**SECTION I—PHOTO IMAGE RELEASE**

I authorize the University of Delaware to record and photograph my image and/or voice, or that of my child, for use by the University of Delaware or its assignees in research, educational, and promotional programs. I understand and agree that these audio, video, film and/or print images may be edited, duplicated, distributed, reproduced, broadcast and/or reformatted in any form and manner without payment of fees, in perpetuity.

**Subject’s name (adult or youth) ____________________________________________**

Signature __________________________________________ Date________

**SECTION II—HOLD HARMLESS CLAUSE**

As the parent or legal guardian of this 4-H member, I give my permission for them to participate in organized events and activities offered by the Delaware 4-H Youth Development Program. I understand and acknowledge that there are certain hazards and risks associated with my child’s participation in 4-H educational activities. These risks may result in injury, death, or damage to property. I understand and accept such risks, and thus waive all claims, demands, and causes of action against the State of Delaware, the University of Delaware, the Delaware 4-H Foundation, New Castle/Kent/Sussex County 4-H and their members, officers, employees, agents, and volunteers acting on their behalf. I understand that I am solely responsible for any costs arising out of any injury or property damage sustained through my child’s participation in 4-H educational programs. After careful deliberation, I voluntarily give my consent to my child’s participation and agree to the terms contained in this Acknowledgement of Responsibility and Release.

I verify that I have READ, UNDERSTOOD AND AGREED TO THIS HOLD HARMLESS CLAUSE.

Parent/Guardian Signature: __________________________________________ Date________

**SECTION III—DELAWARE 4-H CODE OF CONDUCT**

1. Attend all sessions in the planned program. If you are not feeling well or have a schedule conflict that will keep you from attending, please tell the adult in charge.
2. Follow hours and room rules established before the event begins. You are responsible to know the rules for each event.
3. Use language and manners that will bring respect to you and Delaware 4-H. You are responsible to know which language and behavior is appropriate.
4. Be in the assigned program area (dorms, cabins, hotel room, etc.) at all times.
5. Know the use of tobacco, alcohol and non-prescription drugs is prohibited at all times and at all 4-H events.
6. Model respect for other persons in public areas. The adults in charge will help you know rules of courtesy that you will want to follow.
7. Treat program areas, lodging areas and transportation vehicles with respect and care. You will be responsible for any damage, theft, or misconduct in which you participate.
8. Help other members in your group have a pleasant experience by making every attempt to include all participants in activities.
9. Live up to your highest expectations of yourself, so you can return home proud of who you are and what you have accomplished.

Those who are unable to conduct themselves within the guidelines listed above will be expected to:

1. Explain their actions to the adults in charge;
2. Accept the consequences of their actions;
3. Know that the adults in charge will work closely with parents/guardians, Extension personnel, and others to see that action is taken, and that appropriate and logical consequences for all concerned will follow.

I have read the Delaware 4-H Code of Conduct and agree to live up to the expectations. I realize my failure to do so could result in the loss of privileges during this event and/or in the future.

Participant Signature _____________________________ Date________

I have read the Delaware 4-H Code of Conduct and will support the adults in charge in the performance of their responsibilities to see that appropriate behavior is maintained.

Parent/Guardian Signature: ___________________________ Date________
HEALTH INSURANCE INFORMATION

Policyholder’s name and relationship to participant:

____________________________________________________________

Policyholder’s address:

____________________________________________________________

Insurance company’s name and address:

____________________________________________________________

Employer’s name and address:

____________________________________________________________

Primary care physician:

____________________________________________________________

Physician’s phone:

____________________________________________________________

If you have HMO insurance, please list emergency treatment authorization phone number:

________________________________________________________________________________

All policy numbers (please identify):

________________________________________________________________________________

Insurance company’s name and address:

____________________________________________________________

Policyholder’s address:

________________________________________________________________________________

________________________________________________________________________________

Dietary restrictions:

________________________________________________________________________________

________________________________________________________________________________

Activities encouraged or limited by physician:

________________________________________________________________________________

________________________________________________________________________________

List any PRESCRIPTIONS he/she is now taking for treatment of any medical problem:

________________________________________________________________________________

________________________________________________________________________________

________________________________________________________________________________

________________________________________________________________________________

List any ALLERGIES to Medications, Foods, Latex, or local anesthetics:

________________________________________________________________________________

________________________________________________________________________________

________________________________________________________________________________

________________________________________________________________________________

________________________________________________________________________________

Date of last tetanus:

________________________________________________________________________________

Are the immunizations up-to-date?

