

# 4-H BASE CAMP REGISTRATION FORM 2025



- WHO:** Racine and Kenosha County 4-H members who are in 3rd, 4th, or 5th grade during the 2024-2025 school year. Acceptance for camp is first-come, first-served, and space is limited to 40 campers.
- WHAT:** Base Camp is an opportunity for exploration, discovery, building friendships, trying new things, sleeping in cabins, swimming, hiking, campfires, and so much more!
- WHERE:** Upham Woods N194 County Rd N Wisconsin Dells, WI 53965
- WHEN:** **Friday, July 11, 2025 - Sunday, July 13, 2025** – We will roughly be leaving at 9:00 AM and returning at 2:30 PM.
- COST:** The cost is \$140.00 per camper which covers transportation, lodging, meals, t-shirt, supplies, and programming. Please make the check, **one per camper**, payable to **Extension Racine County**.

## ONE CAMPER PER FORM (PLEASE PRINT)

Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_

Parent Phone: \_\_\_\_\_ Grade (2024-2025 School Year): \_\_\_\_\_ Age: \_\_\_\_\_

Parent Email Address: \_\_\_\_\_ Club: \_\_\_\_\_

Gender: \_\_\_\_\_ Parent/Guardian (First and Last Name): \_\_\_\_\_

Please list an alternative contact name and number in case listed parent or guardian cannot be reached. \_\_\_\_\_

Does this youth require special accommodations or have food allergies? ☐ Yes ☐ No

If yes, please describe: \_\_\_\_\_

**Please check one t-shirt size:**

<b>Youth Size</b>	<b>S</b> <input type="checkbox"/>	<b>M</b> <input type="checkbox"/>	<b>L</b> <input type="checkbox"/>	<b>XL</b> <input type="checkbox"/>	
<b>Adult Size</b>	<b>S</b> <input type="checkbox"/>	<b>M</b> <input type="checkbox"/>	<b>L</b> <input type="checkbox"/>	<b>XL</b> <input type="checkbox"/>	<b>XXL</b> <input type="checkbox"/>

**This registration Form, health form media release form and payment are due by Monday, April 28th, 2025.** Forms may be dropped off in person at the Racine County Extension Office (1072 Milwaukee Avenue, Burlington, WI 53105) on weekdays between 8:00 AM-12:00 PM or 12:30-4:30 PM by the stated date, placed in the green drop box in front of the office by the stated date, or postmarked via USPS mail by the stated date. Late forms are not able to be accepted and space is limited.

**Are you interested in chaperoning this overnight program?** ☐ Yes ☐ No \*Please keep in mind that this event is contingent on how many chaperones we can get. If we can't meet our required number, camp cannot take place.

**Chaperone Name:** \_\_\_\_\_ **I am a registered 4-H volunteer:** ☐ Yes ☐ No  
I have completed Supporting Youth Mental Health Training ☐ Yes ☐ No T-Shirt Size: \_\_\_\_\_

**I give my permission for this camper to participate in Base Camp on August 9<sup>th</sup>-11<sup>th</sup>, 2024.**

**Signature of Parent or Guardian:** \_\_\_\_\_ **Date:** \_\_\_\_\_

An EEO/AA employer, University of Wisconsin Extension provides equal opportunities in employment and programming, including Title IX and the Americans with Disabilities Act (ADA) requirements. Requests for reasonable accommodations for disabilities or limitations should be made prior to the date of the program or activity for which it is needed. Please do so as early as possible prior to the program or activity so that proper arrangements can be made. Requests are kept confidential.





UW-MADISON EXTENSION

# 2024-2025 Camp Health Form

Event Name: \_\_\_\_\_

Dates: \_\_\_\_\_

Youth Name: \_\_\_\_\_ Birth date \_\_\_\_/\_\_\_\_/\_\_\_\_ Age on 1<sup>st</sup> day of event \_\_\_\_\_ Sex: ☐ Male ☐ Female

Custodial Parent/Guardian (or spouse) \_\_\_\_\_ E-mail address: \_\_\_\_\_

Phone Numbers: Home (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ Work (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ Cell phone (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

Home address: \_\_\_\_\_

Street

City

State

Zip

Second parent/guardian  
and/or emergency contact: \_\_\_\_\_ Phone: Home (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

