2021 Southeast Region Challenge Camp Registration Form

SUBMIT THIS FORM TO MR. XAVIER BY MONDAY, NOVEMBER 8, 2021

4-H Member Name (First & Last): _____

Mailing Address (City, State, Zip Code): _____

4-H Member Phone Number: _____

Gender: _____ **T-Shirt Size:** _____ **Grade:** _____ **Age:** _____

Will the 4-H'er need transportation: _____ **Yes** _____ **No**

Mother/Guardian Name (First & Last): _____

Phone Number: _____

Father/Guardian Name (First & Last): _____

Phone Number: _____

Emergency Contact Name (First & Last): _____

Phone Number: _____

Emergency Contact Email Address: _____

All participants must sign a waiver to participate in LOOP NOLA activities. Please complete the online waiver at All participants must sign a waiver! This is the link to our online waiver for this event: https://waiver.smartwaiver.com/e/XdCAU9FDfhLd4hPtGiWGrY/

The Southeast Region Challenge Camp will be following the LSU AgCenter COVID Guidelines

Registration Fee: $15.00

Location: LOOP NOLA - City Park, New Orleans, LA *(1031 Harrison Ave., New Orleans, 70124)*

Submit this form to Mr. Xavier by Monday, November 8, 2021 to guarantee a t-shirt.

Make all checks and money orders payable to: East Feliciana 4-H Foundation

Should you need an ADA accommodation, please contact Xavier Bell, East Feliciana 4-H Agent at **225-683-3101** or by email at **XBell@agcenter.lsu.edu** no later than **November 8, 2021**

LOUISIANA 4-H YOUTH DEVELOPMENT PROGRAM

Day Camp Participant Medical Information Form

This medical form is for use with 4-H day camp and day events which do not include high impact experiences, over night lodging, or long distance transportation.

CAMPERS FULL NAME _____ FIRST _____ MIDDLE _____ LAST

_____ ADDRESS _____ STATE _____ ZIP

_____ BIRTHDATE (00/00/0000) _____ AGE _____ GENDER

_____ PARENT/GUARDIAN'S NAME _____ PARENT PHONE NUMBER #1 _____ PARENT PHONE NUMBER #2

_____ EMERGENCY CONTACT NAME IF PARENT NOT AVAILABLE _____ EMERGENCY CONTACT PHONE #1 _____ EMERGENCY CONTACT PHONE #2

_____ PHYSICIAN'S NAME _____ PHYSICIAN'S PHONE NUMBER _____ HEATLH INSURANCE COMPANY NAME

ARE IMMUNIZATIONS CURRENT? _____ INSURANCE POLICY # _____ NAME OF MEMBER

DATE OF LAST TETANUS SHOT? _____

TO THE BEST OF MY KNOWLEDGE, THIS CHILD IS HEALTHY AND FIT FOR AN ACTIVE CAMP PROGRAM. _____

HAS YOUR CHILD BEEN EXPOSED TO ANY COMMUNICABLE DISEASE IN THE PAST 6 MONTHS? _____ IF YES, PLEASE EXPLAIN BELOW:

_____

_____ PREVIOUS HOSPITALIZATIONS/SURGERIES _____ LIMITATIONS OF ACTIVITIES BY PHYSICIAN'S ADVICE (IE SWIMMING, HIKING)

THE CAMPER IS CURRENTLY EXPERIENCING OR HAS RECENTLY HAD PROBLEMS WITH:

ALLERGIES

- ☐ HAY FEVER
- ☐ PENICILLIN
- ☐ ASTHMA
- ☐ OTHER (PLEASE SPECIFY)
- ☐ IVY POISONING, ETC
- ☐ INSECT/BEE STINGS
- ☐ OTHER DRUGS

_____

OTHER

- ☐ FREQUENT EAR INFECTION
- ☐ CONVULSIONS
- ☐ DIABETES
- ☐ BLEEDING/CLOTTING DISORDERS
- ☐ EXPOSURE TO SUN
- ☐ OTHER (PLEASE SPECIFY):

_____

NEURO/PSYCHOLOGICAL

- ☐ ADD/ADHD
- ☐ EPILEPSY
- ☐ CONCUSSION
- ☐ COUNSELING
- ☐ OTHER (PLEASE SPECIFY)

_____

LOUISIANA 4-H YOUTH DEVELOPMENT PROGRAM

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IS CAMPER ON RESTRICTED DIET? _____ IF RESTRICTED DIET, PLEASE EXPLAIN DIETARY ISSUES AND NEEDS BELOW:

_____

PLEASE NOTE: CAMPERS WITH SEVERE FOOD ALLERGIES OR UNIQUE DIETARY NEEDS ARE EXPECTED TO BRING THEIR OWN FOOD. FOOD WILL BE SAFELY STORED BY CAMP HOST. WE CANNOT GUARANTEE THAT ANY AREA AT CAMP IS ALLERGEN-FREE!

MEDICATION INFORMATION

_____

TYPE OF MEDICATION(S)

_____

HOW TO ADMINISTER?

_____

PURPOSE OF MEDICATION(S)?

_____

OTHER COMMENTS OF INFORMATION PERTAINING TO MEDICATION?

Please note that the medication must be in original container with the label still intact.

MEDICINE DISPERSMENT:
We are only able to administer emergency medications, specifically:
Epi-Pens, Benadryl (for anaphylactic allergies), and inhalers.

MEDICAL CONSENT/RELEASE

The health history is correct so far as I know, and the person described has permission to engage in all prescribed camp activities except as noted. In Case of Medical Emergency, if I cannot be contacted, I hereby give permission to a camp representative and the physician he/she selects to secure proper treatment, including: hospitalization, ordering injections, giving anesthesia, x-rays, routine tests, treatment, transporting of child, or performing operations as may be urgently necessary for this child and to release reports necessary for insurance purposes for my son/daughter noted above. This form may be copied for emergency purposes. I understand that every effort will be made to contact the camper's responsible parent or guardian. I further understand that if I do not have medical insurance that covers all costs, I will be responsible for such medical costs.

By my signature below, I agree to this statement and further affirm all information correct as well as all information is provided about my child to ensure a positive, safe, and enjoyable environment for them as well as other campers and camp staff/volunteers

_____ _____

SIGNATURE OF PARENT/GUARDIAN DATE