4-H Base Camp Registration Form 2026

WHO: Racine and Kenosha County 4-H members who are in 3rd, 4th, or 5th grade during the 2025-2026 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, August 14, 2026 - Sunday, August 16, 2026** – We will roughly be leaving at 9:00 AM on Friday and returning at 2:30 PM on Sunday.

COST: The cost is $150.00 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 (2025-2026 School Year): _____ Age: _____

Parent Email Address: _____ Club:

Sex: _____ 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:	**Youth Size**	**S** ☐	**M** ☐	**L** ☐	**XL** ☐				
	Adult Size	**S** ☐	**M** ☐	**L** ☐	**XL** ☐	**XXL** ☐			

This registration Form, health form media release form and payment are due by Thursday, May 28th, 2026. 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 14th-16th, 206..

Signature of Parent or Guardian:_____ **Date:** _____

UW-MADISON EXTENSION

PHOTO RELEASE PERMISSION FORM

☐ 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 and other organizations such as the WI DNR, Xerces Society, Wisconsin Sea Grant, Rural Partnership Institute, National Science Foundation, Sea Tow and/or US Ski and Snowboard Central Cross Country Skiing 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. Photos will only be released to third parties if you have participated in programing that they have supported.

☐ 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 and other organizations such as the WI DNR, Xerces Society, Wisconsin Sea Grant, Rural Partnership Institute, National Science Foundation, Sea Tow and/or US Ski and Snowboard Central Cross Country Skiing 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. Photos will only be released to third parties if you have participated in programing that they have supported.

☐ I do not give permission for myself to be recorded.

☐ I do not give permission for my child to be recorded.

Print Name: _____ Date: _____

_____

Minor child's name (if applicable): _____

Email Address: _____

Phone: _____

Signature: _____

Please sign and return this form to your group leader.

Name of Group:

Date of Visit:

Extension
UNIVERSITY OF WISCONSIN-MADISON

UPHAM WOODS

FORMULARIO DE AUTORIZACIÓN DEL USO DE FOTOGRAFÍAS

☐ Reconozco y acepto que la Universidad puede grabar **mi participación** y aparición en cualquier medio, incluyendo, entre otros, video, audio y fotos (colectivamente, "grabaciones") para su uso en cualquier formato (incluyendo, entre otros, impresos, sitios web, blogs, internet y redes sociales). Autorizo dicha grabación y autorizo a la Universidad y a otras organizaciones como el Departamento de Recursos Naturales de Wisconsin (WI DNR), la Sociedad Xerces, Wisconsin Sea Grant, el Instituto Rural Partnership, la Fundación Nacional de Ciencias, Sea Tow y/o US Ski and Snowboard Central Cross Country Skiing a usar mi nombre, imagen, voz y material biográfico para exhibir o distribuir dichas grabaciones, total o parcialmente, sin restricciones ni limitaciones, con fines educativos o promocionales. Las fotos solo se compartirán con terceros si usted ha participado en programas que ellos han apoyado.

☐ Reconozco y acepto que la Universidad puede grabar la participación y la aparición de **mi hijo/a** en cualquier medio, incluyendo, entre otros, video, audio, fotos (colectivamente, "grabaciones") para su uso en cualquier formato (incluyendo, entre otros, impresos, sitios web, blogs, internet y redes sociales). Autorizo dicha grabación y autorizo a la Universidad y a otras organizaciones como el Departamento de Recursos Naturales de Wisconsin (WI DNR), la Sociedad Xerces, Wisconsin Sea Grant, el Instituto de Asociación Rural, la Fundación Nacional de Ciencias, Sea Tow y/o US Ski and Snowboard Central Cross Country Skiing a usar mi nombre, imagen, voz y material biográfico para exhibir o distribuir dichas grabaciones, total o parcialmente, sin restricciones ni limitaciones, con fines educativos o promocionales. Las fotos solo se compartirán con terceros si su hijo/a ha participado en programas que ellos han apoyado.

☐ No autorizo que me graben.

☐ No autorizo que graben a mi hijo/a.

