CFAES COLLEGE *OF* FOOD, AGRICULTURAL, *AND* ENVIRONMENTAL SCIENCES

4-H Cloverbud Day Camp

REGISTRATION FORM

June 8, 2023 9 a.m. – 2 p.m.

Check in begins at 8:30 a.m.
Hancock County Fairgrounds – Youth Building

Office Use Only

Date Received: _____

Amount Paid: _____

Cash/Check: _____

Must be enrolled as a current Hancock County Cloverbud.

Name: _____ Phone: _____

Address: _____

City: _____ State: _____ Zip: _____

4-H Club: _____ Age as of January 1: _____

Male ☐ Female ☐ Grade just completed: _____

T Shirt Size: ☐ S Youth ☐ M Youth ☐ L Youth ☐ XL Youth ☐ S Adult ☐ M Adult ☐ L Adult

Parent/Guardian Name: _____

Daytime Phone#: _____

☐ **Yes** ☐ **No** I give permission to OSU Extension Hancock County to record and edit into video and/or photographs the likeness, voice, image and video images of my child (named above), and to use all or parts of the video or photographs in print or electronic materials for OSU Extension Hancock County to promote any and all public awareness for the program in which my child is involved.

Fee includes lunch, activities, crafts, and camp picture.

Amount Enclosed: _____

Parent Signature: _____ Date: _____

Return to: **Ohio State University Extension, Hancock County**

Registration Deadline: May 19 - $25, t-shirt included
May 20 or later - $30, t-shirt not guaranteed

This program is **limited to 60 participants**, with registrations accepted on a first come, first served basis

Please make check payable to the 4-H Advisory Council

Health Statement

4-H Cloverbud Day Camp – June 8, 2023

This form must be completed and returned with the registration form to:
Ohio State University Extension Hancock Co., 7868 CR 140 Suite B, Findlay OH 45840

Please check: ☐ Male ☐ Female Date of Birth: _____

Child's Name: _____

In case of emergency, contact:

Name: _____ Relationship: _____ Phone#: _____

Name: _____ Relationship: _____ Phone#: _____

In the event reasonable attempts to contact either parent/guardian or listed emergency contacts have been unsuccessful, I hereby give my consent for the administration of any treatment deemed necessary by:

Preferred Physician: _____ Phone#: _____

Preferred Dentist: _____ Phone#: _____

Or in the event the designated preferred practitioner is not available, by another licensed physician or dentist, and the transfer of the child to Blanchard Valley Hospital, Findlay OH.

The following are facts concerning my child's medical history, including all allergies, medication being taken, and any other physical impairment to which the camp staff or a physician should be alerted.

Date of last tetanus shot: _____

Medications currently being taken: _____

_____

Allergies or other health information about your child that we should know:

_____

_____

_____

Parent/Guardian Signature: _____ Date: _____