



*Reach for the Stars:  
Lighting the Path to Leadership*

**WHY CONFERENCE 2009 Registration Form**  
**September 11-13, 2009 ~ Camp Tehama**  
**Registration Forms and Fees are due August 27, 2009.**

Participant's Name: \_\_\_\_\_

Mailing Address: \_\_\_\_\_  
Street Address or P.O. Box City/Town Zip Code

Phone Numbers: Day (\_\_\_\_\_) \_\_\_\_\_ Evening (\_\_\_\_\_) \_\_\_\_\_

Can your address, phone and email be released to other Conference attendees?  Yes  No

Email: \_\_\_\_\_ County: \_\_\_\_\_

Gender:  Male  Female

Participant Status: (check all that apply)  Intermediate (Gr. 6-8)  Senior (Gr. 9-12)

Adult  4-H Staff  All-Star  Ambassador  Presenter

If you have special meal accommodations, please note here \_\_\_\_\_

Who will be attending as your chaperone? \_\_\_\_\_

List Two Preferences for Cabin Mates \_\_\_\_\_  
(We will do our best to accommodate any requests)

Parent or Guardian's Name (print) \_\_\_\_\_  
(Not needed for adults)

What time can we expect your arrival? (Friday, September 11, 2009) \_\_\_\_\_

An individual will be considered registered when the conference registrar has received the following:

- Registration Form
- Medical Form
- Code of Conduct Form
- Registration Fee - make \$50 check payable to **Glenn County 4-H Council**

**Send Registration Packet to:**  
**Glenn County 4-H**  
**WHY Conference 2009**  
**P.O. Box 697**  
**Orland, CA 95963**

**California 4-H Youth Development Program**  
**Youth Medical Release Form**  
University of California Cooperative Extension

This Medical Release Form is authorized for the Northern Section 4-H WHY Conference to be held October 13-15, 2006 at Camp Tehama, near Mill Creek, CA in Tehama County.

\_\_\_\_\_  
First Name                                      Last Name                                      Club/Unit Name                                      County

While my child is attending or traveling to or from this 4-H function, I HEREBY AUTHORIZE THE ADULT 4-H VOLUNTEER LEADER OR 4-H STAFF MEMBER, or in his/her absence or disability, any adult accompanying or assisting him/her, TO CONSENT TO THE FOLLOWING MEDICAL TREATMENT FOR SAID MINOR:

Any x-ray examination, anesthetic, medical or surgical diagnosis or treatment, and hospital care which is deemed advisable by, and is to be rendered under the general or special supervision of any physician and/or surgeon licensed under the provisions of the Medical Practices Act, California Business and Professions Code Section 2000 et seq.; or any x-ray examination, anesthetic, dental or surgical diagnosis or treatment, and hospital care to be rendered by a dentist licensed under the provisions of the Dental Practices Act, California Business and Professions Code Section 1600 et seq.

This authorization is given pursuant to the provisions of Section 25.8 of the Civil Code of California. This authorization shall remain effective until my child completes his/her activities in this program unless sooner revoked in writing. I understand that as a parent/guardian, I will be responsible for the cost of any service or treatment provided not covered by the 4-H Accident/Sickness Insurance Program sponsored by UC Cooperative Extension.

**Authorization and Consent and Release**

I hereby certify that my child is in good health and can travel to and participate in all functions of the 4-H Youth Development Program as described above. I understand it is my responsibility to keep the information on this form updated (including Health History and parent/guardian status) by contacting the County 4-H Office.

\_\_\_\_\_  
Signature of Parent/Guardian

\_\_\_\_\_  
Date

(\_\_\_\_\_) \_\_\_\_\_  
Emergency Day Phone (with area code)

(\_\_\_\_\_) \_\_\_\_\_  
Emergency Night Phone (with area code)

\_\_\_\_\_  
Mailing Address

\_\_\_\_\_  
City

\_\_\_\_\_  
State

\_\_\_\_\_  
Zip

**Non-Consent**

I do not desire to sign this authorization and understand that this will prohibit my child from receiving any non-life threatening medical attention in the event of an accident or illness.

\_\_\_\_\_  
Signature of Parent/Guardian

\_\_\_\_\_  
Date

University policy and the State of California Information Practices Act of 1977 require the following information be provided when collecting personal information from you: The information entered on this form is collected under authority of the Smith-Lever Act. Submission of the medical data is voluntary. However, a signature is required on one or the other of the two signature lines above. Failure to provide the medical information and authorization may result in our inability to provide necessary medical treatment. You have the right to review University records containing personal information about you/your child, with certain exceptions as set forth in policy and statute. Copies of University policies pertaining to the collection, use, or release of personal data are available for your examination from the local UCCE County Director, 4-H Youth Development Advisor, 4-H Program Representative, or the State 4-H Director at the California 4-H Youth Development Program, University of California, DANR Building, One Hopkins Road, Davis, CA 95616-8575, (530) 754-8518. Only your own/your child's records are open to your review.