Work (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

Address: \_\_\_\_\_

Street

City

State

Zip

Yes	No	Health Conditions (check)	Yes	No	Allergies (check)	List specifics
<input type="checkbox"/>	<input type="checkbox"/>	Asthma	<input type="checkbox"/>	<input type="checkbox"/>	Insect stings	
<input type="checkbox"/>	<input type="checkbox"/>	Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	Foods	
<input type="checkbox"/>	<input type="checkbox"/>	Epilepsy	<input type="checkbox"/>	<input type="checkbox"/>	Medications	
<input type="checkbox"/>	<input type="checkbox"/>	Psychiatric	<input type="checkbox"/>	<input type="checkbox"/>	Other	
<input type="checkbox"/>	<input type="checkbox"/>	Cognitive/Developmental	<input type="checkbox"/>	<input type="checkbox"/>	Do any allergies require an EPIPEN injection?	
<input type="checkbox"/>	<input type="checkbox"/>	Any dizziness, light-headedness or fainting associated with exercise within the past year?	<input type="checkbox"/>	<input type="checkbox"/>	Is insulin required and carried by youth?	
<input type="checkbox"/>	<input type="checkbox"/>	Any unexplained, rapid or irregular heart beat within the past year?	<input type="checkbox"/>	<input type="checkbox"/>	Is an inhaler required and carried by youth?	
<input type="checkbox"/>	<input type="checkbox"/>	A physician has sometime denied or restricted participation in sports due to a heart problem.	Date of last Tetanus booster: (mm/dd/yy)			

Name of Insurance Co.: \_\_\_\_\_ Policy #: \_\_\_\_\_

## Medications camper will be taking during event/camp:

Medication #1	Reason	Dosage (mg)	Times of day given	Prescribing Physician & Phone Number

Describe side effects (mood/behavior changes, upset stomach, diarrhea):

List any special instructions or additional information regarding the medication that would be helpful to the health care staff:



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**UW – Madison Extension  
Youth Event Health Form (Continued)**

Participant Name: \_\_\_\_\_

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

Medication #2	Reason	Dosage (mg)	Times of day given	Prescribing Physician & Phone Number

Describe side effects (mood/behavior changes, upset stomach, diarrhea):

List any special instructions or additional information regarding the medication that would be helpful to the health care staff:

Medication #3	Reason	Dosage (mg)	Times of day given	Prescribing Physician & Phone Number

Describe side effects (mood/behavior changes, upset stomach, diarrhea):

List any special instructions or additional information regarding the medication that would be helpful to the health care staff:

**Programs may have limited over-the-counter medications available. Select medications that can be administered, if available.**

Acetaminophen (Tylenol): ☐ Yes ☐ No

Hydrocortisone (anti-itch) cream: ☐ Yes ☐ No

Benadryl: ☐ Yes ☐ No

Ibuprofen: ☐ Yes ☐ No

Accommodations
Does the youth require an accommodation to participate in this event? Please describe:
Please describe any limitations or restrictions regarding the youth's participation:
Is there any other information you want to share?

# CONSENT FOR MEDICATION ADMINISTRATION AND MEDICAL TREATMENT


## TO THE PARENT(S) OR LEGAL GUARDIAN:

If your son, daughter, or ward will be under the age of 18 while participating in a University of Wisconsin – Madison Division of Extension event/camp/program, it is event/camp/program policy to secure your consent for medication distribution and for the use of medical devices. The medication or medical device must be administered by designated event/camp/program health staff with the exception that a limited amount of medication for life-threatening conditions may be carried and administered by my son/daughter/ward (i.e. bee sting kit, inhaler, insulin syringe).

It is event/camp policy to secure your consent for medication distribution and for the use of medical devices by signing below.

Please check all that apply:

Yes	No	
<input type="checkbox"/>	<input type="checkbox"/>	Medication(s) has been brought to event/camp.
<input type="checkbox"/>	<input type="checkbox"/>	Prescription medication(s) has been brought to event/camp. All prescription medication must be in the original medicine bottle and labeled with the youth participant's name, doctor's name, medication name, dosage, prescription number, date prescribed, and instructions. Also, information about any prescription medications must be provided in writing to event/camp health staff with the information requested in the later section of this form.
<input type="checkbox"/>	<input type="checkbox"/>	Over-the-counter medications have been brought to event/camp and may be administered by event/camp health staff as needed. All over-the-counter medications must be labeled with the youth participant's name, medication name, dosage and instruction.



If your son, daughter, or ward will be under the age of 18 years while at the event/camp, it is our policy to secure your consent for **all of the following**. By signing below,

- I am giving my consent in advance for medical treatment at an appropriate medical facility in case of illness or injury.
- I am stating that I am aware of and accept the risk inherent in the program activity.
- I attest that all information on this form is correct and up-to-date, and that I will provide any and all significant material, and important changes to any information in this form to event/camp staff no later than check-in.
- I agree to hold harmless and indemnify the Board of Regents of the University of Wisconsin System, and the University of Wisconsin – Madison Division of Extension, their officers, agents, and employees from any and all liability, loss, damages, costs, or expenses which are sustained, incurred or required arising out of the actions of my son, daughter or ward in the course of the event/camp.

