



**“STEAM” into Summer!**  
**Ferry County 4-H Tech Wizards Day Camp**  
**2017 Registration Form**



Youth will have an exciting 3 days of learning by doing, making new friends, and having fun. We have a rich slate of activities planned to engage youth in learning about what STEAM (Science, Technology, Engineering, Arts, and Mathematics) means to them.

**June 27<sup>th</sup>-29<sup>th</sup>, 2017**

**Tuesday-Thursday**  
**9:00 am – 3:30 pm**

**Check-in starts at 8:30 am every day. Camp will begin at 9 am sharp**  
**Check-out at 3:30 pm every day.**

Camp will be held at the Ferry County Fairgrounds in Republic, WA  
**Minimum-10 campers and Maximum-50 campers. Open to 4-H and non 4-H youth, ages 5-13**  
**Registration includes all workshop materials, lunch, snacks, and t-shirt.**  
**Breakfast will not be served.**

Registration Fee due Friday June 9<sup>th</sup>.

- \$25 4-H Member or Tech Wizards Mentee
- \$30 Non 4-H Member or Tech Wizards Mentee

**Registration Fee Waived if enrolled as:**  
**(Please check if applicable)**

- 4-H Youth & Adult Leaders as Volunteers

Name \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_

Male \_\_\_\_\_ Female \_\_\_\_\_ Age \_\_\_\_\_

4-H Club Name \_\_\_\_\_

Day Phone \_\_\_\_\_ Evening Phone \_\_\_\_\_

Email \_\_\_\_\_

T-Shirt Size Information: check the appropriate box:

**YOUTH SIZE**

- Small       X Large
- Medium
- Large

**ADULT SIZE**

- Small       X Large
- Medium       2X Large
- Large       3X Large

**Make checks payable to: WSU**

Mail all forms to: WSU Ferry County Extension  
 350 E. Delaware Ave. #9  
 Republic, WA 99166

Follow all the camp updates on  
 Facebook @ WSU Ferry County Extension

WSU Extension program, employment, and volunteer service are available to all without discrimination (See WSU Executive Policy #15). Concerns regarding potential discrimination may be reported through your local Extension office or directly to the WSU Office for Equal Opportunity, web: [oeo.wsu.edu](http://oeo.wsu.edu), email: [oeo@wsu.edu](mailto:oeo@wsu.edu), phone: 509-335-8288. Persons with disabilities who require alternative means for communication or program information or reasonable accommodation should contact Tonia Jordan, [jordant@wsu.edu](mailto:jordant@wsu.edu), 350 E. Delaware Ave, Republic, WA 99166, 509-775-5225 x1116 at least two weeks prior to the event.



## Service Agreement for All Adult & Youth Volunteers & Applicant Authorization



**SERVICE AGREEMENT FOR ALL STAFF** - In order to participate in Day Camp projects and activities, staff volunteers must provide written permission to the terms and conditions as follows. Read carefully and sign below:

I agree to carry out the responsibilities of my position, to the best of my abilities.

I agree to participate in all Day Camp activities, as assigned by the Camp Coordinators, to the best of my abilities.

I agree to model for youth and adults the 4-H philosophy of good citizenship and abide by the policies and standards of 4-H.

I agree to attend all training sessions, to be on time and to be present during the entire training session.

I agree to be on time, be present and participate for the entire duration that I have scheduled.

I agree to notify the Camp Coordinators immediately if, for any reason, I find that I am unable to carry out my responsibilities at Day Camp.

### APPLICANT AUTHORIZATION

**Confirmation** - All statements contained in this application are subject to confirmation by the WSU Ferry County Extension 4-H Program.

**Disclosure** - I understand that Day Camp activities involve a normal level of risk. I assure that I am willing and able to participate in all Day Camp activities, am willing and able to participate in program activities, and am willing to abide by program policies and follow directions of coordinators.

**Medical Care Authorization** - I understand that reasonable measures will be taken to safeguard the health and safety of all participants.

**Over-the-counter and/or Prescription medications** - If your child requires any medications, please make sure they are able to self-dose while at camp and bring a suitable supply with them.