Any known or foreseeable intergovernmental transfer that may be made of the information is as follows: None.

**CONTINUE ON BACK**

# California 4-H Youth Development Program

## Health History Information

University of California Cooperative Extension

	/	/	
First Name	Last Name	Date of Birth	Social Security Number

Subject to:	Yes	No	Now Have or Have Had	Yes	No
Colds			Heart Trouble		
Sore Throat			Asthma		
Fainting Spells			Lung Trouble		
Bronchitis			Sinus Trouble		
Convulsions			Hernia (rupture)		
Cramps			Appendicitis		
Allergies			Has appendix been removed?		
Wear corrective lenses?			Do you walk in your sleep?		
Is hearing good?					
Currently under any type of medical care?					
Is there history of behavior disorders, emotional disturbances, or severe moodiness?					
Been under psychiatric treatment within the past five years?					

Date of last Tetanus Vaccination: \_\_\_\_\_

Please check over-the-counter medications that may be administered:

- Tylenol   
  Ibuprofen   
  Cough Syrup   
  Decongestant   
  Dramamine  
 Antacid   
  Polysporin   
  Hydrocortisone   
  Other: \_\_\_\_\_

Please identify allergies including allergies to food, medications, and drug reactions:

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Please list any disabilities or disorders that may affect participation at 4-H events such as: eyesight, hearing, speech, paralysis, diabetes, ulcer, etc.

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Please list all current medications:

Name of Medication	Dosage	Times Taken

Remarks and special instructions. Please explain "yes" answers on this page.

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

# California 4-H Youth Development Program Code of Conduct

University of California Cooperative Extension

The following guidelines are designed to make everyone's experience at 4-H events satisfying to all attending. This means that all participants, members, volunteers, and 4-H YDP staff, shall adhere to the core values of the University of California 4-H Youth Development Program, respect the individual rights, safety, and property of others.

## **While attending all 4-H meetings, projects, programs, and events, the following apply:**

1. Everyone is expected to attend all planned sessions, workshops, field trips, and meetings of the event, and be appropriately dressed. Chaperones and project volunteers are responsible for ensuring that members participate in all aspects of the planned program activities.
2. The possession and use of alcoholic beverages, tobacco products, and drugs (other than prescription medication) is prohibited.
3. Setting off fire alarms or tampering with fire extinguishing equipment or other emergency equipment is prohibited.
4. Gambling and betting by adults and youth representing 4-H is prohibited.
5. Obscene and discriminatory language, roughhousing, and insubordination will not be tolerated at any time.
6. Youth members and volunteers will demonstrate respect for one another at all times.
7. Display of overly affectionate attention between participants is prohibited.

## **While attending overnight events, the following also apply:**

8. All participants must be in their assigned area at curfew and will comply with the quiet hours and lights out.
9. No member or volunteer may leave the grounds unless permission is secured from the adult in charge. 4-H members must be accompanied by an adult.
10. Only 4-H participants may be in dormitory areas. No one will be in the sleeping areas of members of the opposite gender. Lounges may be used for working committees and social activities.
11. Youth must comply with other rules of the event.

## **PENALTIES FOR INFRACTIONS**

Infractions of the 4-H Code of Conduct must be reported promptly by anyone observing them to the adult in charge of the delegation/project and to the person in charge of the event who will bear final responsibility for disciplinary action. The parent/guardian and the County 4-H Office will be notified of action taken. Penalties may include any or all of the following:

- Sending the participant home
- Barring the participant from future 4-H events
- Assessing the participant the cost of damages and repairs for damage or destruction of property
- Releasing the participant to the nearest law enforcement agency and/or the proper authorities
- Termination of 4-H membership

Signature of 4-Her or Adult 4-H Leader participating:

\_\_\_\_\_ Date: \_\_\_\_\_

Signature of Parent of minor Child participating:

\_\_\_\_\_ Date: \_\_\_\_\_

# California 4-H Youth Development Program Adult Medical Release Form

University of California Cooperative Extension

This Medical Release Form is authorized for the Northern Section 4-H WHY Conference to be held October 13-15, 2006 at Camp Tehama, near Mill Creek, CA in Tehama County.

