



# Stanislaus County 4-H Camp Programs Individual Registration Form – 2010 (Summer)



Please complete all four forms and sign in **three (3)** places: *Registration Form, Code of Conduct, and Medical Treatment Form*

<p style="text-align: center;"><b>2010 4-H Summer Camp June 13 - 18, 2010</b>                  Due April 16, 2010 from <u>Club Leader</u> beginning at 8 am.                  (Registration late fees apply after May 7, 2010)                  All Campers, Counselors and Staff Complete this form                  NEW: Attach Camp Sylvester Waiver (separate form)</p>	<p style="text-align: center;">circle one:</p> <p><b>Youth:</b> Camper Counselor Staff</p> <p><b>Adult:</b> Staff Nurse Cook Cabin Ldr                  Other: _____                  (All adults must be 4-H leaders)</p>
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**Personal Information:**

Are you currently enrolled in 4-H? \_\_\_\_\_ County: \_\_\_\_\_  
 Male: \_\_\_\_\_ Female: \_\_\_\_\_ Club: \_\_\_\_\_

Name: \_\_\_\_\_ Birth date: \_\_\_\_\_ Grade: \_\_\_\_\_  
 Address: \_\_\_\_\_ City/Zip: \_\_\_\_\_  
 Home Phone: (\_\_\_\_) \_\_\_\_\_ Work Phone(\_\_\_\_) \_\_\_\_\_  
 Cell Phone (\_\_\_\_) \_\_\_\_\_ Email Address \_\_\_\_\_  
 T-shirt size (Circle size : ys - ym - yl - AS - AM - AL - AXL - AXXL)

**Emergency Information:**

Name of parent/guardian to be called: \_\_\_\_\_ Home: \_\_\_\_\_  
 Work: \_\_\_\_\_  
 Cell: \_\_\_\_\_

In case the parent/guardian is not available, please list an emergency contact person:  
 Name: \_\_\_\_\_ Home: \_\_\_\_\_ Work: \_\_\_\_\_ Cell: \_\_\_\_\_  
 Relationship \_\_\_\_\_

I agree to pick my child up from camp promptly upon request in case of sickness, injury or disciplinary action (see code of conduct). \_\_\_\_\_ X \_\_\_\_\_  
 Parent Name (please print) Signature of Parent or Guardian

**Note:** Only those forms submitted with full payment will be accepted. Those who are not currently enrolled in 4-H will also need to fill out enrollment and waiver forms.

Participants requiring special arrangements: (please explain)

\_\_\_\_\_

**For Special assistance regarding our programs. please contact us.**

Bunk Buddy Request (must be within 2 yrs of age)

1. \_\_\_\_\_
2. \_\_\_\_\_

**Fees:**

<input type="checkbox"/> Camper in Good Standing Camp Fee:	\$185.00
<input type="checkbox"/> Counselor Fee for 4-H Camp (Sponsored):	\$0
<input type="checkbox"/> Not in Good Standing or Out of County	\$255.00
<input type="checkbox"/> Non-4-H Member (space permitting)	\$265.00
<input type="checkbox"/> Late Fee After May 7, 2010	\$10.00

**Club checks only payable to: Stanislaus County 4-H Summer Camp**

Refunds may be requested until June 1, 2010 and are subject to a \$10 penalty fee. A full refund *may* be made for medical reasons. After that date and prior to arrival, refund will only be unused Bunk Fees.

Last Name	
First Name	
Club	
M/F	
Session	
Cabin	
Date	
Paid	
Receipt No.	

# 4-H Camp Code of Conduct

The Stanislaus County 4-H Youth Development Program of the University of California is committed to an educational environment in which all participants are treated with respect and dignity. Each participant, youth and adult, has the right to learn in an environment that promotes equal educational opportunity, and is free from discriminatory practices.

The following guidelines are designed to make your experience at 4-H camp satisfying to you and others attending. This means that all participants -- members, leaders, and staff- shall respect the individual rights, safety, and property of others. While you are attending 4-H events, you are representing 4-H and the University.