Please list any over-the-counter treatment exceptions under allergies.

### ADULT AND YOUTH CAMPERS

I understand that, unless noted below, photos, video, or audio recordings made of me may be used by WSU Extension and Washington State 4-H, without compensation, to promote the 4-H Youth Development Program. I understand that my name may be revealed in descriptive text or commentary. NO Permission \_\_\_\_\_ YES, with this condition \_\_\_\_\_

As parent/legal guardian of (or if an adult yourself) \_\_\_\_\_ I hereby give my consent for the above named youth to participate in the 4-H Day Camp June 27<sup>th</sup>-29<sup>th</sup>, 2017.

I also hereby waive and forever discharge claims for damages which the above listed individual, their heirs, executors and administrators may have or accrue against Washington State University Extension, Ferry County, their representatives, agents, and accompanying 4-H program leaders, arising from any injuries (physical or mental), including death, suffered in connection with this 4-H sponsored event.

My signature below gives my consent to the above statements.

\_\_\_\_\_  
Participant Signature

\_\_\_\_\_  
Parent/Guardian Signature

\_\_\_\_\_  
Date Signed

\_\_\_\_\_  
Date Signed



Camp is funded by Attendees and Ferry County 4-H Tech Wizards.

**EVENT NAME  
PARTICIPANT HEALTHFORM**

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Mail this form to the address below by \_\_\_\_\_ (date)  
**Event Address**

Attendance dates: from: \_\_\_\_\_ to \_\_\_\_\_

Participant Name: \_\_\_\_\_  
First Middle Last

Male  Female Birth Date \_\_\_\_\_ Age on arrival at program \_\_\_\_\_  
Month/Day/Year

**To Parent(s)/Guardian(s):** Please follow the instructions below. Attach additional information if needed.

1. Complete pages 1, 2 and 3 of this form (and make a copy for yourself).
2. Send the original, signed form to program by requested date.

Participant Home Address: \_\_\_\_\_  
Street Address City State Zip Code

**Parent/guardian with residential placement and/or decision-making authority in the event of illness or injury:**

Name: \_\_\_\_\_ Relationship to Participant: \_\_\_\_\_

Preferred Phones: (\_\_\_\_\_) \_\_\_\_\_ (\_\_\_\_\_) \_\_\_\_\_ Email: \_\_\_\_\_

Home Address: \_\_\_\_\_  
(if different from above) Street Address City State Zip Code

**Second parent/guardian with legal custody to be contacted in case of illness or injury:**

Name: \_\_\_\_\_ Relationship to Participant: \_\_\_\_\_

Preferred Phones: (\_\_\_\_\_) \_\_\_\_\_ (\_\_\_\_\_) \_\_\_\_\_ Email: \_\_\_\_\_

**Additional parent/guardian to be contacted in case of illness or injury:**

Name: \_\_\_\_\_ Relationship to Participant: \_\_\_\_\_

Preferred Phones: (\_\_\_\_\_) \_\_\_\_\_ (\_\_\_\_\_) \_\_\_\_\_ Email: \_\_\_\_\_

**Allergies:**  No known allergies.  This participant is allergic to:  Food  Medicine  The environment (insect stings, hay fever, etc.)  Other  
*(Please describe below what the participant is allergic to and the reaction seen, in detail. Please describe preventative or responsive measures.)*  
 This participant has a life-threatening allergy. An emergency care plan signed by physician is required.

**Diet, Nutrition:**  This participant eats a regular diet.  This participant eats a vegetarian diet (describe details below).  
 This participant has special food needs. *(Please describe below.)*

**Immunizations:**

My child is up-to-date on his/her immunizations and tetanus shots as required by Washington State law. Date of last Tetanus shot: \_\_\_\_\_

My child has an immunization exemption on file with his/her school. I understand and accept the risks to my child from not being fully immunized.

**Medication:**

We will be unable to administer medication to children. If your child requires a dosage during activity/event hours, please make appropriate arrangements. Medication<sup>1</sup> is any substance a person takes to maintain and/or improve their health. This includes vitamins & natural remedies. All medications must be in their original containers. Prescriptions must have the child's name and how the medication should be given printed on the prescription container. Please send only those medications that are necessary.

