2016 Registration Form

Ferry County 4-H Tech Wizards Day Camp

Outdoor Adventures!

Ferry County 4-H
Washington State University Extension

Saturday September 17th, 2016

Check-in at Republic School from 7:00-7:20 am (Bus Leaves @7:30am sharp)
Check-out at Republic School at 4:30 pm
Camp will be held at the Swan Lake Campground
Minimum of 10 campers and Maximum of 50 campers. Open to Tech Wizards mentees.
Registration due September 12th
NO Late Registrations Accepted

☐ $7.00 Tech Wizards Mentee

Name _____

Address _____

City _____

Male _____ Female _____ Age _____

Grade in School _____

4-H Club/TW Mentor Name _____

Day Phone _____

Evening Phone _____

Email _____

Make checks payable to: WSU

Mail all forms to: WSU Ferry County Extension
350 E. Delaware Ave. #9
Republic, WA 99166

Follow all the camp updates on
Facebook @ WSU Ferry County Extension

Questions? Please call (509) 775-5225 x1116

Service Agreement for All Adult & Youth Volunteers & Applicant Authorization

SERVICE AGREEMENT FOR ALL STAFF - In order to participate in Day Camp projects and activities, staff volunteers must provide written permission to the terms and conditions as follows. Read carefully and sign below:

I agree to carry out the responsibilities of my position, to the best of my abilities.
I agree to participate in all Day Camp activities, as assigned by the Camp Director, to the best of my abilities.
I agree to model for youth and adults the 4-H philosophy of good citizenship and abide by the policies and standards of 4-H.
I agree to attend all training sessions, to be on time and to be present during the entire camp.
I agree to be on time, be present and participate for the entire duration that I have scheduled.
I agree to notify the Camp coordinator immediately if, for any reason, I find that I am unable to carry out my responsibilities at Day Camp.

APPLICANT AUTHORIZATION

Confirmation - All statements contained in this application are subject to confirmation by the WSU Ferry County Extension 4-H Program.

Disclosure - I understand that Day Camp activities involve a normal level of risk. I assure that I am willing and able to participate in all Day Camp activities, am willing and able to participate in program activities, and am willing to abide by program policies and follow directions of supervisors.

Medical Care Authorization - I understand that reasonable measures will be taken to safeguard the health and safety of all participants.

Over-the-counter and/or Prescription medications - If your child requires any medications, please make sure they are able to self-dose while at camp and bring a suitable supply with them.
Please list any over-the-counter treatment exceptions under allergies.

ADULT AND YOUTH CAMPERS

I understand that, unless noted below, photos, video, or audio recordings made of me may be used by WSU Extension and Washington State 4-H, without compensation, to promote the 4-H Youth Development Program. I understand that my name may be revealed in descriptive text or commentary. NO Permission_____ YES, with this condition_____

As parent/legal guardian of *(or if an adult yourself)* _____ I hereby give my consent for the above named youth to participate in the 4-H Day Camp Saturday, September 17th, 2016.

I also hereby waive and forever discharge claims for damages which the above listed individual, their heirs, executors and administrators may have or accrue against Washington State University Extension, Ferry County, their representatives, agents, and accompanying 4-H program leaders, arising from any injuries (physical or mental), including death, suffered in connection with this 4-H sponsored event.

My signature below gives my consent to the above statements.

_____ _____

Participant Signature *Parent/Guardian Signature*

Date Signed _____ *Date Signed* _____

OJJDP Office of Juvenile Justice and Delinquency Prevention
Office of Justice Programs • U.S. Department of Justice

Camp is funded by Mentees, and Ferry County 4-H Tech Wizards, and Ferry County 4-H Leaders' Council.

EVENT NAME
PARTICIPANT HEALTHFORM

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Mail this form to the address below by (date)
Event Address

Attendance dates: from: _____ to _____

Participant Name: _____ (First / Middle / Last)

☐ Male ☐ Female Birth Date _____ (Month/Day/Year) Age on arrival at program ____

***To Parent(s)/Guardian(s)*: Please follow the instructions below. Attach additional information if needed.**

1. ***Complete pages 1, 2 and 3 of this form (and make a copy for yourself).***
2. ***Send the original, signed form to program by requested date.***

Participant Home Address: _____ (Street Address / City / State / Zip Code)

Parent/guardian with residential placement and/or decision-making authority in the event of illness or injury:

Name: _____ Relationship to Participant: _____

Preferred Phones: (____) _____ (____) _____ Email: _____

Home Address: _____ (If different from above) (Street Address / City / State / Zip Code)

Second parent/guardian with legal custody to be contacted in case of illness or injury:

Name: _____ Relationship to Participant: _____

Preferred Phones: (____) _____ (____) _____ Email: _____

Additional parent/guardian to be contacted in case of illness or injury:

