Sonoma County 4-H Camp
2015 Camper Application

Open to youth ages 9 (as of 6/1/15) to 14

Applications received on or after June 15th *must pay by cash or cashier's check—no personal checks.*

No Refunds after June 19th for either camp

Space is limited and applications are accepted on a first come, first served basis.

Fees
$245 4-H Members (must be currently enrolled in a 4-H Club)

$296 Non-Members (includes $51 enrollment- *you must join 4-H to attend camp*)

Camp I - June 29h to July 4th 2015 **Camp II - July 6th to July 11th 2015**

Choose One: CAMP I _____ CAMP II _____ Either _____

Camper's Name_____ Gender: Male _____ Female_____

T-shirt size: Child's Large _____ Adult Small _____ Adult Medium_____ Adult Large_____ Adult X Large_____

Address_____
Street City Zip

Parent's Home Phone _____ Cell _____ Work _____

Email_____ Childs Age (as of June 1, 2015) _____

Current Grade_____ Name of 4-H Club (if enrolled for 2014-2015 club year) _____

Parent/Guardian's signature _____Print name_____

Place photo Here

Parents to deliver campers to camp bring sack lunches and please stay for Opening Ceremonies.
Parents will pick up child from camp and please stay for closing ceremonies.

INCOMPLETE APPLICATIONS WILL NOT BE ACCEPTED

- Your name will not be added to the camp list until you **ENROLL ONLINE and** you Submit A **COMPLETE APPLICATION PACKET** which includes:
- 2015 Camper application completed and signed by a parent.
- Payment for the full camp fee (make payable to ***Sonoma County 4-H***) *Applications received after 6/15 will need to be cash or money order.*
- Your photograph attached to the application
- A signed Medical Treatment Form.
- A signed Over the Counter Medication Release Form
- A signed copy of the camp rules.
- Prescription Medication Form if applicable.
- **A completed 4-H ONLINE Enrollment for all campers URL: california.4honline.com** see addition instruction sheet
- Please retain a copy of this page for your records.

Mail or bring applications to:
4-H Office
Attn: 4-H Camp
133 Aviation Blvd. Suite 109
Santa Rosa, Ca 95403

QUESTIONS?
Call: Camp I Coordinators- Lisa Bianchi (707)484-5374, Gabriella McGrath (707)696-3796
Camp II Coordinator- Michelle Machado (707)529-1511
Email: sonomacounty4hcamp@gmail.com

Call the 4-H Office: 707-565-2681 or visit http://cesonoma.ucdavis.edu/Youth_Development/4-H_Events_and_Activities/4-H_Camp/

Sonoma County 4-H Camp 2015

Check one: Camp I _____ Camp II_____

Over The Counter Medical Release Form - Minor

Child's Name: _____

NON CONSENT

Sign here only if you do not want any form of over the counter medications given to your child.

_____ _____

PARENT / LEGAL GUARDIAN SIGNATURE **DATE**

_____ _____ _____

HOME PHONE **WORK PHONE** **CELL PHONE**

CONSENT

The following medications may be administered to my child while they are at 4-H Camp:

Acetaminophen (Tylenol) Yes____ No____
Given for headaches, muscular aches, fever reduction.
If yes:
My child has used this before Yes_____ No_____
My child has had a reaction to
this medication Yes____ No ____

If yes, please give details of the reaction:_____

_____

Dipenhydramine (Benadryl) Yes____ No_____
Antihistamine, given for bug bites and bee stings.
If yes:
My child has used this before Yes_____ No_____
My child has had a reaction to
this medication Yes____ No ____

If yes, please give details of the reaction:_____
_____

Ibuprofen (Advil, Motrin) Yes ____ No____
Pain reliever, anti-inflammatory, fever reduction.
If Yes:
My child has taken this before Yes____ No_____
My child has had a reaction to
this medication Yes_____ No_____

If yes, please give details of the reaction:_____

_____

Anti-itch gel, cream, or lotion Yes____ No____
Itch relief for poison oak and bug bites.
If Yes:
My child has taken this before Yes___ No_____
My child has had a reaction to
this medication Yes_____ No_____

