have carefully read all of the information in this application form and agree to all conditions.

Expectations of Delegate

RESPECT

Respect for one another is of primary importance in order for all delegates and staff members to learn and grow throughout the week. Treat others with respectful behavior so that you may expect the same in return. Respectful behavior includes:

- Respect requests made by MLW staff members and campus employees.
- Avoid the use of profanity/obscene language.
- Respect the privacy of MLW participants and other groups who may be using the campus.
- Avoid touching of other people and their belongings (this includes fights and theft).
- Respect all ideas and beliefs and avoid the use of derogatory comments towards others.

ATTENDANCE

It is expected that you will attend all scheduled activities. We have many fun and challenging activities for you and expect that you will be a part of each one.

Eating three balanced meals a day, drinking plenty of liquids, and getting enough sleep will ensure that attending all activities will be no problem.

In case of an emergency or any circumstance preventing participation in activities, notify a staff member immediately!

Rules and Procedures to Follow for a SAFE and FUN week

IN AND AROUND DORMITORIES

There will be no guys on girls' halls and no girls on guys' halls unless approved in advance for an official activity. This includes stairwells that lead from such halls, which are labeled "off limits." Common areas are open to all delegates.

No outside visitors are permitted at anytime during the week without prior permission from the program director.

In the event of a fire, pull the fire alarm and exit the building quickly, knocking on the doors that you pass. Check in with your assigned staff member at the designated meeting location.

In the event of another type of emergency, contact the staff member who is on Dorm Duty. His/her name will be posted on your hall each day.

Do not prop open outside doors at anytime.

CHECK-IN AND LIGHTS OUT

Check-in will occur every night at the time indicated in the guidebook you receive at registration. You must check in with a staff member from your hall by the stated time. We will give you time to get ready for bed, and we will usually schedule a hall meeting after check-in.

Lights must be TURNED OFF at the time designated in your guidebook. Although you may be accustomed to staying up a bit later, remember that this week is very active and demands your full energy every day. You will need your sleep to fully participate in all activities.

AROUND THE CAMPUS

At registration, you will receive an MLW button with your name on it. This button must be worn at all times unless, of course, you are in the shower or sleeping. You must also wear shoes at all times except when showering and sleeping (although you may want to wear shower shoes).

You may NOT leave campus at any time or for any reason. If you are uncertain of campus boundaries, ask a staff member. Commercial properties located near the campus are not part of the campus. If you have forgotten a necessity item, give the office staff money and a written description of the item, and they will secure it for you.

If you are driving yourself to the program, please inform the MLW Executive Director Anita Anderson at anita@leadershipmd.org so that parking and other arrangements can be made for you.

Do NOT walk alone anywhere — always take a buddy with you.

TOBACCO, ALCOHOL, AND OTHER DRUGS

The possession and/or use of drugs, alcohol, and tobacco is absolutely forbidden at all times during the week. No over the counter or prescription medication is allowed in dorm rooms. All medication is to be turned in to the health consultant at registration and will be available by coming to the MLW onsite office. Only delegates with forms signed by a health practitioner will be allowed to take over the counter or prescription medication.

INAPPROPRIATE BEHAVIOR AND CONSEQUENCES

These expectations are intended to allow all delegates and staff members to have a safe and successful week. Any behavior described in this document or at the discretion of a staff member that threatens or jeopardizes the safety of other persons or their enjoyment of the program will not be tolerated. The MLW directors and staff may take any of the following actions as a consequence for delegates who do not meet the expectations outlined above:

- A conference with the delegate and a staff member.
- A conference with the delegate and a program director.
- A phone call home informing a parent/guardian of the incident.
- A delegate-written letter of apology to the offended party.
- The withholding of participation in social activities.
- Removal from the program (a parent/guardian will be requested to pick up the student).

MEDICATION AND HEALTH CARE RELEASE

PARENTAL RELEASE AND ACKNOWLEDGMENT:

I give permission to authorized personnel to carry out such emergency diagnostic and therapeutic procedures as may be necessary for my son/daughter, and also permit such procedures to be carried out at, and by, local hospital(s) in the event that my son/daughter is taken there for emergency care. I agree to the release of any records necessary for insurance purposes. I grant permission to Maryland Leadership Workshops, Inc. to arrange any related transportation necessary to care for my child. I understand that any medical expenses will be directly billed to my insurance company or me. **I certify that all medical and health history information provided in this application is complete and accurate to the best of my knowledge. I hereby release and hold harmless Maryland Leadership Workshops, Inc. and its agents, servants, contractors and employees from any and all liability that may result from medical care of my son/daughter. I further certify, that unless indicated on the Delegate Medication Form, my son/daughter is capable of self-administering any prescribed medication(s) and I assume all responsibility and liability stemming from my decision to have my child self-administer medication(s).**

In the event that there is no medical insurance in effect to cover my above-named son/daughter for any illnesses, injuries, or other adverse health outcomes that he/she may experience. I hereby agree to assume direct and complete financial responsibility for any and all medical care of any kind that my above-mentioned son/daughter receives while attending Maryland Leadership Workshops, Inc.'s 2018 summer residential leadership programs. Further, I hereby agree to reimburse Maryland Leadership Workshops, Inc. for any and all costs, medical expenses, and other sums that Maryland Leadership Workshops, Inc. advances that relate to the medical treatment of my son/daughter while he/she is attending Maryland Leadership Workshops, Inc.'s 2018 summer programs.

