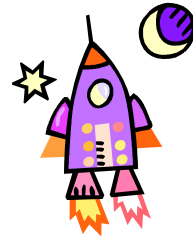


# 4-H Cloverbud Camp 2011



**WHEN:** July 19 & 20  
**WHERE:** Coldwater Lake 4-H Camp  
**AGES:** 5-8 (by 1/1/11)  
**COST:** \$25.00 - 4-H members  
 \$35.00 - Non 4-H members

**Check-In Daily:**  
 9:30 a.m. - 10:00 a.m.

**Check-Out Daily:**  
 4:30 p.m.

**T-Shirt Size (youth):** S \_\_\_\_\_ M \_\_\_\_\_ L \_\_\_\_\_ XL \_\_\_\_\_  
**(adult):** S \_\_\_\_\_ M \_\_\_\_\_ L \_\_\_\_\_ XL \_\_\_\_\_

Name of Camper: \_\_\_\_\_ County: \_\_\_\_\_

Address: \_\_\_\_\_  
street city zip

Phone: (\_\_\_\_\_) \_\_\_\_\_ Age (as of 1/1/11): \_\_\_\_\_

Grade: \_\_\_\_\_ Gender: M F

OFFICE USE

Ck# \_\_\_\_\_

Date \_\_\_\_\_

Are you currently a 4-H member in Isabella County? Yes \_\_\_ No \_\_\_

Any food allergies: \_\_\_\_\_

Any restrictions on activities: \_\_\_\_\_

Residence: \_\_\_ Farm \_\_\_ Town Under 10,000 \_\_\_ Town/city w/population of 10,000-50,000

Racial-Ethnic background: *(for statistical purposes only)*  
 \_\_\_ White, not of Hispanic origin \_\_\_ Asian or Pacific Islander \_\_\_ Hispanic  
 \_\_\_ American Indian or Alaskan Native \_\_\_ Black, not of Hispanic Origin

Handicapper Status: \_\_\_ Emotional \_\_\_ Learning \_\_\_ Mental \_\_\_ Physical

**\*\*Registration Deadline - June 17th! Camp session will be filled on a first come basis.\*\***

Return and make check payable to: Isabella County MSU Extension  
 200 N. Main Street  
 Mt. Pleasant, MI 48858



# MEDIA RELEASE/MEDICAL TREATMENT AUTHORIZATION

Event: 4-H Cloverbud Camp  
Date: July 19 & 20  
County: \_\_\_\_\_

## SECTION 1 – RELEASE FOR AUDIO, VIDEO, FILM AND PHOTOGRAPHS

Participants in events sponsored by MSU 4-H are sometimes photographed and videotaped for use in MSU 4-H promotional and educational materials.

I authorize Michigan State University to record the image and voice of the subject named below and give MSU and all persons or entities acting pursuant to MSU's permission or authority, all rights to use of these recorded images and voice. I understand that said images and/or voice will be used for educational, advertising and promotional purposes in all conventional and electronic media, including but not limited to the Internet, and any future media. I also authorize the use of any printed material in connection therewith.

I understand and agree that these images and recordings may be duplicated, distributed, with or without charge, and/or altered in any form or manner without future or further compensation or liability, in perpetuity.

Print subject's name (adult or youth) \_\_\_\_\_

Signature \_\_\_\_\_

(Parent or guardian must sign here if subject is under age 18.)

Date \_\_\_\_\_

## SECTION 2 – MEDICAL TREATMENT AUTHORIZATION

**This section must be completed and signed by a parent or guardian for all youth participants before they can participate in this program. If this form is not completed, youth participants will not be allowed to participate. Completing this section is optional but encouraged for adult participants.**

Please complete this form to give a medical facility permission to treat the participant for minor injuries or medical problems. In the event of serious injury or illness, the parent or person designated will be contacted. Treatment will proceed before contacting the parent or person designated **only if the situation is urgent and does not permit delay.**

Participant's full name \_\_\_\_\_

Birth date \_\_\_\_\_ Phone (\_\_\_\_\_) \_\_\_\_\_

Mailing address \_\_\_\_\_

Primary care physician's name \_\_\_\_\_

Physician's address \_\_\_\_\_

Physician's phone (\_\_\_\_\_) \_\_\_\_\_

## HEALTH INSURANCE INFORMATION:

Policy holder's name and relationship to participant \_\_\_\_\_

Policy holder's address \_\_\_\_\_

**Please attach a photocopy of both sides of your insurance card (preferred) OR complete the information requested here:**

Insurance company name and address \_\_\_\_\_

Insurance company phone number (\_\_\_\_\_) \_\_\_\_\_

All policy numbers (please identify) \_\_\_\_\_

If you have HMO insurance, please list emergency treatment authorization phone number (\_\_\_\_\_) \_\_\_\_\_

Employer's name and address \_\_\_\_\_

## INFORMATION NEEDED ABOUT PARTICIPANT:

Please check yes or no. If yes, explain below or on another sheet if you need more room.

**Yes No**

Does the participant have any chronic health problem or illness? \_\_\_\_\_

Does he or she have any acute illness now? \_\_\_\_\_

Has the person been treated recently for some medical problem? \_\_\_\_\_

List any medications he or she is now taking for treatment of any medical problem. \_\_\_\_\_

Does the participant have any allergies to medication or local anesthetics? \_\_\_\_\_

Does he or she have any allergies? \_\_\_\_\_

Date of his or her last tetanus shot: \_\_\_\_\_

## OFFICIAL AUTHORIZATION FOLLOWS:

I (parent or legal guardian), \_\_\_\_\_ recognize that while attending this program, medical treatment on an emergency basis may be necessary for my child, and I further recognize that MSU 4-H staff may be unable to contact me for my consent for emergency medical care. I do hereby consent in advance to such emergency care, including hospital care, as may be deemed necessary under the circumstances and to assume the expenses of such care. I also authorize the medical facility to release any and all information required to complete insurance claims and also authorize insurance payment directly to the medical facility.

Signature \_\_\_\_\_

(Parent or guardian must sign here if participant is under age 18.)

Date \_\_\_\_\_

Mailing address \_\_\_\_\_

Daytime phone (\_\_\_\_\_) \_\_\_\_\_

Evening phone (\_\_\_\_\_) \_\_\_\_\_