If yes, please give details of the reaction:_____
_____

Upset stomach / antidiarrheal
(GasX, Tums, Pepto-Bismol.) Yes____ No____
If Yes:
My child has taken this before Yes___ No_____
My child has had a reaction to this medication Yes_____ No_____

If yes, please give details of the reaction:_____
_____

Sunscreen Yes____
No____

If Yes:
My child has used this before Yes_____ No_____
My child has had a reaction to this medication Yes_____ No_____

If yes, please give details of the reaction:_____
_____

Cough Syrup or drops Yes____
No____

If Yes:
My child has taken this before Yes____ No_____
My child has had a reaction to this medication Yes_____ No_____

If yes, please give details of the reaction:_____
_____

Antibiotic ointment (Neosporin) Yes____ No_____

If Yes:
My child has taken this before Yes____ No_____
My child has had a reaction to this medication Yes_____ No_____

If yes, please give details of the reaction:_____
_____

Insect Repellent with deet Yes____ No_____
without deet Yes____ No_____
If Yes:
My child has taken this before Yes____ No_____
My child has had a reaction to this medication Yes_____ No_____

If yes, please give details of the reaction:_____
_____

Food Allergies Yes_____No_____
Please identify any **medically determined food allergies**. Is your child able to manage his diet/allergies without supervision?

You will be contacted in June to discuss what, if any, food items need to be sent from home.

Is there anything else you think we should know to help your child have a successful Camp experience?

_____ _____
SIGNATURE OF PARENT / LEGAL GUARDIAN **DATE**

_____ _____ _____
HOME PHONE WORK PHONE CELL PHONE

SONOMA COUNTY CAMP RULES

READ AND SIGN THIS FORM AND RETURN IT WITH YOUR CAMP PACKET

1. **Cell phones may be used as cameras only.**
2. **Campers may go barefoot in shower and swimming pool areas only.**
3. **Be considerate of others. Do not push people, throw rocks or food.**
4. **Practice safety. Do not run in camp.**
5. **Hikers require permission from the Hike Director, must sign up, and an adult must accompany each hiking group.**
6. **Socks, long pants, and sturdy shoes must be worn on all hikes. Sandals or thongs are not allowed AT ANY TIME.**
7. **Preserve our camp atmosphere. Leave curling irons, hair dryers, and all food and drink at home. iPods may only be used on the bunks.**
8. **Respect the camp schedule and always stay with the group or program to which you are assigned.**
9. **Only adults may have cars at camp. Staffers are not permitted to drive to camp.**
10. **You may leave camp only with permission from the adult advisor, and with an adult chaperone to accompany you.**
11. **Alcohol, illegal drugs, cigarettes and chewing tobacco may not be brought to camp, or be used by campers at camp.**
12. **Do not bring knives, slingshots, firearms or fireworks to camp.**
13. **Campers will remain in their assigned sleeping areas at night unless accompanied by an adult.**
14. **No boys in the girl's sleeping area, and no girls in the boy's sleeping area after opening ceremony and before closing ceremony.**

PENALTY FOR INFRACTION OF THESE RULES MAY RESULT IN ANY OR ALL OF THE FOLLOWING:

1. **Your parents will be called to come take you home.**
2. **You will not be allowed to attend the next Sonoma County Summer Camp session.**
3. **You will be expelled from 4-H club work.**

_____ _____

SIGNATURE OF CAMPER **SIGNATURE OF PARENT / GUARDIAN**

_____

PRINT CAMPER NAME

University of California, Division of Agriculture & Natural Resources
4-H Youth Development Program

University of California Division of Agriculture and Natural Resources

10/22/

Youth Treatment Authorization Form

(PAGE SUBMITTED TO AND RETAINED BY THE 4-H CLUB/UNIT LEADER)

This Treatment Authorization Form is authorized for all 4-H Youth Development meetings and activities during the dates specified below. (Please Note: This information must be updated annually)

First Name Last Name

Club/Unit Name

County and State

From: **July 1, 2014** to **December 31, 2015**

While my child is attending or traveling to or from this 4-H function, I HEREBY AUTHORIZE THE 4-H ADULT VOLUNTEER 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.

