

ASHTABULA COUNTY

4-H Cloverbud

Adventure Day

July 13, 2022**8:00 a.m. – 2:00 p.m.**

\$25.00

Open to all youth ages 5 – 8 as of 1/1/22.

**Adventures in Nature & Science, Crafts and Animal Encounter, and more!**

The number of participants is limited to 40 so sign up now! Pre-registration is necessary to insure adequate supplies and supervision for your children.

Participants are asked to bring their own lunch and water bottle.

Refrigeration available. Snack will be provided.**4-H Expo Building – Ashtabula
County Fairgrounds
127 N. Elm Street Jefferson OH
asthabula.osu.edu**

Registration is limited. Please mail this completed form and the attached health form along with payment made out to OSU Extension by July 1 to: 4-H Cloverbud Adventure Day c/o OSUE – Ashtabula Co. 39 Wall Street, Jefferson, OH 44047. For more information, contact the Extension Office at 440-576-9008.

Camper Name: _____ Age (as of January 1) _____ Grade (as of January 1) _____

Parent/Guardian Name: _____ Address: _____

Phone: _____ Email: _____

I give permission for my child to attend 4-H Cloverbud Adventure Day and participate in all programs and activities.

Photo/Video Release Many times pictures of 4-H Cloverbuds are used for news releases and other PR purposes therefore we ask your permission to use pictures that may include your child. Photo/Video Release – I give/ do not give permission to The Ohio State University, OSU Extension, and The Ohio 4-H Program to use photographs, voice video images of the participant below and photographs, voice and video images of any activities in which the participant is involved in, any and all public awareness programs of The Ohio State University, OSU Extension, and The Ohio 4-H Program.

Parent/Guardian Signature: _____ Date: _____

**THE OHIO STATE UNIVERSITY**
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Ohio 4-H Health Statement

ALL SIDES of this form MUST be completed for each participant. Minors must have the form completed and signed by a parent/guardian. This information will be kept confidential and used only for the welfare of the participant. PRINT neatly using blue or black ink.

REQUIRED!
Attach Picture
 (for I.D. purposes only)

Participant/Member Information:

| | | |
|----------------------|---------------|--------------------|
| Name: _____ | | |
| (Last) | (First) | (Middle) |
| Address: _____ | | |
| (Street) | (City) | (State) (Zip) |
| Home Phone: _____ | County: _____ | |
| Date of Birth: _____ | Male / Female | Age (today): _____ |

Emergency Contact Information:

| | | |
|-----------------------------------|-------------------|--------------|
| Parent/Guardian Name: _____ | Cell Phone: _____ | Email: _____ |
| Other Contact/Relationship: _____ | Cell Phone: _____ | Email: _____ |
| Other Contact/Relationship: _____ | Cell Phone: _____ | Email: _____ |
| Physician: _____ | Phone: _____ | |
| Dentist: _____ | Phone: _____ | |

Health History:

Communicable Diseases:
 Provide the date (approximate is acceptable) at which participant has had or was exposed to:

Chicken Pox _____ Measles _____ Whooping Cough _____
 Tuberculosis _____ Mumps _____ Other Communicable Diseases _____

Immunization/Vaccine Record:

To the best of knowledge, the participant is up-to-date on all immunizations which may include, but is not limited to: Diphtheria/Pertussis (Whooping Cough-TDAP), Polio, Measles/Rubella/Mumps (MMR), Haemophilus Influenza (HIB), Varicella (Chickenpox) that are required for school.

The participant has received a Tetanus Booster. Date of last booster: _____

If the participant is not current or up-to-date with immunizations, please complete the Ohio 4-H Immunization Exemption Form.

Instructions for Medications:

- All prescription drugs must be carried in the container in which they were issued (with medical orders and physician's name intact) and given to the nurse/health director. Other prescription drugs will not be accepted. Only bring the amount needed for your stay at camp.
- If you need regular over-the-counter medications, they must be in the original container. Like prescription medications, these medications must be given to the nurse/health director.
- All medications will be given as directed on the original package/container. If there are any dosage adjustments, you must bring signed documentation from your physician.

