



# JOURNEY 2012 Application

**JOURNEY PROGRAM DATES: June 24 – June 30, 2012**

Journey, a residential summer camp program for Howard County girls, will run from Sunday, June 24 through Saturday, June 30, at Washington College in Chestertown, MD. Student delegates to the program will live in the college dorms, eat in the college cafeteria, and experience a collegiate atmosphere during the weeklong program. Current 7<sup>th</sup> and 8<sup>th</sup> grade girls who have some previous experience in leading peers, a willingness to try new experiences in a safe environment, and a desire to serve the community are encouraged to apply.

Journey program components will include:

- Workshops on empowerment and motivation, communication skills, decision making skills, group dynamics, self-awareness, goal setting, and conflict resolution
- Small and large group projects for delegates to apply and get feedback on their leadership and interpersonal skills
- One-on-one interactions between staff and delegates to address specific areas of growth for individual delegates and identify an action plan for post-site implementation
- Recreational activities and team building games and activities, including a Confidence Course

The Women's Giving Circle of Howard County, an organization of women philanthropists dedicated to addressing the needs of women and girls in Howard County, sponsors Journey. Maryland Leadership Workshops, Inc. (MLW) will operate Journey, as it has for the past six years. MLW has been providing leadership training programs for middle and high school students in the state of Maryland for over 55 years.

Applications are available on the Women's Giving Circle website at [www.womensgivingcircle.org](http://www.womensgivingcircle.org) or the MLW website at [www.mlw.org](http://www.mlw.org)

**To apply to Journey 2012, submit the application and deposit by the \*deadline of March 31, 2012**

**MLW • PO Box 83846 • Gaithersburg, MD 20883-3846**

**or email scanned application to [office@mlw.org](mailto:office@mlw.org).**

**\*Please note that requests for financial aid must be received by March 17, 2012.**

## APPLICATION PROCESS CHECKLIST

Please use the following checklist to ensure a smooth registration process. The total cost for the week is \$600.

\_\_\_\_\_ **\$100 deposit is required of all applicants.** Scholarship applicants are required to include the deposit to be considered for scholarship funds. The \$100 deposit will be refunded to scholarship applicants in the event that a scholarship is not provided or if funds are not adequate.

[The \$500 balance will be due upon acceptance into the program. Payment can be made by check made out to Maryland Leadership Workshops, Inc. or by credit card. MLW will accept Visa and Master Card payments by phone at 301-527-8222.]

\_\_\_\_\_ A completed **Journey Application**, including:

\_\_\_\_\_ The 2012 **Journey Application form** (page 3) **due March 31**

\_\_\_\_\_ A completed **Applicant Survey** (page 4) **due March 31**

\_\_\_\_\_ An **Applicant Medical Record** completed by your Parent/Guardian (pages 6-8) **due March 31**

\_\_\_\_\_ A completed **Scholarship Application**, if applicable, accompanied by appropriate documentation, as indicated in instructions (pages 13-14) **due March 17**

\_\_\_\_\_ A **Recommendation Form** completed by a staff member at your school who can speak to your leadership abilities and potential (page 15) [The Recommendation Form should be sent by the recommender directly to the MLW office **due March 31**]

## APPLICATION ACKNOWLEDGEMENT

Once we have received a completed Journey Application, we will send you a confirmation noting that your application has been received.

## APPLICANT DECISIONS

The Women's Giving Circle of Howard County will review all applications, and acceptance/wait list letters will be mailed out by April 21, 2012. In the event that an applicant is not accepted into Journey 2012, the deposit check will be refunded.

## ACCEPTANCE FOLLOW-UP

Upon acceptance into Journey 2012, the following documents will be sent for completion and must be submitted by **May 1, 2012** to complete the application:

\_\_\_\_\_ **\$500 balance** [Payment can be made by check made out to Maryland Leadership Workshops, Inc. or by credit card. MLW will accept Visa and Master Card payments by phone at 301-527-8222.] After May 1, the rate will increase to \$550.