\_\_\_\_\_  
First Name                                      Last Name                                      Club/Unit Name                                      County

While I am attending or traveling to or from this 4-H function, I HEREBY AUTHORIZE THE ADULT 4-H LEADER OR STAFF MEMBER, or in his/her absence or disability, any adult accompanying or assisting him/her, TO CONSENT TO THE FOLLOWING MEDICAL TREATMENT FOR ME SHOULD I BE UNABLE TO MAKE A DECISION:

Any x-ray examination, anesthetic, medical or surgical diagnosis or treatment, and hospital care which is deemed advisable by, and is to be rendered under the general or special supervision of any physician and/or surgeon licensed under the provisions of the Medical Practices Act, California Business and Professions Code Section 2000 et seq.; or any x-ray examination, anesthetic, dental or surgical diagnosis or treatment, and hospital care to be rendered by a dentist licensed under the provisions of the Dental Practices Act, California Business and Professions Code Section 1600 et seq.

This authorization is given pursuant to the provisions of Section 25.8 of the Civil Code of California. This authorization shall remain effective until I complete my activities in this program unless sooner revoked in writing. I understand that I will be responsible for the cost of any service or treatment provided not covered by the 4-H Accident/Sickness Insurance Program sponsored by UC Cooperative Extension.

## Authorization and Consent and Release

I hereby certify that I am in good health and can travel to and participate in all functions of the 4-H Youth Development Program as described above. I understand it is my responsibility to keep the information on this form updated (including Health History) by contacting the County 4-H Office.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

(\_\_\_\_\_) \_\_\_\_\_  
Emergency Day Phone (with area code)

(\_\_\_\_\_) \_\_\_\_\_  
Emergency Night Phone (with area code)

\_\_\_\_\_  
Mailing Address

\_\_\_\_\_  
City

\_\_\_\_\_  
State

\_\_\_\_\_  
Zip

## Non-Consent

I do not desire to sign this authorization and understand that this will prohibit me from receiving any non-life threatening medical attention in the event of an accident or illness.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

University policy and the State of California Information Practices Act of 1977 require the following information be provided when collecting personal information from you: The information entered on this form is collected under authority of the Smith-Lever Act. Submission of the medical data is voluntary. However, a signature is required on one or the other of the two signature lines above. Failure to provide the medical information and authorization may result in our inability to provide necessary medical treatment. You have the right to review University records containing personal information about you, with certain exceptions as set forth in policy and statute. Copies of University policies pertaining to the collection, use, or release of personal data are available for your examination from the local UCCE County Director, 4-H Youth Development Advisor, 4-H Program Representative or the State 4-H Director of the California 4-H Youth Development Program, University of California, DANR Building, One Hopkins Road, Davis, CA 95616-8575, (530) 754-8518. Only your own records are open to your review.

Any known or foreseeable intergovernmental transfer that may be made of the information is as follows: None.

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# California 4-H Youth Development Program

## Health History Information

University of California Cooperative Extension

_____	____/____/____		
First Name	Last Name	Date of Birth	Social Security Number

Subject to:	Yes	No	Now Have or Have Had	Yes	No
Colds			Heart Trouble		
Sore Throat			Asthma		
Fainting Spells			Lung Trouble		
Bronchitis			Sinus Trouble		
Convulsions			Hernia (rupture)		
Cramps			Appendicitis		
Allergies			Has appendix been removed?		
Wear corrective lenses?			Do you walk in your sleep?		
Is hearing good?					
Currently under any type of medical care?					
Is there history of behavior disorders, emotional disturbances, or severe moodiness?					
Been under psychiatric treatment within the past five years?					

Date of last Tetanus Vaccination: \_\_\_\_\_

Please identify allergies including allergies to food, medications, and drug reactions:

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Please list any disabilities or disorders that may affect participation at 4-H events such as:  
eyesight, hearing, speech, paralysis, diabetes, ulcer, etc.

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Please list all current medications:

Name of Medication	Dosage	Times Taken

Remarks and special instructions. Please explain "yes" answers on this page.

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The University of California prohibits discrimination or harassment of any person on the basis of race, color, national origin, religion, sex, gender identity, pregnancy (including childbirth, and medical conditions related to pregnancy or childbirth), physical or mental disability, medical condition (cancer-related or genetic characteristics), ancestry, marital status, age, sexual orientation, citizenship, or status as a covered veteran (covered veterans are special disabled veterans, recently separated veterans, Vietnam era veterans, or any other veterans who served on active duty during a war or in a campaign or expedition for which a campaign badge has been authorized) in any of its programs or activities.

University policy is intended to be consistent with the provisions of applicable State and Federal laws.

Inquiries regarding the University's nondiscrimination policies may be directed to the Affirmative Action/Staff Personnel Services Director, University of California, Agriculture and Natural Resources, 300 Lakeside Drive, 6th Floor, Oakland, CA 94612-3550, (510) 987-0096.