The Health Museum
JOHN P. MCGOVERN MUSEUM OF HEALTH & MEDICAL SCIENCE
A real body of knowledge

The Health Museum – Camp Office • 1515 Hermann Drive • Houston, Texas 77004-7126
PH. 713-521-1515 ext. 121 • FX. 713-942-7055
Website: www.thehealthmuseum.org • **E-mail:** camps@thehealthmuseum.org

GENERAL RELEASE & CONSENT

2020 Discovery Camps

PLEASE READ AND SIGN

The Health Museum is offering camps in its 2019 Discovery Camps Program. While every preventative measure will be taken, injuries may occur during a camper's participation in the 2019 Discovery Camps Program. This is a risk that the camper and his/her legal guardians voluntarily agree to assume in exchange for the privilege of registering for and participating in the chosen camp(s). The camper and his/her guardians understand and agree that this risk is one that The Health Museum does not assume and that the Health Museum is not responsible for any injuries to the camper.

Accordingly, _____ (the "guardian"), the legal
Please print name of parent or legal guardian

guardian of _____(the "camper") voluntarily
Please print name of child/camper

releases The Health Museum and its directors, officers, employees, volunteers, agents, and all persons acting by, through, under or in concert with The Health Museum (collectively called the "Released Parties") from any and all losses, demands, claims, suits, causes of action, liabilities, costs, expenses, and judgments whether arising in equity, at common law, or by statute, under the law of contracts, torts, or property, for personal injury (including without limitation emotional distress), arising in favor of the guardian or the camper based upon, in connection with, relating to or arising out of, directly or indirectly, the camper's participation in the camp (collectively called "Claims") AND EVEN IF ANY SUCH CLAIMS ARE DUE TO THE RELEASED PARTIES' OWN NEGLIGENCE, STRICT LIABILITY WITHOUT REGARD TO FAULT, VIOLATION OF STATUTE OR OTHER FAULT. The guardian and the camper hereby give their permission to the Released Parties to seek emergency medical treatment for the camper if any Released Party deems in its discretion that such emergency medical treatment is necessary.

CAMPER SIGNATURE _____ DATE _____

PARENT/GUARDIAN SIGNATURE _____ DATE _____

BY SIGNING THIS DOCUMENT, YOU ARE WAIVING CERTAIN LEGAL RIGHTS. PLEASE READ THIS DOCUMENT CAREFULLY BEFORE SIGNING.

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2020 DISCOVERY CAMPS GUIDELINES

We want your child's experiences with The Health Museum Discovery Camps to be extraordinary! Please review the following guidelines with your child and return this form to the Camp Office along with the General Release & Consent form.

Campers:

- ✓ Treat others as you would like to be treated.
- ✓ Respect the property of others, including the property of both the Museum and fellow campers.
- ✓ Listen to and follow the directions given to you by Museum staff at all times.
- ✓ Be curious! Participate in activities and ask questions!
- ✓ Remember that safety is a priority.
- ✓ Appropriate behaviors include, but are not limited to the following:
  - Being respectful
  - Being courteous
  - Being helpful
- ✓ All cell phones and portable electronic devices are expected to be turned off and put away during the camp day.*

*The Health Museum is not responsible for the safety or replacement of personal items brought to camp by campers. We discourage campers from bringing non-camp related items with them – particularly items that may have significant monetary or personal value.

We have read and understand the guidelines and expectations on this form and understand that inappropriate behavior could result in dismissal from camp. If a camper is dismissed from camp for inappropriate behavior, no refund will be given.

CAMPER SIGNATURE _____ DATE _____

PARENT/GUARDIAN SIGNATURE _____ DATE _____

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2020 DISCOVERY CAMPS DISCIPLINARY PROCEDURES

Each camper has a reasonable expectation to enjoy a positive camp experience. Therefore, the misbehavior of one camper, or a group of campers, should not be permitted to impact negatively on the camp experience of others. Prompt action is required when problems occur. Parents and campers should be aware of the disciplinary policy.

First Offense: Campers failing to adhere to camp rules, or exhibiting behavior clearly intended to annoy or endanger other campers, will be privately and formally warned by the Camp Instructor and informed that subsequent misbehavior will result in formal counseling by the Senior Program Manager.

Second Offense: Subsequent misconduct will result in counseling by the Senior Program Manager and a warning that further misconduct will result in removal from camp. At this point, the Senior Program Manager will contact the parent or guardian to advise him/her of the situation and the possible need for picking the child up from camp if there is further misconduct.

Third Offense: Any further inappropriate behavior will result in counseling by the Director of the Education Department and expulsion from camp.

NOTE: THE HEALTH MUSEUM EXPECTS EACH CAMPER TO HAVE A SUCCESSFUL CAMP EXPERIENCE. ANY OF THE STEPS OUTLINED ABOVE MAY BE OMITTED OR REPEATED AT THE DISCRETION OF CAMP STAFF. CAMPERS DISMISSED FROM CAMP FOR DISCIPLINARY REASONS WILL NOT RECEIVE A REFUND OF ANY FEES PAID TO ATTEND CAMP.

Parent and Student Pledge:

I/we understand the disciplinary procedures described above. I/we understand failure to demonstrate proper conduct during camp may result in early dismissal from camp without any refund of fees paid to attend. We pledge to abide by all camp rules and to exercise good behavior and proper respect for others.