\_\_\_\_\_ **Rules and Expectations Agreement** signed by participant. Please see <http://mdleadershipworkshops.org/programs/program-registration> for the 2012 MLW Expectations of Delegates and Rules for a Safe Week.

\_\_\_\_\_ **Medication Forms** for prescription and non-prescription medication and copy of immunization certificate **completed and signed by your physician and dated after February 1, 2011** (pages 9-12)

## REFUND POLICIES

- If we do not receive all of the above-mentioned items prior to **May 1, 2012**, your space in the program may be forfeited in order to make room for the applicants who are on the waiting list.
- In the case of a forfeited registration or any cancellation, the following refund schedule applies and refunds will be issued by September 1, 2012:
  - ◆ Anyone who cancels before May 1, 2012 will receive a \$500 refund.
  - ◆ Anyone who cancels between May 1 and June 1, 2012 will receive a \$300 refund.
  - ◆ Cancellations after June 1, 2012 cannot be refunded.
- Students participating in MLW's summer programs must participate in the entire weeklong residential experience (1pm on June 24 through 11am on June 30). Students are not permitted to leave early for other commitments, vacations, etc. 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 good cause.

## FINANCIAL AID

Financial aid and payment plans are available. WGC has scholarship money available. Please complete the financial aid request form on pages 13-14 and submit it with the completed application and \$100 deposit by the **financial aid request deadline of March 17, 2012**. The MLW office will accept Master Card and Visa payments by telephone.

**Please contact us via email at [office@mlw.org](mailto:office@mlw.org) with questions or call the Maryland Leadership Workshop Office at (301) 527-8222.**





## Journey 2012 Applicant Survey

Student's Name: \_\_\_\_\_ Grade Entering in Fall 2012: \_\_\_\_\_

School in Fall 2012: \_\_\_\_\_

*We really want to get to know you as a person. Please be sure the answers to the survey questions are in your own words. Please type or neatly write the answers to the questions below. Feel free to use additional sheets of paper. Please include your name and program on any sheets attached to this application.*

1. Why are you interested in attending Journey? What skills would you like to gain?
2. What are your interests/hobbies?
3. What are some of the most important issues/problems that you face as a young person today?
4. Describe a few of your strengths.
5. What is one possible area for improvement on which you would like to focus on during Journey?

### JOURNEY RECOMMENDATION FORM

Please ask a teacher, counselor or other school staff member who can speak to your leadership potential to act as a recommender. Please ask them to complete p. 15 and to return it directly to MLW by March 31, 2012.

**Please include contact information for the person completing the recommendation form:**

**Name:** \_\_\_\_\_

**Title:** \_\_\_\_\_

**Phone:** \_\_\_\_\_ **Email address:** \_\_\_\_\_

Delegate Name: \_\_\_\_\_ Program: Journey  
Last First

## MLW DELEGATE MEDICAL FORM

### IMPORTANT MEDICAL FORM INSTRUCTIONS

To ensure the safety and well being of all our participants and to maintain our certification as a Youth Camp with the State of Maryland Department of Health and Mental Hygiene (DHMH), all applicants must complete all the medical information requested in this application, including obtaining a licensed health care provider signature where necessary.

Pages 6-12 of the application are the medical forms that should be completed and returned with necessary signatures as part of a complete application. You are encouraged to make a copy of this application for your own files.

If part of the application does not apply to you, please indicate that by putting a N/A (not applicable) in the appropriate section rather than leaving it blank. If you would like to include more information, please attach additional pages.

### MLW HEALTH PROCEDURES

MLW has a licensed health consultant on call. If any of your health information should change between now and the beginning of the program (for example, you get a new prescription that is not included in this form or you have a change in your health status), please let us know as soon as possible so our health consultant can be notified and is able to review the information in a timely manner. He/she is on site as delegates check-in at registration.