YES NO

________________________________________________________________________________

Signature of parent, guardian or adult camper/staff member:

_________________________________________________ Date: ________________________

SECTION IV — HEALTH

RECENT MEDICAL HISTORY

Please check yes or no. If yes, explain (include another sheet if needed.)

YES NO

Has the participant had any recent surgeries or fractures?

________________________________________________________________________________

Does the participant have any chronic health problems or illnesses, such as seizures, asthma, other?

________________________________________________________________________________

Has the participant been treated recently for any kind of medical problem?

________________________________________________________________________________

Does the participant have contacts, glasses, orthodontic appliances?

________________________________________________________________________________

________________________________________________________________________________

Are the immunizations up-to-date?

YES NO

________________________________________________________________________________

List any ALLERGIES to Medications, Foods, Latex, or local anesthetics:

________________________________________________________________________________

________________________________________________________________________________

________________________________________________________________________________

________________________________________________________________________________

________________________________________________________________________________

________________________________________________________________________________

Date of last tetanus:

________________________________________________________________________________

Are the immunizations up-to-date?

YES NO

________________________________________________________________________________

Signature of parent, guardian or adult camper/staff member:

_________________________________________________ Date: ________________________

Authorization for Treatment: I hereby give permission to the medical personnel, selected by the activity director, to order X-rays, routine tests, treatment, permission to release any record necessary for insurance purposes, and to provide and arrange necessary related transportation for my child. If I cannot be reached in the event of an emergency, I hereby give my permission to the physician to secure and administer treatment, including hospitalization for the person named above.

Signature of parent, guardian or adult camper/staff member:

_________________________________________________ Date: ________________________

PERMISSION TO MEDICATE

I understand that my child may require medication for minor medical conditions. Such conditions may include headaches, sunburn, poison ivy, bug bites, upset stomach, scrapes, cuts, and/or bee bites. I understand there will be a camp nurse to handle minor health problems and medication administration, but the camp nurse will not be able to medicate my child without permission from the parent or guardian. The following over-the-counter medications may be administered to my child, as needed, following the suggested dosage guidelines. (initial all that you give permission for the camp nurse to administer.) Medication and/or conditions not covered by your advance permission will require a phone call to you before any medication can be given, and may cause a delay in treatment.

- Tylenol / Acetaminophen for headaches, muscle aches and pains, cramps
- Advil / Ibuprophen for headaches, muscle aches and pains, cramps
- Maalox, Mylanta for upset stomach, stomachache, gas, nausea
- Tums for stomachache, upset stomach, nausea
- Imodium for diarrhea
- Pepto-Bismol for nausea, diarrhea
- Milk of Magnesia for constipation
- Calamine, Caladryl, Insect Bite Pen for insect bites, stings, jelly fish stings
- Benadryl Lotion (topical) for insect bites, stings, poison ivy
- Adolph’s Meat Tenderizer (enzyme deactivates the poison) for jelly fish stings
- Triple Antibiotic Ointment, Hydrogen Peroxide for scrapes and cuts
- Solarcaine for sunburn
- Benadryl (oral) for sinus, allergies, hay fever, rashes
- Sore throat spray or lozengers
- Robitussin DM

For Females:

Has this person menstruated? ________ If not, has she been told about it? ________

If so, is her menstrual history normal? ________ Special consideration__________

________________________________________________________________________________

________________________________________________________________________________

________________________________________________________________________________

________________________________________________________________________________

I understand any prescription medications taken by my child and/or to be dispensed to my child MUST be in the original container from the pharmacy with the original label and directions attached, or I must have a copy of the prescription from the doctor, in order to be dispensed by the camp nurse. If your child takes any over the counter medicine regularly or on an as-needed basis, for example, Sudafed or Benadryl, please send the medication with written instructions and parent signature. Failure to follow these rules will result in the parent or guardian being required to deliver these before any medications can be given.

This health history is correct, to the best of my knowledge, and the person herein described has my permission to engage in all activities, except as noted.

Signature of parent, guardian or adult camper/staff member:

_________________________________________________ Date: ________________________

I, as the participant, understand and agree to abide by the restrictions placed on my activities should my physician require it.

Signature of minor or adult camper/staff member:

_________________________________________________ Date: ________________________