1. Everyone is expected to participate in all planned activities as defined by the camp schedule and to be in appropriate dress (see camp brochure). Counselors are responsible for ensuring that campers participate in all sessions of the planned program activities, unless excused by the camp nurse or the director.
2. All participants are to be in their assigned area at curfew and to comply with quiet hours and lights out.
3. Campers must sleep in assigned cabins; no boys in girls cabins and no girls in boys cabins.
4. The possession and use of alcoholic beverages and/or drugs, other than prescribed medication is prohibited by both campers and adults. Medications must be kept in the nurses cabin.
5. No matches, lighters, chewing tobacco or smoking at camp by youth.
6. No member or leader may leave the grounds unless permission is secured from the adult in charge of the delegation. Private summer homes, campsites and local facilities are off limits at all times.
7. Setting off fire alarms or tampering with fire extinguishing equipment is prohibited.
8. Gambling and betting by adults and youth representing 4-H is prohibited.
9. Obscene and discriminatory language, roughhousing, running through camp, throwing rocks and/or sticks, and insubordination will not be tolerated at any time.
10. Youth members should demonstrate respect to older adults.
11. Display of overly affectionate attention between boys and girls is discouraged.
12. Sexual harassment is not tolerated in the 4-H program. (a copy of the University policy is available upon request)
13. Abide by the dress code (a picture copy is to be giving to you by your leader)

## Penalties for Infractions:

Any or all of the following may be enforced for infractions; sending a member home; barring that member from future 4-H events; assessing the member the cost of damages and repairs in the event of damage/destruction of property; releasing the member to nearest law enforcement agency and/or proper authorities; and/or termination of 4-H membership (youth or adult).

Parents will be notified of action taken. If a member is sent home, fees will not be refunded, and transportation will be at the member's own expense.

I, \_\_\_\_\_ (participant) have read the Code of Conduct and agree to abide by its rules. I understand that infractions of this Code will result in any or all of the penalties listed above.

**X** \_\_\_\_\_  
Participant's Signature County Date

**X** \_\_\_\_\_  
Parent Signature County Date

**MEDICAL TREATMENT FORM**  
**University of California 4-H Youth Program**

**YOUTH**

I hereby certify that my child is in good health and can travel to and participate in this 4-H function.

My Child \_\_\_\_\_  
 name of youth under 18

has my permission to attend the **Stanislaus County 4-H Camp**

located near **Pincrest in Tuolumne County, California**

between the dates of **June 20—June 24, 2009**

While my child is attending or traveling to or from this 4-H function, **I HEREBY AUTHORIZE THE ADULT 4-H VOLUNTEER LEADER OR 4-H STAFF MEMBER**, or in his/her absence or disability, any adult accompanying or assisting him/her, **TO CONSENT TO THE FOLLOWING MEDICAL TREATMENT FOR SAID MINOR:**

Any x-ray examination, anesthetic, medical or surgical diagnosis or treatment, and hospital care which is deemed advisable by, and is to be rendered under the general or special supervision of any physician and/or surgeon licensed under the provisions of the Medical Practices Act, California Business and Professions Code Section 2000 et seq.; or any x-ray examination, anesthetic, dental or surgical diagnosis or treatment, and hospital care to be rendered by a dentist licensed under the provisions of the Dental Practices Act, California Business and Professions Code Section 1600 et seq.

This authorization is given pursuant to the provisions of Section 25.8 of the Civil Code of California. This authorization shall remain effective until my child completes his/her activities in this program unless sooner revoked in writing. I understand that as a parent/guardian, I will be responsible for the cost of any service or treatment provided not covered by the 4-H Accident/Sickness Insurance Program sponsored by UC Cooperative Extension.

**AUTHORIZATION AND CONSENT  
AND RELEASE**

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

I hereby certify that my child is in good health and can travel to and participate in all functions of the 4-H Youth Development Program as described above. I understand it is my responsibility to keep the information on this form updated (including Health History and parent/guardian status) by contacting the County 4-H Office.

**NON-CONSENT**

I do not desire to sign this authorization and understand that this will prohibit my child from receiving any medical attention in the event of illness or accident.

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

**ADULT**

*(This information is confidential and will be used only in case of emergency.)*

Name \_\_\_\_\_  
 name of adult

Event: **Stanislaus County 4-H Camp**

located near **Pincrest in Tuolumne County, California**

between the dates of **June 20—June 24, 2009**

While I am attending or traveling to or from this 4-H function, **I HEREBY AUTHORIZE THE ADULT 4-H LEADER OR STAFF MEMBER**, or in his/her absence or disability, any adult accompanying or assisting him/her, **TO CONSENT TO THE FOLLOWING MEDICAL TREATMENT FOR ME SHOULD I BE UNABLE TO MAKE A DECISION:**

Any x-ray examination, anesthetic, medical or surgical diagnosis or treatment, and hospital care which is deemed advisable by, and is to be rendered under the general or special supervision of any physician and/or surgeon licensed under the provisions of the Medical Practices Act, California Business and Professions Code Section 2000 et seq.; or any x-ray examination, anesthetic, dental or surgical diagnosis or treatment, and hospital care to be rendered by a dentist licensed under the provisions of the Dental Practices Act, California Business and Professions Code Section 1600 et seq.