Name: _____ Relationship to Participant: _____

Preferred Phones: (____) _____ (____) _____ Email: _____

Allergies: ☐ No known allergies. ☐ This participant is allergic to: ☐ Food ☐ Medicine ☐ The environment (insect stings, hay fever, etc.) ☐ Other
(Please describe below what the participant is allergic to and the reaction seen, in detail. Please describe preventative or responsive measures.)
☐ **This participant has a life-threatening allergy. An emergency care plan signed by physician is required.**

Diet, Nutrition: ☐ This participant eats a regular diet. ☐ This participant eats a vegetarian diet (describe details below).
☐ This participant has special food needs. ***(Please describe below.)***

Immunizations:

☐ My child is up-to-date on his/her immunizations and tetanus shots as required by Washington State law. Date of last Tetanus shot: _____

☐ My child has an immunization exemption on file with his/her school. I understand and accept the risks to my child from not being fully immunized.

Medication:

We will be unable to administer medication to children. If your child requires a dosage during activity/event hours, please make appropriate arrangements. Medication" is any substance a person takes to maintain and/or improve their health. This includes vitamins & natural remedies. **All medications must be in their original containers. Prescriptions must have the child's name and how the medication should be given printed on the prescription container. Please send only those medications that are necessary.**

Medications Currently being taken: (must list)

☐ This participant will not take any daily medications while attending the activities.

☐ This participant will be **self-administering** the following daily medication(s) while attending the activities.[1]

Participant Name: First / Middle / Last

(For Camp Use) Cabin or Group _____

(For Program Use) Session Code(s)

[1] Note: These provisions regarding administration of medication shall not abrogate minors' rights to provide their own consent to certain services under Washington law.

EVENT NAME
PARTICIPANT HEALTH FORM

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Participant Name: _____
First Middle Last

Birth Date: _____
Month/Day/Year

General Health History: ***Check "Yes" or "No" for each statement. Explain "Yes" answers below.***

Has/does this participant:

1. Ever been hospitalized?	☐ Yes	☐ No	12. Passed out/had chest pain during exercise?	☐ Yes	☐ No
2. Ever had surgery?	☐ Yes	☐ No	13. Had mononucleosis ("mono") during the past 12 months?	☐ Yes	☐ No
3. Have recurrent/chronic illnesses?	☐ Yes	☐ No	14. Ever had back/joint problems?	☐ Yes	☐ No
4. Had a recent infectious disease?	☐ Yes	☐ No	15. Have problems with diarrhea/constipation?	☐ Yes	☐ No
5. Had a recent injury?	☐ Yes	☐ No	16. Have any skin problems?	☐ Yes	☐ No
6. Has asthma/wheezing/shortness of breath?	☐ Yes	☐ No	17. Traveled outside the country in the past 9 months?	☐ Yes	☐ No
7. Have diabetes?	☐ Yes	☐ No	18. Had Sickle Cell disease or traits?	☐ Yes	☐ No
8. Had seizures?	☐ Yes	☐ No	19. Had high blood pressure?	☐ Yes	☐ No
9. Had headaches?	☐ Yes	☐ No	20. Had cardiovascular disease or other heart problems?	☐ Yes	☐ No
10. Wear glasses, contacts, or protective eyewear?	☐ Yes	☐ No	21. Have a history of heart disease (not limited to conjunctive heart defect, cardiomyopathy, ahbrythemia?)	☐ Yes	☐ No
11. Had fainting or dizziness?	☐ Yes	☐ No			

Please explain "Yes" answers in the space below, noting the number of the questions. For travel outside the country, please name countries visited and dates of travel.

Restrictions:

☐ I have reviewed the program and activities of the program and feel the participant can participate without restrictions.
☐ I have reviewed the program and activities of the program and feel the participant can participate with the following restrictions or adaptations. ***(Please describe below.)***

Does the participant require reasonable accommodation for a disability in order to access or be part of the activities?

What Have We Forgotten to Ask? ***Please provide in the space below*** any additional information about the participant's health that you think important or that may affect his or her ability to fully participate in the program. ***Attach additional information if needed.***

This health history is correct and accurately reflects the health status of the participant to whom it pertains. The person described has permission to participate in all program activities except as set forth by me and/or an examining physician. If you fail to advise WSU of a medical condition, WSU is not responsible for related injuries. I understand the information on this form will be shared on a "need to know" basis with WSU staff and volunteers. I give permission to photocopy this form. In addition, the health care provider has permission to obtain a copy of my child's health record from providers who treat my child and these providers may talk with the program's staff about my child's health status.

Signature of Custodial _____ Relationship to Participant: _____

Parent/Guardian: _____ Date: _____

Parent/Guardians: Keep a copy for your records.