Medical Instructions: Medications/Allergies, Current/Past Medical Conditions:

Current Medications (Prescribed and Over-The-Counter, Current or Past Medical Treatment):
 (please list additional medications or needs on a separate sheet)

| Name of Medication: | Dosage: | Frequency/Instructions: |
|---------------------|---------|-------------------------|
| | | |
| | | |



Check below if the participant is subject to any of the following conditions:

| | | | | | | |
|---|---------------------------------------|---|---|---|--|---|
| <input type="checkbox"/> Asthma Controlled? yes/no | <input type="checkbox"/> Bronchitis | <input type="checkbox"/> Cramps | <input type="checkbox"/> Fainting | <input type="checkbox"/> Heart Trouble | <input type="checkbox"/> Seizures | <input type="checkbox"/> Sore Throat |
| <input type="checkbox"/> Athlete's Foot | <input type="checkbox"/> Constipation | <input type="checkbox"/> Diarrhea | <input type="checkbox"/> Frequent Colds | <input type="checkbox"/> Home Sickness | <input type="checkbox"/> Sinusitis | <input type="checkbox"/> Other? |
| <input type="checkbox"/> Bed Wetting | <input type="checkbox"/> Convulsions | <input type="checkbox"/> Ear Infections | <input type="checkbox"/> Headaches | <input type="checkbox"/> Kidney Trouble | <input type="checkbox"/> Sleep Walking | |

Allergies:

If none, please write NONE here: _____

Food allergies: _____

Medication allergies: _____

Serious Ivy, Oak or Sumac Poisoning: What is the prescribed treatment? _____

Serious bee or insect sting reactions: What is the prescribed treatment? _____

NOTE: If participant's allergy may require use of an "EPI-PEN", then the participant must provide the "Epi-Pen(s)" and discuss possible administration with health care professional upon arrival to camp.

Check below if the participant displays any of the following behaviors:

| | | | | |
|---|---|---------------------------------------|--|---|
| <input type="checkbox"/> Abusive to Others | <input type="checkbox"/> Easily Distracted | <input type="checkbox"/> Manipulative | <input type="checkbox"/> Self Abusive | <input type="checkbox"/> Withdrawn/Shy |
| <input type="checkbox"/> Bites | <input type="checkbox"/> Hyperactive | <input type="checkbox"/> Mood Swings | <input type="checkbox"/> Severe Fears (Please comment) _____ | <input type="checkbox"/> Behavior Plan in Place (please attach a copy or description) |
| <input type="checkbox"/> Easily Discouraged | <input type="checkbox"/> Inappropriate Language | <input type="checkbox"/> Runs Away | <input type="checkbox"/> Short Attention Span | <input type="checkbox"/> Other? _____ |

Accommodations for Camp:

Please tell us about the accommodations your child may need at 4-H camp:

- I will be bringing medications to camp (please describe whether they require refrigeration or special storage below).
- I have dietary restrictions (describe below).
- I have limited mobility (e.g. crutches, cane, etc.).
- I have ADHD or a related attention deficit disorder; a visual, hearing, cognitive processing, reading, or a speech impairment. (describe any needs you anticipate at camp and the accommodations you typically receive at school and home below).
- I require the use of medical equipment that needs electricity (describe below).
- I require other accommodations not listed above (describe below).
- I do NOT require any special accommodations (none of the above apply to me).

Description of any past or current physical, mental, or psychological conditions requiring medication, treatment, or special restrictions or considerations while at camp: _____

Description of any camp activities from which my child should be exempted for health reasons: _____

Check medication(s) that participant may receive if deemed necessary and administered by a health professional. Examples of brand names are given in parentheses. Generic or other name brands may be provided:

| | | | |
|--|---|---|---|
| <input type="checkbox"/> Acetaminophen (ex: Tylenol) | <input type="checkbox"/> Antibiotic Ointment (ex: Neosporin) | <input type="checkbox"/> Dramamine | <input type="checkbox"/> Poison Ivy Medicine (ex: Calamine Lotion) |
| <input type="checkbox"/> Aloe Lotion | <input type="checkbox"/> Cough Syrup/Drops | <input type="checkbox"/> Ibuprofen (ex: Advil, Motrin) | <input type="checkbox"/> Sore Throat Medicine |
| <input type="checkbox"/> Antacids (ex: Maalox, Tums) | <input type="checkbox"/> Decongestant (ex: Sudafed) | <input type="checkbox"/> Insect Repellent | <input type="checkbox"/> Sun Screen |
| <input type="checkbox"/> Antihistamine (ex: Benadryl, Claritin) | <input type="checkbox"/> Diarrhea Medication (ex: Imodium) | <input type="checkbox"/> Laxative (ex: Milk of Magnesia) | <input type="checkbox"/> Swimmer's Ear Medicine |
| <input type="checkbox"/> Antiseptics | | | |

Emergency Medical and Informed Consent/Camp/Program Release

I understand that my child, _____ will be a participant in the Ohio 4-H program and I grant permission for him/her to participate in this program and associated activities with the exception of any restricted activities that I have listed below. I understand that my child must follow the *Ohio 4-H Code of Conduct*; consequences for *Code of Conduct* violations may result in my child being sent home at the sole discretion of OSU Extension at my expense.

