

# 4-H CAMP COUNSELOR APPLICATION

4-H Overnight Camp (Ages 14-19 years old by January 1, 2011)

Cloverbud Camp (Ages 12-19 years old by January 1, 2011)

NAME: \_\_\_\_\_ BIRTHDATE: \_\_\_\_\_

ADDRESS: \_\_\_\_\_ CITY: \_\_\_\_\_ AGE: \_\_\_\_\_

PARENT'S NAME: \_\_\_\_\_ PHONE: \_\_\_\_\_

NUMBER OF YEARS IN 4-H: \_\_\_\_\_ CLUB NAME: \_\_\_\_\_

EMAIL: \_\_\_\_\_

T-shirt Size (check one) Adult: S \_\_\_\_\_ M \_\_\_\_\_ L \_\_\_\_\_ XL \_\_\_\_\_ 2X \_\_\_\_\_ 3X \_\_\_\_\_

Please check all the areas listed below as to your capability (Teaching or Helping with).

Use **T** for teach and **H** for help.

_____ Sports	_____ Waterfront	_____ Crafts	_____ Other
_____ Singing	_____ Games	_____ Nature	

Are you certified for any of the following (not required)?  CPR  First Aid  Water Front Safety

Please write a paragraph describing your leadership experiences in 4-H and other activities such as school, church, etc.

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Check the camps below that you want to work at:

\_\_\_\_\_ July 12 & 13 **4-H Summer Camp** - overnight camp for 9-13 year olds  
(July 11 - Camp counselor training and camp prep)

\_\_\_\_\_ July 19 & 20 **Cloverbud Camp** - day camp for 5-8 year olds

**Due in the MSU Extension office by April 29, 2011!**



# MEDIA RELEASE/MEDICAL TREATMENT AUTHORIZATION

Event: \_\_\_\_\_  
Date: \_\_\_\_\_  
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 (\_\_\_\_\_) \_\_\_\_\_