My child and I have read and understand the policies, expectations, and rules stated above and acknowledge that violation of any of these rules may result in dismissal.

Delegate First and Last Name: _____

Delegate Signature: _____ Date: _____

Parent/Guardian First and Last Name: _____

Parent/Guardian Signature: _____ Date: _____

MLW PACKING LIST

- Enough comfortable, weather appropriate clothing for the week. Your clothes for the week should be school-appropriate; if you wouldn't be allowed to wear it at school, please do not bring it to MLW. MLW staff and delegates all wear casual, comfortable clothing. It's a good idea to bring shorts, t-shirts, jeans, sneakers, and a sweatshirt, as we'll be doing activities both inside the air conditioning and outside in the summer heat.
- There will be a variety show/showcase that delegates will plan and implement. Please bring any instruments, equipment, or anything else that will help you share your talent with the rest of the MLW community, if you like.
- Sheets for an extra-long twin bed (and/or a sleeping bag) and a blanket (the dorms are air conditioned so it can get cold)
- Pillow
- Towels – bath towel, hand towel, wash cloth
- Toiletries (don't forget a toothbrush, toothpaste, hand soap, shower soap, and deodorant)
- Shower Shoes
- A rain jacket/umbrella
- Alarm Clock
- Pens or pencils
- Reusable water bottle
- Small backpack or drawstring bag to carry guidebook, pens, etc.
- Athletic equipment for recreation time
- Light snacks and drinks for evenings (optional – MLW will also provide).
- An outfit (shorts, tshirt, old shoes) that can get wet and dirty
- One business casual outfit
- Sunscreen and Bug Spray, as we do activities outdoors during the day and in the evenings.



ALS Application Recommendation Form

Also available online at goo.gl/c8eFxR

To the Applicant: If you have never attended an MLW program, please give this form to be completed by someone who can write about your leadership potential. Be sure to complete your information before giving the form to your recommender. It is also a good idea to provide a self-addressed, stamped envelope.

To the Recommender: Please answer the questions below based on your interaction with the applicant. If accepted, this student will spend a week with student leaders from the Mid-Atlantic region, developing his/her leadership skills, implementing a project, and setting goals for action at home. For more information, visit www.mlw.org.

To be completed by Applicant:

Delegate (Student) Name: _____

Recommender Name: _____

To be completed by Recommender:

Recommender Address: _____

City/State/Zip: _____

Phone: _____ Email address: _____

Relationship to Student: _____

Length of Time You Have Known Student: _____

Please rate applicant in the following areas using a scale from 1-5

(1=not at all strong in this area, 2=low in this area, 3=average in this area, 4=good in this area, 5=very strong in this area)

Ability to work with others	1	2	3	4	5
Self-awareness	1	2	3	4	5
Communication skills	1	2	3	4	5
Ability to give and receive feedback	1	2	3	4	5
Ability to empower and motivate others	1	2	3	4	5

Please respond to the following questions in order to give us additional insight on the applicant. If you would prefer, you may use an additional sheet of paper to record your answers.

1. What are the applicant's strengths and weaknesses?

2. How does the applicant demonstrate leadership potential?

3. How would the MLW community be enriched by the applicant's participation?

4. Other comments:

Signature

Date

Please return this form directly to: MLW, c/o Leadership MD., 134 Holiday Court, Suite 318, Annapolis, MD 21401 or Fax: 410-841-2104; email a pdf copy to matt@leadershipmd.org



ALS Application

Student Leadership Insights Questionnaire

Please answer the following questions on a separate sheet of paper in complete sentences. You may either type or write neatly in blue or black ink. Please put your full name at the top of each page. Applicant answers are usually about a half-page to full page in length, but please feel free to use as much space as you would like.

The answers to these questions are a factor used in the process to determine whether you are accepted to ALS. If you are accepted, the staff will use your answers to design a program to meet your needs.

