CENTRAL ILLINOIS 4H MEMORIAL SUMMER CAMP REGISTRATION 2009

★*4H Membership* **NOT REQUIRED** ★

This form and the health form on back must be completed and signed for each participant by the parent/guardian. **Please choose the appropriate payment method as follows**: Make check payable for appropriate fee to: your local **University of Illinois Extension office** if you plan to attend with your home county (see schedule below) ***OR*** if attending a different week, make check payable to and send to: **4-H Memorial Camp, 499 Old Timber Rd, Monticello IL 61856**.

Circle: MALE FEMALE Age_____

For return correspondence, PLEASE PRINT LEGIBLY

Camper's Name _____
(First) (Last)

County of Residence_____ Current 4-H Member? YES NO

Is this your first year at Memorial camp? YES NO If no, how many years? (including this yr.)_____

Parent/Guardian Name _____

Parent/Guardian Address _____
(Street) (City) (State) (Zip)

Home Phone_____ Work Phone_____Cell_____

Other Contact (if parent unavailable)_____ Phone_____

Email address, if you wish to receive email correspondence _____

One cabin mate request *please*_____

4-H SUMMER CAMPS **(Ages 8-16) All sessions begin at 2pm**. First Child **$160** Additional Siblings $**140**

Camp 1 June 7 – 11, 2009 ***(Sun-Thurs)***	**$**	**Camp 4 July 5 – 9, 2009** ***(Sun-Thurs.)***	**$**
Camp 2 June 14 – 18, 2009 ***(Sun-Thurs)***	**$**	**Camp 5 July 12 – 16, 2009** ***(Sun.-Thurs.)***	**$**
Camp 3 June 28 – July 2, 2009 (***Sun-Thurs)***	**$**		

SPECIAL DISCOUNTS

Sibling Discount: First child **$160**; others in the family **$140**

Name of full-fee sibling registered on another form_____

Bring-a-Friend Credit: Campers returning from 2008 pay full fee but get $10 credit at the Trading Post toward snacks and souvenirs for bringing **one** new friend who didn't attend in 2008.

Name of new camper friend_____

Extension offices reserve slots according to the schedule below. The 4-H Camp office accepts registrations outside of this schedule.

June 7-11	Clay, Cumberland, Fayette, Ford/Iroq., H-M-W, Jasper, Knox, Moultrie-Douglas, Tazewell, Vermilion, Woodford
June 14-18	Champaign (1/2 group), Christian, Crawford, Logan, Piatt (1/2 group)
June 28-July 2	Champaign (1/2 group), DeWitt, McLean
July 5-9	Coles, Clark, Effingham, Macon, Montgomery, Shelby
July 12-16	Edgar, Lawrence, Peoria, Piatt (1/2 group)

********** **Please Read Carefully** **********

CENTRAL ILLINOIS CAMPING ASSOCIATION REFUND POLICY - **75% of fee refundable if cancellation is 7 days or more prior to first day of camping session. No refund when cancellation is made 6 days or less prior to first day of camping session.**

FEE ENCLOSED:_____

HEALTH HISTORY ON REVERSE SIDE

CENTRAL ILLINOIS 4H CAMP ASSOCIATION HEALTH HISTORY

This form must be completed for each child by the parent/guardian. This information will be kept confidential and used only for the welfare of your child.

Please circle: Male Female Date of Birth_____Dates of Camp Program _____

CAMPER'S NAME _____

(First) (Last)

Physician's Name_____ Phone_____

----------Instructions for Medications----------

1. All prescription drugs or over the counter medications you are presently taking MUST be carried in the container in which they were issued (with medical orders and physician's name intact), and given to the nurse/health director. Others will not be accepted.

2. If you need over-the-counter medications not listed below, they must be in the original container (no loose pills or pill boxes) and must be stored under lock and key by the nurse/health director or a responsible adult during the 4-H event.

Check Over-the-Counter Medications That Your Child May Receive if Deemed Necessary:

	Antiseptics		Diarrhea medication		Robitussin cough syrup
	Benadryl		Non aspirin pain medication		Sudafed

List Approximate Date if Your Child Has Had or Been Exposed to:

Chicken Pox_____Tuberculosis_____Measles_____Mumps_____German Measles_____

Last Booster: Tetanus_____Polio_____

Check Below if Your Child is Subject To:

	Asthma, controlled? Y N		Convulsions/seizures		Fainting		Sinusitis
	Bedwetting		Cramps		Headaches		Sleepwalking
	Bronchitis		Diarrhea		Heart condition(s)		Other, please specify
	Constipation		Ear infections		Kidney problems		

Please list any medical conditions or diagnosis_____

Please List Your Child's Allergies (If none, please indicate with N/A) :

Food Allergies (specify) _____

Allergies to Medications: Prescription or non-prescription drugs (specify) _____

Serious Ivy, Oak, or Sumac Poisoning_____ Bee or Insect Stings_____ Prescribed Treatment_____

Please List Your Child's Medication(s) That Will be Brought to Camp (If none, please indicate with N/A) :

Name of Medication(s): _____

Dosage(s) _____

Circle Time(s) When Medication(s) Need(s) to be Administered: 8 am Noon 6 pm 9 pm Other _____

To the best of my knowledge my child's health history is as indicated and he/she may participate in an active camp program except as noted. Authorization for treatment: I hereby give permission to the medical personnel selected by the camp director to order x-rays, routine tests, treatment; to release any records necessary for insurance purposes; and to provide or arrange necessary related transportation for me or my child. In the event I cannot be reached in emergency, I hereby give permission to the physician selected by the camp director to secure and administer treatment, including hospitalization, for the person named above and understand that the accident/illness insurance coverage does not cover pre-existing conditions. I give permission for my child to participate in all camp activities including swimming, boating, climbing, team challenge course, archery, and out of camp travel into adjacent Robert Allerton Park when it is a part of the camp program. This child may appear in pictures for publicity purposes for 4-H Memorial Camp. I understand my child will be informed of the camp's code of conduct and that I will be notified to come and get my child if he/she shows a blatant disregard for these rules.

PARENT'S NAME (*Please Print Legibly*)_____

SIGNATURE OF PARENT/GUARDIAN (mandatory)_____**Date**_____