

Gallia County Cloverbud Day Camp

Exploring Earth's Beautiful Biomes

Date: June 29, 2021

Location: Gallia County Jr. Fairgrounds

Time: 9:00am-3:00pm

Camper Fee: \$20

There will be a limit of 30 campers this year



Join us as we explore Earth's beautiful biomes such as the ocean, forest, desert, and tundra. We will be exploring these beautiful biomes through crafts, games, water games, songs, and other activities. Lunch and snacks will be offered.

Unfortunately, due to COVID-19 restrictions, our camp will be limited to kids ONLY. Parents will not be allowed to attend in order for more children to have the opportunity to attend and maintain designated capacity recommendations.

Registration will take place from 9:00am to 9:20am. Our day will conclude at 3:00pm. **Both pick up and drop off will be located at the Bill Gray Pavilion on the Gallia county fairgrounds.**

Return this form to the Gallia County Extension Office by Tuesday, June 22, 2021

Please follow the OSU Extension- Gallia County Facebook page for more information on what to bring as we approach the camp date.



2021 Gallia County Cloverbud Day Camp Registration

Exploring Earth's Beautiful Biomes

June 29, 2021

Name: _____ Grade Completed: _____ Club Name: _____

Address: _____ City: _____ Zip: _____

Cloverbud Day Camp in Gallia county will be for Cloverbuds ONLY. No parents will be permitted to stay for the camp in order to meet COVID-19 safety requirements. There will be a limit of 30 campers this year. Camper Fee: \$20.00 per camper

Number of Little Caesars Kits Sold in 2020 ___ X \$ 6.00

= \$ ___ (Kits sold based on 4-H club records)

Amount Enclosed: _____

Please make check or money order payable to the OSU Extension Office Gallia County

Return this registration form and health forms on or before **June 22nd with payment to:**

OSU Extension, Gallia Co. 111 Jackson Pike Suite 1572 Gallipolis, Ohio 45631

I understand that this is a 4-H event and agree that I will act in a responsible manner as a 4-H member. I will obey the rules set forth by OSU Extension Personnel and adult volunteers in attendance. Any violation of the rules including destructive behavior, lack of respect for other members or adults, possession of alcohol, tobacco products, or possession of a weapon will be reason or to be dismissed from the camp and dismissal of being a camp counselor.

Member Signature

Date

I understand that my child's participation in this event is a privilege and not a right I understand that my child must abide by the rules and regulations of OSU Extension, or I, as a parent guardian, will assume responsibility of the child being sent home.

Parent/Guardian Signature

Date

Photo/Video Release

Many times, pictures of 4-H members 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 permission to The Ohio State University, OSU Extension, and The Ohio 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 Program.

Participant Name

Parent/Guardian Signature

Date

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: _____	Parent/Guardian Cell Phone: _____
Other Contact: _____	Other Cell Phone: _____
Other Contact: _____	Other Cell Phone: _____
Physician: _____	Physician Phone: _____
Dentist: _____	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.

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.

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: _____

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.

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"/> Decongestant (ex: Sudafed)	<input type="checkbox"/> Poison Ivy Medicine (ex: Calamine Lotion)
<input type="checkbox"/> Aloe Lotion	<input type="checkbox"/> Cough Syrup/Drops	<input type="checkbox"/> Diarrhea Medication (ex: Imodium)	<input type="checkbox"/> Sore Throat Medicine
<input type="checkbox"/> Antacids (ex: Maalox, Tums)	<input type="checkbox"/> Decongestant (ex: Sudafed)	<input type="checkbox"/> Dramamine	<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	<input type="checkbox"/> Dramamine		

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 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