Delegate First and Last Name:

Date: ___ / ___ / ____

1. Why do you want to attend ALS?
2. Using your own words, how would you best define or describe "leadership"? Think about characteristics, skills, qualities, and/or behaviors leaders possess in creating your definition/description.
3. Using your definition/description of leadership from question 2, tell us about one instance in which you demonstrated leadership. Describe the skills and qualities you used, the challenges you faced, and how you overcame those challenges.
4. Imagine that you were the leader of a committee that was put in charge of fixing a serious issue facing high school students in Maryland. What serious issue would you choose? Why would you choose this issue? What specifically could your committee do to help?
5. Describe yourself. What are your interests and/or talents? What types of activities are you involved with? What do you like to do in your spare time?
6. ALS is a learning experience designed to help you grow. What aspect of your leadership potential would you like to work on while at ALS? What skills would you like to develop or polish while here at ALS?
7. What is one piece of advice that you have for the upcoming ALS staff as we design our program? Consider what topics or activities you would like us to include, how you'd like us to schedule the days, things you want us to keep the same as other MLW programs and things you'd like to change from other MLW programs.
8. Please list the years that you have previously attended MLW, the program and group that you were in for those years, the main idea of your group's project, and the major concepts or skills that you took out of each year.

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 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 ____/____/____ MonthDay Year	
3. CONDITION FOR WHICH MEDICATION IS BEING ADMINISTERED:		4. EMERGENCY MEDICATION <input type="checkbox"/> YES -If yes, see Section III below. <input type="checkbox"/> 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 ____/____/____ MonthDay 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		
14a. PRESCRIBER'S SIGNATURE (Parent/guardian cannot sign here) <i>(ORIGINAL SIGNATURE OR SIGNATURE STAMP ONLY)</i>		14b. DATE	

II. PARENT/GUARDIAN AUTHORIZATION

I request the authorized youth camp operator, staff member or volunteer to administer the medication or 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, 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

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) <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> N/A - Not emergency medication	16c. DATE
17a. PARENT/GUARDIAN'S SIGNATURE authorizing self-administration	17b. SELF-CARRY EMERGENCY MEDICATION (Check One) <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> N/A - Not emergency medication	17c. DATE

MLW DELEGATE MEDICAL FORM –Over the Counter Medication Form

The delegate will only be allowed to have OTC medicine and self-administer medication on an as needed basis if this form is filled out correctly and in our files. Therefore, please fill this form out completely, sign at the bottom, and return to MLW (or upload to your online account) by May 15th. THESE MEDICATIONS WILL BE STORED IN THE MLW OFFICE, and delegates can request to take them as needed.

Program:	ALS	MSEL	SHW	Journey	Delegate Name: _____
Delegate's Age: _____					Delegate's Weight: _____

Drug Name Generic may be substituted for brand name	Route/How it is taken	Dosage & Schedule (per label instructions by age/weight, unless otherwise indicated)	Indications	Parent/Guardian/ Health Care Provider Permission (circle one)	Things to be aware of when on this medication/Comments
Tylenol (or generic)	PO (chewable, elixir, or tabs) PR (suppository)	Per label Instructions	Pain or Fever	Yes or No	
Ibuprofen	PO (chewable tabs, suspension, or tablets)	Per label Instructions	Pain or Fever	Yes or No	
Robitussin (or generic)	PO (syrup)	Per label Instructions	Cough	Yes or No	
Pepto-Bismol (or generic)	PO (liquid or chewable tabs)	Per label Instructions	Upset stomach, Diarrhea	Yes or No	
Kaopectate (or generic)	PO (liquid or tab)	Per label Instructions	Diarrhea	Yes or No	
Children's Mylanta (or generic)	PO (chewable)	Per label Instructions	Upset stomach	Yes or No	
Sudafed (or generic)	PO (tabs or liquid)	Per label Instructions	Nasal congestion, Eustachian tube congestion	Yes or No	
Chlorpheniramine	PO (chewable tabs, suspension, or tabs)	Per label Instructions	Seasonal allergy symptoms	Yes or No	
Zyrtec/Claritin	PO	Per label Instructions	Seasonal allergy symptoms	Yes or No	
Dramamine/Bonine (or generic)	PO (chewable/regular tabs)	Per label Instructions	Motion Sickness	Yes or No	
Dimetapp (or generic)	PO (elixir or tabs)	Per label Instructions	Nasal congestion, Season allergy	Yes or No	
Benadryl (or generic)	PO (elixir, chewable, tab, or pills); topical ointment	Per label Instructions	Allergic reactions (hives, insect bite, allergies)	Yes or No	
Antibiotic ointment	Topical	Per label Instructions	Superficial cuts/abrasions	Yes or No	
Hydrocortisone Cream	Topical	Per label Instructions	Allergic reactions, contact dermatitis, insect bite	Yes or No	
Calamine Lotion	Topical	Per label Instructions	Allergic reaction (insect bite, hives)	Yes or No	
Vitamins and/or Supplements*	PO	Per label Instructions		Yes or No	

I, _____ (parent/guardian name), give permission for my child to take the medications listed "YES" above and my child has taken at home at least 1 dose of the medication(s) listed as "YES" above.

I do NOT want my child to take the following medications: _____

Parent or Legal Guardian's Signature _____ **Date** _____