

Member Code of Conduct

(PAGE RETAINED BY THE COUNTY 4-H OFFICE)

The 4-H Policy Handbook tells me my rights as a 4-H member, and the rules I have to follow. 4-H calls the most important rules for members the “Code of Conduct”. When members follow the Code of Conduct, it helps keep 4-H safe and fun for everyone.

I will follow the 4-H Code of Conduct (rules) and I will:

- Be nice, kind, helpful, and respectful to other 4-H members; and to adult volunteers, youth leaders, 4-H staff, and other adults in charge.
- Be honest, honor my commitments, and accept responsibility for my choices.
- Use language that is respectful and kind. Not use curse words.
- Wear appropriate clothes that are allowed by 4-H rules.
- Not have or use alcohol, tobacco (like cigarettes, e-cigarettes, or chew) or other drugs (unless my doctor gives them to me).
- Not bother or attack others, not carry or use a weapon; and not do anything else illegal or unsafe.
- Know that adults can search my things (like my backpack) if they think I might have broken the 4-H rules.
- Not touch anyone in a way that is too affectionate, and not engage in sexual behavior.
- Follow the 4-H *Guidelines for Social Media* - <http://4h.ucanr.edu/files/133821.docx>.
- Not do things outside of 4-H that are harmful to anyone in 4-H or the 4-H program.
- Follow the *California 4-H Dress Guidelines* - <http://4h.ucanr.edu/files/210170.pdf>

While attending 4-H overnight events I will:

- Be in my room when I’m supposed to be there.
- Not leave the grounds unless an adult in charge gives me permission, and only if there are two adults with me.
- Only enter my own assigned sleeping area and will not invite any kids who aren’t 4-H members into the sleeping areas.
- Be responsible for any damage caused by my actions.
- Follow all the rules for that event.

Consequences

Anyone who sees someone break the Member Code of Conduct should tell the adult in charge right away. That adult will tell that member’s parent or guardian. Consequences for breaking the 4-H rules may include:

- Sending the member home.
- Having the member meet with 4-H adults, talk about how the member can learn from what they’ve done, and decide what the member should do to make up for any harm done.
- Charging the member (or their parents/guardians) for the cost of repairs to property that the member damaged.
- Giving the member a warning, barring them from future events, suspending their membership, or terminating their membership.
- Taking the member to the nearest law enforcement agency or other proper authority.

Photograph and Information Release

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County: _____ Member Name: _____

Signature of Member: _____ Date: _____

Signature of Parent/Guardian: _____ 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 child

has my permission to attend the **Madera County 4-H Camp**
located near **Huntington Lake, California**
between the dates of **June 8-13, 2020**

While my child is attending or traveling to or from this 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 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/legal guardian, I will be responsible for the cost of any service or treatment provided not covered by the 4-H Youth Accident Insurance Program sponsored by the University of California Cooperative Extension.

**AUTHORIZATION AND CONSENT
AND RELEASE**

_____ date _____ signature

Should there be any changes in the status of parent/legal guardian, it will be my responsibility to keep the County 4-H Office informed.

ADULT

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

Name _____
name of adult

Event: **Madera County 4-H Camp**
Located near **Huntington Lake, California**
between the dates of **June 8-13, 2020**

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

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.

AUTHORIZATION AND CONSENT

_____ date _____ signature

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

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 requires 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 needed 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 at the Division of Agriculture and Natural Resources, 4-H, DANR, One Shields Avenue, University of California, Davis, California 95616-8565. Only your own/your child's records are open to your review. Any known or foreseeable intergovernmental transfer which may be made of the information is as

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/Breathing Trouble		
Fainting spells			Lung /Sinus trouble		
Bronchitis			Bleeding Disorder		
Convulsions/Seizures			Hernia (rupture)		
Cramps			Appendicitis		
Allergies <i>(See below)</i>			Has participant's appendix been removed?		
Physical Disability (of any kind)			Does participant sleep walk?		
			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?					
Has participant been under psychiatric treatments within the last three years?					

If participant is a minor, we may administer over-the-counter medications to your child. For example: Antacid, Tylenol, itch cream, antibiotic ointment, etc.

YES _____ NO _____

Date of last Tetanus Vaccination: _____ / _____ / _____ Up-to-date: Y / N

Please identify participant's allergies, including **allergies to food, medications, or drug reactions (including OTC meds)** you know about:

Please list any disabilities or disorders that may affect participant's participation at this 4-H function, such as eyesight, hearing, speech, paralysis, diabetes, ulcer, etc.

Please list all medications that are presently being taken by participant:

Name of Medication

Dosage

Times Taken

<i>Name of Medication</i>	<i>Dosage</i>	<i>Times Taken</i>

Remarks and any special instructions: _____

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