MLW does not have an onsite *nurse* during the course of the week. Many of our staff are certified and trained in CPR and First Aid. If a delegate experiences any significant health difficulties during the program:

- her parent/guardian will be immediately notified;
- the delegate may be taken to the Kent & Queen Anne's Hospital (located next to campus);
- campus security (which is AED and CPR trained) may be called;
- and/or 911 may be called.

### MEDICATION

Delegates must turn in ALL medication (prescription AND over the counter) to the Health Consultant at registration. All medications must arrive in their **original containers**. **For prescriptions, this means as prepared by pharmacy complete with pharmacy prepared labels that are consistent with the prescriber's order.**

Per the State of Maryland Department of Health and Mental Hygiene Youth Camp regulations, MLW office staff keeps medication in the office. Delegates come to the office to self-administer medication under the supervision and observation of MLW staff. Delegates are only permitted to take medication for which there is a health care provider's signature. Please see medical form pages 9 and 10.



Delegate Name: \_\_\_\_\_ Program: Journey  
Last First

**MLW DELEGATE MEDICAL FORM – Contact and Insurance Information**

Name of delegate’s physician \_\_\_\_\_ Phone \_\_\_\_\_  
Address \_\_\_\_\_

Name of family dentist/orthodontist \_\_\_\_\_ Phone \_\_\_\_\_  
Address \_\_\_\_\_

Name of any specialist delegate (eg. Endocrinologist, Orthopedist) if used \_\_\_\_\_  
Phone \_\_\_\_\_ Address \_\_\_\_\_

**INSURANCE INFORMATION:** Is the delegate covered by medical/hospital insurance?

**Yes - Please attach a photocopy of the front and back of health insurance card**

Insurance Company: \_\_\_\_\_ Policy Number: \_\_\_\_\_

Group Number: \_\_\_\_\_ ID Number: \_\_\_\_\_

**No - Please read and sign below.**

There is no medical insurance in effect to cover my above-named daughter for any illnesses, injuries, or other adverse health outcomes that 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 daughter receives while attending Maryland Leadership Workshops, Inc.’s 2012 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 daughter while she is attending Maryland Leadership Workshops, Inc.’s 2012 summer programs.

\_\_\_\_\_  
Parent/Legal Guardian Signature Printed Name Date

Delegate Name: \_\_\_\_\_ Program: Journey  
Last First

**MLW DELEGATE MEDICAL FORM – Delegate Health History**

**The following information is required for a delegate/camper to be admitted to a residential camp:**

<p style="text-align: center;"><b>CAMPER IMMUNIZATION INFORMATION</b></p> <p>All campers must be current on all immunizations, see <a href="http://www.EDCP.org">www.EDCP.org</a> (immunization).</p> <p>The Maryland Department of Health and Mental Hygiene Immunization Certificate Form is attached. <b><u>Please complete OR provide a photo copy of existing records and submit to MLW</u></b> in order for the delegate to be onsite for MLW’s residential program.</p> <p>If the camper is <u>exempt from any immunization on medical or religious grounds</u>, provide a signed copy of Maryland Department of Health and Mental Hygiene Immunization Certificate from:</p> <ul style="list-style-type: none"><li><input type="checkbox"/> a licensed physician indicating that the immunization is medically contraindicated , or</li><li><input type="checkbox"/> the parent or guardian indicating that they object to immunizations for religious reasons.</li></ul>
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**Health Information:** Provide information on any medical conditions, psychological conditions, behavioral conditions, medications, dietary restrictions, allergies, or special needs that we need to be aware of to ensure that your child’s camp experience is positive (please attach additional pages, if necessary):

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**ALLERGIES** List all known allergies and describe reaction and management of the reaction or indicate N/A.

Medication allergies

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Food allergies & Other allergies

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**DIETARY RESTRICTIONS OR OTHER NEEDS** Please let us know if you will need accommodations during the week

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Parent or Legal Guardian’s Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Delegate Name: \_\_\_\_\_ Program: Journey

Last First

### MLW DELEGATE MEDICAL FORMS – Over the Counter Medication Form

The following standard over the counter (OTC) medications are available in the MLW Office. If a delegate needs medication, he/she will come to the office and requests medication which will be provided at the discretion of the MLW office staff. If the delegate brings their own OTC medicines, they must be stored in the MLW Office and taken in the presence of MLW staff.