I understand that my child is not required to participate in this program, but grant my permission for him/her to do so, despite the potential risks. I recognize that by participating in this program, as with any physical activity, my child may risk personal injury, paralysis and/or death. I understand program participants will be supervised and acknowledge that the 4-H staff and volunteers, OSUE, The Ohio State University, and the 4-H Camp Site are not responsible for any potential injury or illness resulting from my child's participation. I hereby attest and verify that I have been advised of the potential risks, that I have full knowledge of the risks involved and that I assume any expense that may be incurred in the event of an accident, illness, or other incapacity, regardless of whether I have authorized such expenses.

I understand that most program activities are conducted outdoors and that wearing proper dress (e.g., rain gear, warm clothing) is an essential part of the camp safety rules and procedures. I am aware of and have discussed with my child the established safety rules and procedures.

In the case of serious illness or injury of my child, I understand that I will be notified. If I cannot be contacted, unless otherwise specified below, I grant permission to the attending medical professional to secure proper treatment, hospitalize, and/or take any other action deemed necessary for the immediate care of my child.

In consideration of the opportunity for my child to participate in this program, I, acting for my child, myself and our respective heirs, executors, administrators and assigns, agree to assume any and all risks associated with this activity and do hereby release, indemnify and hold harmless The Ohio State University, its Board of Trustees, OSUE, the Ohio 4-H program, the 4-H camping facility, and their respective officers, agents, and employees from any and all liability, damage, and/or claim of any nature resulting from or arising out of my child's participation in this program and its activities.

Restricted activities and/or special notification instructions: _____

Photo and Video Release

I give permission to The Ohio State University, OSUE, the Ohio 4-H program, and the 4-H camping facility to record and edit into video and/or photographs the likeness, voice, image and video images of my child, _____, and to use all or parts of the video or photographs in print or electronic materials for The Ohio State University, OSUE, the Ohio 4-H program, and 4-H camping facility to promote any and all public awareness for the program(s) in which my child is involved.

| | | |
|------------------------------|---------------------------|------|
| Parent/Guardian Printed Name | Parent/Guardian Signature | Date |
|------------------------------|---------------------------|------|

Ohio 4-H Camp COVID-19 Acknowledgement

I will not send my child to camp if they, or any member in their household, have tested positive for COVID-19 or in the past 14 days have experienced any of the following COVID-19 symptoms:

- Congestion or runny nose
- Cough
- Diarrhea
- Fatigue
- Fever or chills
- Headache
- Muscle or body aches
- Nausea or vomiting
- New loss of smell or taste
- Sore throat
- Shortness of breath or difficulty breathing

I understand that camp participation is voluntary. I acknowledge the contagious nature of COVID-19 (and its variants) and voluntarily assume the risk that my child(ren) and I may be exposed to, or infected by, COVID-19 (or its variants) by attending the 4-H Camp, and that such exposure or infection may result in personal injury, illness, permanent disability and/or death. I understand that the risk of becoming exposed to, or infected by, COVID-19 (or its variants) may result from the actions, omissions, or negligence of my child(ren), myself and others, including, but not limited to, The Ohio State University, OSU Extension, 4-H camp site, and the employees, agents, representatives, volunteers and program participants and their families.

I further understand that dangers may be increased if I or my child(ren) have previously had COVID-19. Because COVID-19 is a developing disease, I understand that all of the current and future risks associated with COVID-19 are not known at this time and it is not possible to fully list every risk associated with contracting the virus. However, I am aware that COVID-19 complications while engaging in physical activity without appropriate medical clearance may lead to further injury or illness, including, but not limited to: dizziness; respiratory issues and lung damage; cardiac issues, including myocarditis (heart muscle inflammation); blood clots; general inflammation; and muscle inflammation/breakdown. I am choosing to send them to camp despite the potential risks.

As recommended by the American Academy of Pediatrics, I understand my pediatrician can advise me on whether it is safe for my child to attend camp based on his or her medical history.

I understand my child must follow all COVID-19 guidance (e.g., wearing masks, distancing, etc.). Failure to do so may result in my child being sent home from camp.

I also understand I will be required to immediately pick up my child if they experience any symptoms listed above while at camp or are exposed to COVID-19. I understand I will receive a full refund of any fees paid before the start of camp. Refunds will be prorated for the days not attended if participants need to depart due to COVID-19 symptoms.

Parent/Guardian Printed Name

Parent/Guardian Signature

Child Printed Name

Date