EMERGENCY CONTACT INFORMATION

Name

Relationship to Youth Identified Above

( ) Emergency Day Phone (with area code)

( ) Emergency Night Phone (with area code)

Mailing Address City State Zip

AUTHORIZATION AND CONSENT AND RELEASE

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 is it my responsibility to keep the information on this form updated (including Health History) by contacting the County 4-H Office.

_____
Signature of Parent/Guardian

Date

NON-CONSENT

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

_____
Signature of Parent/Guardian

Date

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, 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 Associate Director of 4-H Program & Policy at University of California, Division of Agriculture and Natural Resources, California State 4-H Office, 2801 Second Street, Davis, CA 95618-7774, (530) 750-1334, ca4h@ucanr.edu. Only your own records are open to your review.

University of California, Division of Agriculture & Natural Resources
4-H Youth Development Program

University of California
Division of Agriculture and Natural Resources

Health History Information

(PAGE SUBMITTED TO AND RETAINED BY THE 4-H CLUB/UNIT LEADER)

First Name _____ Last Name _____ County _____ Date of Birth ___/___/___

Subject to:	YES	No	Now Have or Have Had	Yes	No
Colds			Heart Trouble		
Sore Throat			Asthma		
Fainting Spells			Lung Trouble		
Bronchitis			Sinus Trouble		
Convulsions			Hernia (rupture)		
Cramps			Appendicitis		
Allergies			Has appendix been removed?		
Wear corrective lenses?			Do you walk in your sleep?		
Is hearing good?					

Date of last Tetanus Vaccination:

Please check over-the-counter medications that may be administered:
☐ Tylenol ☐ Ibuprofen ☐ Cough Syrup ☐ Decongestant ☐ Dramamine ☐ Antacid ☐ Polysporin ☐ Hydrocortisone
☐ Other:

Please identify allergies including allergies to food, medications, and drug reactions:

_____

_____

_____

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

_____

_____

_____

Please list all current medications:

Name of Medication	Dosage	Times Taken

Please include any additional remarks and special instructions to better assist emergency service personnel. Please explain “yes” answers on this page.

_____

_____

MEDICATION AUTHORIZATION FORM

TO BE COMPLETED BY PARENT

Child's Name_____Date of Birth_____/____/___
Program Name_____Today's Date_____/____/___
****

To administer a prescription medication:

- The medication must be in it's original container, with a legible label from the pharmacy indicating the child's name, date, name of medicine, dosage, and time, number of days medication is to be given, and expiration date of medication, doctor's/nurse practitioners name, pharmacy name and telephone number
- Samples must be accompanied by a doctor's written prescription
- Medications are to be given only to the child indicated on the label (twins and siblings can not share.)
- A separate authorization is required for *each medication* and *each episode* of illness
- Label constitutes the physicians/nurse practitioner's order
- Parent/Guardian is to give as many doses as possible at home.

Medication:_____
Reason for giving:_____
Start date_____/____/___ End date____/____/____

Dosage:_____ Times to be given at child care:_____AM_____PM

Last dosage was given at_____AM/PM On date____/____/____
Route: by mouth, skin (location)_____, eye (R/L)

Possible side effects:_____

Special handling/storage Instructions_____Refrigeration Y/N

Parent/Guardian Signature (required)_____
Physician/Nurse Practitioners Signature_____
****

Non-Prescription Medication:

- Parent is required to bring these medications from home.
- Medication must be in an original container, with child's name on the container.

Medication:_____Health Care Provider_____
"For children under 2, list the name of the health care provider who recommended this medication."

Reason for giving:_____
Start date_____/____/___ End date____/____/____
Dosage:_____ Times to be given at child care:_____AM_____PM

Last dosage was given at_____AM/PM on date____/____/____
Route: by mouth, skin (location)_____, eye (R/L)
Possible side effects:_____
Special handling/storage Instructions_____Refrigeration Y/N

Parent/Guardian Signature (required)_____

Unused medication: Returned to Parent Y/N or, discarded appropriately (circle one)