**Medications Currently being taken: (must list)**

This participant will not take any daily medications while attending the activities.

This participant will be self-administering the following daily medication(s) while attending the activities.<sup>1</sup>

Participant Name:

First

Middle

Last

(For Camp Use) Cabin or Group \_\_\_\_\_

(For Program Use) Session Code(s) \_\_\_\_\_

<sup>1</sup> Note: These provisions regarding administration of medication shall not abrogate minors' rights to provide their own consent to certain services under Washington law.

**EVENT NAME**  
**PARTICIPANT HEALTH FORM**

Participant Name: \_\_\_\_\_  
First Middle Last

Birth Date: \_\_\_\_\_  
Month/Day/Year

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**General Health History: Check "Yes" or "No" for each statement. Explain "Yes" answers below.**

Has/does this participant:

- |  |  |  |  |
|--|--|--|--|
| 1. Ever been hospitalized?.....                    | <input type="checkbox"/> Yes <input type="checkbox"/> No | 12. Passed out/had chest pain during exercise?.....  | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 2. Ever had surgery?.....                          | <input type="checkbox"/> Yes <input type="checkbox"/> No | 13. Had mononucleosis ("mono") during the past 12 months?.....   | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 3. Have recurrent/chronic illnesses?.....          | <input type="checkbox"/> Yes <input type="checkbox"/> No | 14. Ever had back/joint problems?.....   | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 4. Had a recent infectious disease?.....           | <input type="checkbox"/> Yes <input type="checkbox"/> No | 15. Have problems with diarrhea/constipation?.....   | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 5. Had a recent injury?.....                       | <input type="checkbox"/> Yes <input type="checkbox"/> No | 16. Have any skin problems?.....   | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 6. Has asthma/wheezing/shortness of breath?.....   | <input type="checkbox"/> Yes <input type="checkbox"/> No | 17. Traveled outside the country in the past 9 months?.....  | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 7. Have diabetes?.....                             | <input type="checkbox"/> Yes <input type="checkbox"/> No | 18. Had Sickle Cell disease or traits?.....  | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 8. Had seizures?.....                              | <input type="checkbox"/> Yes <input type="checkbox"/> No | 19. Had high blood pressure? .....   | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 9. Had headaches?.....                             | <input type="checkbox"/> Yes <input type="checkbox"/> No | 20. Had cardiovascular disease or other heart problems? .....  | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 10. Wear glasses, contacts, or protective eyewear? | <input type="checkbox"/> Yes <input type="checkbox"/> No | 21. Have a history of heart disease (not limited to conjunctive heart defect, cardiomyopathy, ahbrythemia?)..... | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 11. Had fainting or dizziness?.....                | <input type="checkbox"/> Yes <input type="checkbox"/> No |  |  |

*Please explain "Yes" answers in the space below, noting the number of the questions. For travel outside the country, please name countries visited and dates of travel.*

**Restrictions:**

- I have reviewed the program and activities of the program and feel the participant can participate without restrictions.  
 I have reviewed the program and activities of the program and feel the participant can participate with the following restrictions or adaptations. *(Please describe below.)*

**Does the participant require reasonable accommodation for a disability in order to access or be part of the activities?**

**What Have We Forgotten to Ask?** *Please provide in the space below any additional information about the participant's health that you think important or that may affect his or her ability to fully participate in the program. Attach additional information if needed.*

This health history is correct and accurately reflects the health status of the participant to whom it pertains. The person described has permission to participate in all program activities except as set forth by me and/or an examining physician. If you fail to advise WSU of a medical condition, WSU is not responsible for related injuries. I understand the information on this form will be shared on a "need to know" basis with WSU staff and volunteers. I give permission to photocopy this form. In addition, the health care provider has permission to obtain a copy of my child's health record from providers who treat my child and these providers may talk with the program's staff about my child's health status.

Signature of Custodial \_\_\_\_\_ Relationship to Participant \_\_\_\_\_

Parent/Guardian: \_\_\_\_\_ Date: \_\_\_\_\_

**Parent/Guardians: Keep a copy for your records.**