YOUTH VOTED! OVERNIGHT CAMPING EXPERIENCE

Nicianak 4-H Club

Ages: 8-14

# 4-H OVERNIGHT SUMMER CAMP

## @ UPHAM WOODS IN WI DELLS

$10 FEE PER CHILD

14-16 JULY 2025

DEADLINE TO REGISTER JUNE 12, 2025

BUS PICK-UP JULY 16 @CMN: 8:00AM

BUS DROP-OFF JULY 18 @CMN: 4:00PM



*Camp this year will be in partnership with the Milwaukee 4-H Program! This camp will be led by staff at Upham Woods and certified 4-H Leaders. This will be a high quality camping experience for young people to have fun, meet new friends and do some outdoor camping in cabins.*

Schedule for Each Day at Camp:

Day 1 - 11am Arrive & Un-pack, Orientation, Lunch, Large Field Play, Swimming, Dinner, Arts & Crafts, Campfire fun, Cabin Time Lights out (8:30-10pm)

Day 2 - 8am Breakfast, Hike, Canoeing, Rec Time, Lunch, Archery, Swimming, Snack, eDNA & Water sampling, Rec Time, Dinner, Campfire Rehearsal performance, Talent Show, Cabin Time Lights out (8:30-10pm)

Day 3 - 7am Pack-up & Breakfast, Clean Cabins, Hike & Granola Bar, Capture the Flag, Lunch, Bus Pick-up & Depart Home (2pm)

**MORE INFORMATION WILL BE SENT AFTER REGISTRATION IS COMPLETE**
**FOR QUESTIONS CONNECT WITH SOFIE.TELLER@WISC.EDU**

# 4-H Summer Camp Sign-Up Form

## July 14-16, 2025 – Upham Woods Learning Center, WI Dells

### Parent 1 Info

First Name _____

Last Name _____

Cell Phone _____ Is your child a 4-H Member? _____

Email _____

### Youth Info

First Name _____

Last Name _____

Cell Phone _____ T-Shirt Size _____

Age & Grade _____

Camp Fee: $10

Check or Cash made payable to: Menominee 4-H Leader Council due on or before July 16, 2025. This fee will cover the cost of their T-Shirt.

Nicianak 4-H Club

N172 State Hwy 47-55

Po Box 1179

Keshena, WI 54135

# 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<br>☐ Lunch<br>☐ Dinner<br>☐ Bedtime<br>☐ Other time: _____ | | |
| | | | ☐ Breakfast<br>☐ Lunch<br>☐ Dinner<br>☐ Bedtime<br>☐ Other time: _____ | | |
| | | | ☐ Breakfast<br>☐ Lunch<br>☐ Dinner<br>☐ Bedtime<br>☐ Other time: _____ | | |
| | | | ☐ Breakfast<br>☐ Lunch<br>☐ Dinner<br>☐ Bedtime<br>☐ Other time: _____ | | |

| | | | | | |
|---|---|---|---|---|---|
| | | | ☐ Breakfast<br>☐ Lunch<br>☐ Dinner<br>☐ Bedtime<br>☐ 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.**