CAMPER SIGNATURE _____ DATE _____

PARENT/GUARDIAN SIGNATURE _____ DATE _____

LIFE-THREATENING ALLERGY CARE PLAN

NAME:	**Severe ALLERGY to:**
	Other Allergies:
Please list the specific symptoms the student has experienced in the past:	**Asthma?** ☐ Yes (High risk for severe reaction) ☐ No
Date of Birth:	**Grade:** / **Routine medications (at home/school):**
	Date of last reaction:
Location(s) where Epipen®/Rescue medications is/are stored: ☐ **Office** ☐ **Backpack** ☐ **On Person** ☐ **Other**_____	

Allergy Symptoms: If you suspect a severe allergic reaction, immediately ADMINISTER Epinephrine and call 911

MOUTH	Itching, tingling, or swelling of the lips, tongue, or mouth
SKIN	Hives, itchy rash, and/or swelling about the face or extremities
THROAT	Sense of tightness in the throat, hoarseness, and hacking cough
GUT	Nausea, stomachache/abdominal cramps, vomiting, and/or diarrhea
LUNG	Shortness of breath, repetitive coughing, and/or wheezing
HEART	"Thready" pulse, "passing out," fainting, blueness, pale
GENERAL	Panic, sudden fatigue, chills, fear of impending doom
OTHER	Some students may experience symptoms other than those listed above

MEDICATION ORDERS

EpiPen® (0.3) ☐ EpiPen Jr.® (0.15) ☐	Side Effects:
Repeat dose of EpiPen®: ☐ Yes ☐ No	If YES, when
Antihistamine: _____cc/mg	Give: _____ Teaspoons _____ Tablets by mouth Side Effects:

- It is medically necessary for this student to carry an Epipen® during school hours. ☐ Yes ☐ No
- Student may self-administer Epipen®. ☐ Yes ☐ No
- Student has demonstrated use to LHCP. ☐ Yes ☐ No

Parent Name:	**Parent Phone Number :**
Licensed Health Care Provider's Printed Name:	Phone: Fax Number:

ACTION PLAN

- **GIVE MEDICATION AS ORDERED ABOVE. AN ADULT IS TO STAY WITH STUDENT AT ALL TIMES.**
  - **NOTE TIME_____AM/PM (Epipen®/adrenaline given)** **NOTE TIME_____AM/PM (Antihistamine given)**
- **CALL 911 IMMEDIATELY. 911 must be called WHENEVER Epipen® is administered.**
- **DO NOT HESITATE to administer Epipen® and to call 911 even if the parents cannot be reached.**
- Advise 911 student is having a severe allergic reaction and Epipen® is being administered.
- An adult trained in CPR is to stay with student–monitor and begin CPR if necessary.
  - Notify the administrator and parent/guardian. _____
  - Student should remain with a staff member trained in CPR at the location where symptoms began until EMS arrives.
  - Dispose of used EpiPen® in "sharps" container or give to EMS along with a copy of the Care Plan.

AUTHORIZATION FOR ADMINISTRATION OF MEDICATION

Student Name: _____ Birth Date: _____

Class: _____ Grade: _____

THIS PORTION TO BE COMPLETED BY A LICENSED HEALTH PROFESSIONAL (LHP) PRESCRIBING WITHIN THE SCOPE OF THEIR PRESCRIPTIVE AUTHORITY OR A PARENT (Please clearly print legible instructions)

Name of Medication	Dosage	Method of Administration	Time(s) to Be Taken

Diagnosis or reason for medication: _____

If given PRN, specify the minimum length of time between doses: _____

I request and authorize this student to carry their medication. _____ Yes _____ No

I request and authorize this student to self-administer their medication. _____ Yes _____ No

This student has been instructed and has demonstrated the ability to properly manage self-administration of medication.

Possible medication side effects: _____

Emergency procedure in case of serious side effects: _____

I request and authorize the above-named student be administered the above identified medication in accordance with the instructions indicated above from _____ (date) to _____ (date) **(not to exceed current summer)**. There exists a valid health reason which may make administration of the medication advisable during school hours.

_____ _____

Parent Signature/ Date Name of Licensed Health Professional (LHP)

_____ _____

Parent Contact Number **LHP Contact Number**

THIS PORTION TO BE COMPLETED BY THE PARENT/GUARDIAN

- I request this medication to be given as ordered by the licensed health professional.
- I give Health Services Staff permission to communicate with the medical office about this medication. I understand oral medications may be administered by nonlicensed staff members who have been trained and are supervised by a Registered Nurse.
- Medication information may be shared with school staff working with my child and 911 staff, if they are called.
- All medication supplied must be brought to school in its original container with instructions as noted above by the licensed health professional.

I request and authorize my child to carry and/or self-administer their medication. _____ Yes _____ No

_____ _____

Date of Signature Parent/Guardian Signature

Telephone Numbers: _____(home) _____ (work) _____(cell)

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Date: _____

Medication Administration Schedule

Time, Dosage, & Any Instructions	Initial and Document Time Completed Note any additional information

If the medicine is PRN what is the least amount of time between doses? _____

Comments:

_____

_____

_____

_____

_____

_____

_____

Parent Signature: _____ Date: _____