Escriba su nombre con letra de imprenta: _____Fecha:_____

Escriba el nombre de su hijo/a menor de edad: _____

_____

Correo electrónico: _____

Teléfono:

Firma:

Por favor firme y mande este formulario al líder del grupo.

Nombre del grupo:

Fecha(s) de visitar:

Wisconsin 4-H Camp Health Form

UW-MADISON EXTENSION

Event Name: _____

Dates: _____

PARTICIPANT'S PERSONAL INFORMATION *(please print)*

FIRST NAME:	MIDDLE INIT.:	LAST NAME:	BIRTHDATE (Mo/Day/Yr.):	SEX:	PRIMARY PHONE NUMBER:

MAILING ADDRESS STREET:	CITY:	STATE:	ZIP:

NAME OF PRIMARY PARENT/LEGAL CUSTODIAN IN CASE OF ILLNESS OR INJURY:	WORK TELEPHONE NUMBER:	CELL PHONE NUMBER:

NAME OF SECOND PARENT/LEGAL CUSTODIAN IN CASE OF ILLNESS OR INJURY:	WORK TELEPHONE NUMBER:	CELL PHONE NUMBER:

PARTICIPANT'S HEALTH CARE PROVIDER INFORMATION

HEALTH CARE PROVIDER NAME:

MEDICAL FACILITY NAME:	TELEPHONE NUMBER:

☐ This participant has no known allergies.

☐ This participant is allergic to this food(s):	■ Does this allergy cause anaphylaxis? ☐ Yes ☐ No
☐ This participant is lactose intolerant.	☐ This participant is gluten intolerant.

☐ Other *(please explain):*

☐ This participant is allergic to medication(s):	☐ Environment (insect stings, hay fever, etc)	☐ Other:

Please describe below what this participant is allergic to and the reaction seen:

MEDICATION

☐ This participant will NOT take any prescription medications while attending camp.

☐ This participant will take the following prescription 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)
			☐ Breakfast ☐ Lunch ☐ Dinner ☐ Bedtime ☐ Other time: _____		
			☐ Breakfast ☐ Lunch ☐ Dinner ☐ Bedtime ☐ Other time: _____		
			☐ Breakfast ☐ Lunch ☐ Dinner ☐ Bedtime ☐ Other time: _____		
			☐ Breakfast ☐ Lunch ☐ Dinner ☐ Bedtime ☐ Other time: _____		

			☐ Breakfast ☐ Lunch ☐ Dinner ☐ Bedtime ☐ Other time: _____		

MEDICAL INSURANCE INFORMATION:

The participant is covered by family medical/hospital insurance. ☐ Yes ☐ No	
Insurance Company:	Policy Number:
Subscriber:	Insurance Company Phone Number:

ASTHMA

☐ This participant **does NOT** have asthma.	☐ This participant **does** have asthma.

Asthma Triggers (check all that apply)		Signs/Symptoms of asthma episode	Frequency of episodes	How episode is managed
☐ Exercise	☐ Colds			
☐ Infections	☐ Emotions			
☐ Allergies (to what?)				
☐ Weather (what type?)				
☐ Other (list)				

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.dhfswir.org 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) ☐ Tdap ☐ 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? ☐ Yes, year: ☐ 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.*

RESTRICTIONS:

☐ I have reviewed the program and activities of the event and feel the participant can participate without restrictions.

☐ I have reviewed the program activities of the event and feel the participant can participate with the following restrictions or adaptations *(Please describe below):*

OTHER CAMPER CONSIDERATIONS

PLEASE INDICATE ANY OTHER IMPORTANT MEDICAL CONDITIONS
(eg. Diabetes; seizures; physical conditions; non-prescription medications not to be given; mental, emotional, or social health)

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 _____

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		
☐	☐	Over-the-counter medication(s) has been brought to event/camp.	
☐	☐	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.	
☐	☐	Over-the-counter medications may be administered by event/camp health staff as needed. The following over-the-counter medications may NOT be administered by event/camp health staff:	

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.

Participant Name (Please Print)

SIGNATURE OF PARENT OR LEGAL GUARDIAN **Date**

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