The delegate will only be allowed to have OTC medicine and self-administer medication if there is a signed Health Care Provider order in the file. Therefore, please fill this form out completely whether or not your child regularly takes medication and have your health care provider sign the form below.

Delegate's Age: \_\_\_\_\_ Delegate's Weight: \_\_\_\_\_

Drug Name	Route	Dosage & Schedule	Indications	Delegate Health Care Provider Order (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 by age/weight	Pain or Fever	Yes or No	
Ibuprofen	PO (chewable tabs, suspension, or tablets)	Per label Instructions by age/weight	Pain or Fever	Yes or No	
Robitussin (or generic)	PO (syrup)	Per label Instructions by age/weight	Cough	Yes or No	
Pepto-Bismol (or generic)	PO (liquid or chewable tabs)	Per label Instructions by age/weight	Upset stomach, Diarrhea	Yes or No	
Kaopectate (or generic)	PO (liquid or tab)	Per label Instructions by age/weight	Diarrhea	Yes or No	
Children's Mylanta (or generic)	PO (chewable)	Per label Instructions by age/weight	Upset stomach	Yes or No	
Sudafed (or generic)	PO (tabs or liquid)	Per label Instructions by age/weight	Nasal congestion, Eustachian tube congestion	Yes or No	
Chlorpheniramine	PO (chewable tabs, suspension, or tabs)	Per label Instructions by age/weight	Seasonal allergy symptoms	Yes or No	
Dramamine/Bonine (or generic)	PO (chewable/regular tabs)	Per label Instructions by age/weight	Motion Sickness	Yes or No	
Dimetapp (or generic)	PO (elixir or tabs)	Per label Instructions by age/weight	Nasal congestion, Season allergy	Yes or No	
Benadryl (or generic)	PO (elixir, chewable, tab, or pills); topical ointment	Per label Instructions by age/weight	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	
<b>Vitamins and/or supplements</b>	PO	Per label Instructions		Yes or No	

- I, \_\_\_\_\_ (parent/guardian name), give permission for my child to take the medications listed "YES" above.
- 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** \_\_\_\_\_

**REQUIRED: Health Care Provider's Signature** \_\_\_\_\_ **Date** \_\_\_\_\_

Print Name \_\_\_\_\_



**MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE IMMUNIZATION CERTIFICATE**

CHILD'S NAME \_\_\_\_\_  
 LAST FIRST MI  
 SEX: MALE  FEMALE  BIRTHDATE \_\_\_\_/\_\_\_\_/\_\_\_\_  
 COUNTY \_\_\_\_\_ SCHOOL \_\_\_\_\_ GRADE \_\_\_\_\_

PARENTNAME \_\_\_\_\_ PHONE NO. \_\_\_\_\_  
 OR  
 GUARDIAN ADDRESS \_\_\_\_\_ CITY \_\_\_\_\_ ZIP \_\_\_\_\_

**RECORD OF IMMUNIZATIONS (See Notes On Other Side)**

Vaccines Type													
Dose #	DTP-DTaP-DT Mo/Day/Yr	Polio Mo/Day/Yr	Hib Mo/Day/Yr	Hep B Mo/Day/Yr	PCV Mo/Day/Yr	Rotavirus Mo/Day/Yr	MCV Mo/Day/Yr	HPV Mo/Day/Yr	Dose #	Hep A Mo/Day/Yr	MMR Mo/Day/Yr	Varicella Mo/Day/Yr	History of Varicella Disease
1									1				Mo/Yr
2									2				
3										Td Mo/Day/Yr	Tdap Mo/Day/Yr	FLU Mo/Day/Yr	Other Mo/Day/Yr
4										-----	-----	-----	-----
5										-----	-----	-----	-----

To the best of my knowledge, the vaccines listed above were administered as indicated.

Clinic / Office Name \_\_\_\_\_  
 Office Address/ Phone Number \_\_\_\_\_

1. \_\_\_\_\_  
 Signature Title Date  
 (Medical provider, local health department official, school official, or child care provider only)

2. \_\_\_\_\_  
 Signature Title Date

3. \_\_\_\_\_  
 Signature Title Date

Lines 2 and 3 are for certification of vaccines given after the initial signature.

**LOST OR DESTROYED RECORDS: (Must be reviewed and approved by a medical provider or the local health department. See notes)**

I hereby certify that the immunization records of this child have been lost, destroyed or are unobtainable.

Signed: \_\_\_\_\_ Date: \_\_\_\_\_  
 Parent or Guardian

**COMPLETE THE APPROPRIATE SECTION BELOW IF THE CHILD IS EXEMPT FROM IMMUNIZATION ON MEDICAL OR RELIGIOUS GROUNDS. ANY IMMUNIZATIONS THAT HAVE BEEN RECEIVED SHOULD BE ENTERED ABOVE.**

**MEDICAL CONTRAINDICATION:**

The above child has a valid medical contraindication to being immunized at this time.

This is a  permanent condition  temporary condition until \_\_\_\_/\_\_\_\_/\_\_\_\_

Check appropriate box, indicate vaccine(s) and reasons: \_\_\_\_\_

Signed: \_\_\_\_\_ Date \_\_\_\_\_  
 Medical Provider / LHD Official

**RELIGIOUS OBJECTION:**

I am the parent/guardian of the child identified above. Because of my bona fide religious beliefs and practices, I object to any immunizations being given to my child. This exemption does not apply during an emergency or epidemic of disease.

Signed: \_\_\_\_\_ Date: \_\_\_\_\_

## How To Use This Form

The medical provider that gave the vaccinations may record the dates directly on this form (check marks are not acceptable) and certify them by signing the signature section. Combination vaccines should be listed individually, per each component of the vaccine. A different medical provider, local health department official, school official, or child care provider may transcribe onto this form and certify vaccination dates from any other record which has the authentication of a medical provider, health department, school, or child care service.

**Only a medical provider, local health department official, school official, or child care provider may sign 'Record of Immunization' section of this form. This form may not be altered, changed, or modified in any way.**

### Notes:

1. When immunization records have been lost or destroyed, vaccination dates may be reconstructed for all vaccines except **varicella, measles, mumps, or rubella**.
2. Reconstructed dates for all vaccines must be reviewed and approved by a medical provider or local health department no later than 20 calendar days following the date the student was temporarily admitted or retained.
3. Blood test results are NOT acceptable evidence of immunity against diphtheria, tetanus, or pertussis (DTP/DTaP/Tdap/DT/Td).
4. Blood test verification of immunity is acceptable in lieu of polio, measles, mumps, rubella, hepatitis B, or varicella vaccination dates, but **revaccination may be more expedient**.
5. History of disease is NOT acceptable in lieu of any of the required immunizations, except varicella.

## Immunization Requirements

The following excerpt from the DHMH Code of Maryland Regulations (COMAR) 10.06.04.03 applies to schools:

“A preschool or school principal or other person in charge of a preschool or school, public or private, may not knowingly admit a student to or retain a student in a:

- (1) Preschool program unless the student's parent or guardian has furnished evidence of age appropriate immunity against Haemophilus influenzae, type b, and pneumococcal disease;
- (2) Preschool program or kindergarten through the second grade of school unless the student's parent or guardian has furnished evidence of age-appropriate immunity against pertussis; and
- (3) Preschool program or kindergarten through the 12th grade unless the student's parent or guardian has furnished evidence of age-appropriate immunity against: (a) Tetanus; (b) Diphtheria; (c) Poliomyelitis; (d) Measles (rubeola); (e) Mumps; (f) Rubella; (g) Hepatitis B; and (h) Varicella.”

Please refer to the **“Minimum Vaccine Requirements for Children Enrolled in Pre-school Programs and in Schools”** to determine age-appropriate immunity for preschool through grade 12 enrollees. The minimum vaccine requirements and DHMH COMAR 10.06.04.03 are available at [www.EDCP.org](http://www.EDCP.org) (Immunization).

Age-appropriate immunization requirements for licensed childcare centers and family day care homes are based on the Department of Human Resources COMAR 13A.15.03.02 and COMAR 13A.16.03.04 G & H and the **“Age-Appropriate Immunizations Requirements for Children Enrolled in Child Care Programs”** guideline chart are available at [www.EDCP.org](http://www.EDCP.org) (Immunization).

## JOURNEY

### Financial Assistance/Scholarship Application (page 1 of 2)

If financial aid is requested, this form and application are due on March 17, 2012

#### (THIS FORM IS OPTIONAL)

Name of Applicant: \_\_\_\_\_

Address: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

County: \_\_\_\_\_

School: \_\_\_\_\_

Telephone Number: \_\_\_\_\_

Email Address: \_\_\_\_\_

The Women's Giving Circle of Howard County (WGC) has limited financial assistance/scholarship funds available. Many requests for financial aid are received, and we cannot guarantee a positive response to every request. Every request will receive a confidential, thorough, and fair assessment of financial need and every effort to be supportive will be made. We require the submission of a copy of the federal tax returns of the applicant's parent or guardian to be used in our review process. Consideration for financial assistance/scholarships will be given first to students from families who meet the requirements for free or reduced lunch. Geographic diversity and other factors may also be considered.

Applications must be received by the March 17<sup>th</sup> financial aid request deadline. **Your \$100 deposit must be received with your application for consideration for scholarship funds.** WGC generally does not provide full scholarships to students. The deposit will be refunded if the applicant is not accepted or if the scholarship funds offered are not adequate.

Decisions regarding a student's admission to MLW's summer programs are independent of requests for financial assistance/scholarships.

**Please forward your completed application with a copy of the applicant's parent's/guardian's most recent tax return by March 17<sup>th</sup> to:**

Maryland Leadership Workshops, Inc.

P.O. Box 83846

Gaithersburg, Maryland 20883-3846

or fax: (301) 670-1407

or email scanned documents to [office@mlw.org](mailto:office@mlw.org)





# Journey Recommendation Form

To be completed by a teacher, counselor or other school staff member.

Student's Name: \_\_\_\_\_

**To The Recommender:** The student listed above is an applicant for Journey 2012, a residential summer camp for rising 8<sup>th</sup>-9<sup>th</sup> grade girls. The week-long program is designed to foster a sense of identity, self-awareness and empowerment in young women. The focus will be on what it means to be a woman in contemporary society. Applicants should have some previous experience in leading her peers, a willingness to try new experiences in a safe environment, and a desire to serve her community.

Your Name: \_\_\_\_\_

Your Position: \_\_\_\_\_

Your Address: \_\_\_\_\_

Your City/State/Zip \_\_\_\_\_

Your Phone: \_\_\_\_\_ Your email address: \_\_\_\_\_

Your Relationship to Student: \_\_\_\_\_ Length of Time You Have Known Student: \_\_\_\_\_

Please respond to the following questions to provide us insight on the above student so that we may better tailor our program. You may attach a separate letter if you prefer.

1. Please identify why you believe the above student will benefit from Journey 2012.

2. What do you consider to be the applicant's primary talents or strengths?

3. What would you like to tell the selection committee about the applicant?

\_\_\_\_\_  
Signature Date

**Please return this form by March 31** to Maryland Leadership Workshops, Inc.  
P.O. Box 83846, Gaithersburg, MD 20883-3846 or fax: (301) 670-1407 or email to [office@mlw.org](mailto:office@mlw.org).  
Also, please notify the above student when you have sent this form. Thank you for your assistance.