This authorization is given pursuant to the provisions of Section 25.8 of the Civil Code of California. This authorization shall remain effective until I complete my activities in this program unless sooner revoked in writing. I understand that I will be responsible for the cost of any service or treatment provided not covered by the 4-H Accident/Sickness Insurance Program sponsored by UC Cooperative Extension.

**AUTHORIZATION AND CONSENT  
AND RELEASE**

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

I hereby certify that I am in good health and can travel to and participate in all functions of the 4-H Youth Development Program as described above. I understand it is my responsibility to keep the information on this form updated (including Health History) by contacting the County 4-H Office.

**NON-CONSENT**

I do not desire to sign this authorization and understand that this will prohibit my receiving any medical attention in the event of illness or accident.

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

University policy and the State of California Information Practices Act of 1977 require the following information be provided when collecting personal information from you: The information entered on this form is collected under authority of the Smith-Lever Act. Submission of the medical data is voluntary. However, a signature is required on one or the other of the two signature lines above. Failure to provide the medical information and authorization may result in our inability to provide necessary medical treatment. You have the right to review University records containing personal information about you/your child, with certain exceptions as set forth in policy and statute. Copies of University policies pertaining to the collection, use, or release of personal data are available for your examination from the local UCCE County Director, 4-H Youth Development Advisor, 4-H Program Representative, or the State 4-H Director at the California 4-H Youth Development Program, University of California, DANR Building, One Hopkins Road, Davis, CA 95616-8575, (530) 754-8518. Only your own/your child's records are open to your review.

Any known or foreseeable intergovernmental transfer that may be made of the information is as follows: None.

# HEALTH HISTORY INFORMATION

(This information is confidential and will be used only in case of emergency.)

Name of Participant: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Is participant subject to:	Yes	No	Does participant have or ever had:	Yes	No
Colds			Heart trouble		
Sore throat			Asthma (If using inhaler, include usage instructions below)		
Fainting spells			Lung trouble		
Bronchitis			Sinus trouble		
Convulsions			Hernia (rupture)		
Cramps			Appendicitis		
Allergies			Has participant's appendix been removed?		
Wear corrective lenses?			Does participant sleep walk?		
Hearing is good?			Is participant now under medical care?		
Is there any history of behavior disorders or emotional disturbances, such as difficulties in relationships with authority figures or peers, or abnormally severe moodiness? <b>EXPLAIN BELOW</b>					
Has participant been under psychiatric treatments within the last three years?					

If participant is a minor, **please identify over-the-counter medications** that we may administer to your child. Check box for YES.

- |  |  |
|--|--|
| <input type="checkbox"/> Tylenol, Aleve, or Motrin for pain, headaches or cramp<br><input type="checkbox"/> Benadryl, Zyrtec, Alavert, Loratadine for allergies<br><input type="checkbox"/> Antifungal - Lamisal or Mycelex<br><input type="checkbox"/> Anti-Itch - Cortaid, Benadryl ointment or tablets<br><input type="checkbox"/> Other: _____ | <input type="checkbox"/> Antacids (Tums Mylanta, Prilosec Pepto-Bismol for stomach pain or nausea<br><input type="checkbox"/> Kaopectate, Imodium, anti-diarrhea meds <input type="checkbox"/> Cough drops for sore throat<br><input type="checkbox"/> Cough & Cold medications - such as Robitussin, Dimitapp, cough drops<br><input type="checkbox"/> Constipation medications - such as mineral oil, stool softeners, Exlax |
|--|--|

Other: \_\_\_\_\_ Other that participant cannot take: \_\_\_\_\_

Date of last Tetanus Vaccination: \_\_\_\_/\_\_\_\_/\_\_\_\_

Please identify participant's allergies, including type of reactions you know about:

Medication Allergies \_\_\_\_\_

Food Allergies: \_\_\_\_\_ Other (i.e. Bee Stings) \_\_\_\_\_

Please list any disability accommodations you will need in order to participate in this program or activity.

Please list all medications that are presently being taken by participant: Remember: Please bring all prescription drugs in a labeled bottle with correct dose patient is receiving. If the person only takes 1 tablet and it is worked 2 tablets, we must give what is prescribed.

**If using inhaler:**     Ok to check in with Nurse     Must carry at all times    Please list with medications below.

Name of Medication	Dosage	Times Taken

Remarks and any special instructions to better assist emergency service personnel (explain "yes" answers on this page):

\_\_\_\_\_  
 \_\_\_\_\_