Participant Name (Please Print)

SIGNATURE OF PARENT OR LEGAL GUARDIAN

Date

**This is the approved health form for 4-H events and camps.**



UW-MADISON EXTENSION



# Wisconsin 4-H Camp Health Form Addendum

Event Name: \_\_\_\_\_

Dates: \_\_\_\_\_

Participant Name: \_\_\_\_\_

Birth Date: \_\_\_\_\_

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

E-mail address: \_\_\_\_\_

Phone Numbers: Home \_\_\_\_\_

Phone Numbers: Cell \_\_\_\_\_

## IMMUNIZATIONS

List the MONTH, DAY, AND YEAR your child received each of the following immunizations. DO NOT USE (✓) OR (X) except to answer the question about chickenpox, Tdap or Td. If you do not have an immunization record for this child at home, contact your doctor or public health department to obtain it. A copy of the child's complete immunization record from the WIR may be attached to this form <http://www.dhfs.wisconsin.gov> or from healthcare providers, state, or local government are also acceptable.

TYPE OF VACCINE*	FIRST DOSE Mo/Day/Yr	SECOND DOSE Mo/Day/Yr	THIRD DOSE Mo/Day/Yr	FOURTH DOSE Mo/Day/Yr	FIFTH DOSE Mo/Day/Yr
DTaP/DTP/DT/Td (Diphtheria, Tetanus, Pertussis)					
Adolescent booster (Check appropriate box) <input type="checkbox"/> Tdap <input type="checkbox"/> Td					
Polio (IPV)					
Hepatitis B					
MMR (Measles, Mumps, Rubella)					
Varicella (Chickenpox) Vaccine Vaccine is needed only if your child has not had Chickenpox disease.			Has your child had Varicella (chickenpox) disease? <input type="checkbox"/> Yes, year: _____ <input type="checkbox"/> No or Unsure (vaccine needed)		

☐ For health reasons, this child is not fully immunized.

☐ For personal conviction or religious reasons, this child is not fully immunized. \*Include any immunizations received above.

## ADDITIONAL MEDICATIONS NOT PREVIOUSLY LISTED

☐ This participant will take the following medication(s) while attending camp. I am bringing enough medication to last the entire session and it is in the original container labeled by the pharmacy. (If more space for medications is needed, staple another page with additional medications to the end of the form.)

Name of Medication	Amount or Dose Given	Reason for Taking It	When It Is Given	How It Is Given	Emergency Medication Only Legal Guardian to initial below if camper is able to carry and self- administer (i.e. inhaler, epi-pen)
			<input type="checkbox"/> Breakfast <input type="checkbox"/> Lunch <input type="checkbox"/> Dinner <input type="checkbox"/> Bedtime <input type="checkbox"/> Other time: _____		
			<input type="checkbox"/> Breakfast <input type="checkbox"/> Lunch <input type="checkbox"/> Dinner <input type="checkbox"/> Bedtime <input type="checkbox"/> Other time: _____		

## SIGNATURE

This health history is correct and accurately reflects the health status of the participant. The person described has permission to participate in all event activities except as noted by me or an examining physician. I give permission to the event to provide routine healthcare services, administer medications, and seek emergency services.

SIGNATURE – Parent/Guardian/Legal  
Custodian

DATE



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**UPHAM  
WOODS**

## PHOTO RELEASE PERMISSION FORM

*Adult*

*Participant:* \_\_\_\_ I recognize and acknowledge that the University may record my participation and appearance on any recorded medium including, but not limited to video, audio, photos (collectively, "recordings") for use in any form (including, but not limited to print, websites, blogs, internet, and social media). I authorize such recording and release the University to use my name, likeness, voice, and biographical material to exhibit or distribute such recordings in whole or in part without restrictions or limitations for any educational or promotional purpose.

*Youth*

*Participant:* \_\_\_\_ I recognize and acknowledge that the University may record my child's participation and appearance on any recorded medium including, but not limited to video, audio, photos (collectively, "recordings") for use in any form (including, but not limited to print, websites, blogs, internet, and social media). I authorize such recording and release the University to use my child's name, likeness, voice, and biographical material to exhibit or distribute such recordings in whole or in part without restrictions or limitations for any educational or promotional purpose.

Print Name: \_\_\_\_\_ Date \_\_\_\_\_

Minor child's name (if applicable): \_\_\_\_\_

Address: \_\_\_\_\_

Phone: \_\_\_\_\_

Signature: \_\_\_\_\_

Please sign and return this form to your group leader.

Name of Group:

Date(s) of Visit: