

Name _____ State/Province _____

(Print clearly.)

EXPECTATION STATEMENT FOR ADULTS ACCOMPANYING YOUTH TO NATIONAL 4-H DAIRY CONFERENCE

September 28- October 1, 2008

University of Wisconsin- Madison

Capable caring adults play important roles in the lives of youth involved in UW-Extension Programs. This expectation statement acknowledges the need to provide the safest environments possible for youth.

This form applies to all adults, paid staff and volunteers, accompanying youth on an UW-Extension-sponsored trip or event. The adult, by signing this form, agrees to conduct herself/himself in a responsible manner and abide by all expectations as stated below.

Adult Responsibilities:

1. The adult agrees to accept supervision and support from salaried Extension staff or designated management volunteers.
2. The adult will consider herself/himself the youth's support person.
3. The adult will enforce all written and signed behavior expectations established for youth participation in the event. This will include room checks, when appropriate.
4. The adult will keep health and insurance information available as may be needed in handling emergency situations.
5. The adult will not dispense medication, or anything relating to the physical or mental health of the youth, unless specifically directed in writing by the parent or guardian. The adult should be aware of any medications to be taken by youth.
6. In an emergency situation, the adult will act in the best interest of the youth. Seek assistance from an event coordinator, professional staff, medical and/or law enforcement personnel as needed.
7. The adults should provide the youth with information on how they can be reached, and should be accessible to consult with youth participants when needed.
8. In the case of inappropriate youth behavior, the adult will consult with local and/or home county contacts in determining appropriate disciplinary action.
9. The accompanying adult will participate in assigned activities and assist with tasks as needed.
10. The adult will not ignore situations involving bullying, hazing or harassment, or fail to intervene if youth are being threatened, humiliated or intimidated by other youth or adults.
11. The use of illegal drugs is not allowed during the entire trip or event.
12. The possession and/or use of alcohol is not allowed during the entire trip or event.
13. The use of any form of tobacco should be avoided in the obvious or known presence of youth.
14. Sexual contact of any type with youth is strictly forbidden. Any behavior considered in violation of the Wisconsin child abuse and sexual assault laws are grounds for suspension of affiliation until investigation is completed.
15. Swearing, cursing and abusive language is not condoned.
16. Operate motor vehicles (including machines or equipment) in a safe and reliable manner when working with youth, only with a valid operator's license and the legally required insurance coverage.
17. The adult will observe the curfew hour. The adult is expected to remain in the dormitory during curfew hours.
18. The adult will make contact with each youth he/she has assumed supervision responsibility for at least twice a day.

(over)

Enforcement:

1. Allegations should be written and signed.
2. The person or group responsible should investigate the charge to determine what type of action is needed.
3. An executive committee of National 4-H Dairy Conference Planning Committee members will determine action for failure to meet expectations.
4. Home state/province 4-H staff will determine action for failure to meet the expectations for volunteer staff.
5. The county office chair will receive complaints and determine action for state/province staff.

Support for Adults Accompanying Youth on UW-Extension-Sponsored Trips/Activities:

1. Orientation will be provided.
2. Youth taking part in overnight activities will submit a signed Expectation Statement that they understand the rules and the roles of the accompanying adult(s). Youth will be required to submit a health form that includes information on any special needs, medication to be taken, and how to contact a parent or guardian.

Adult Leader's Statement of Agreement

I have read and understand the rules and penalties in this agreement and agree to be bound by them. In addition, I understand that participants of this event are occasionally photographed and/or videotaped for 4-H promotional or educational materials. I also understand that no personal information about the participant, such as name, age or address, will be used with photos or videos in state promotional program materials. However, photos may be released to county Extension staff for local publication where participants may be identified. I give my permission to U.W.-Extension to use such images of this participant without any expectation of compensation.

Signature of Adult Leader

Date

**Postmark by September 2, 2008 to
Wisconsin 4-H Outreach, 431 Lowell Center, 610 Langdon St., Madison WI 53703-1195**

ADULT HEALTH INFORMATION & CONSENT FOR EMERGENCY TREATMENT

Attach photo here with name on back.

NATIONAL 4-H DAIRY CONFERENCE

September 28- October 1, 2008
University of Wisconsin - Madison

This information is confidential and necessary for proper care by staff advisors and medical personnel. Information must be legibly printed in black ink or typed. Do not leave empty blanks; enter N/A if not applicable.

Participant Information:

Last Name _____ First name _____ MI _____
Address _____ City _____ State _____ Zip _____
Birth Date _____ Height _____ Weight _____ Female Male

Health: Have you experienced any of the following illnesses/injuries/diseases/disorders/problems or symptoms? If you check "yes" to any of the following, **enter the details below** including diagnosis, treatment, date of illness or injury, name of hospital, name of physician and telephone number. Continue on reverse side of page, if necessary.

YES	NO	CONDITION
<input type="checkbox"/>	<input type="checkbox"/>	Allergies to bee stings. Explain _____
<input type="checkbox"/>	<input type="checkbox"/>	Allergies to dyes (red dye, food coloring). Explain _____
<input type="checkbox"/>	<input type="checkbox"/>	Allergies to environmental factors (pollen, mold, dust, hay fever). Explain _____
<input type="checkbox"/>	<input type="checkbox"/>	Allergies to foods: Explain _____
<input type="checkbox"/>	<input type="checkbox"/>	Allergies to latex. Explain _____
<input type="checkbox"/>	<input type="checkbox"/>	Allergies to medicines including penicillin, tetanus, etc. Explain _____ How do you react to the(se) allergy(ies)? _____ Normal treatment? _____
<input type="checkbox"/>	<input type="checkbox"/>	Bladder or bowel control problems. Explain _____
<input type="checkbox"/>	<input type="checkbox"/>	Diabetes or hypoglycemia (low blood sugar). Explain _____
<input type="checkbox"/>	<input type="checkbox"/>	Eating disorders (anorexia, bulimia or other). Explain _____
<input type="checkbox"/>	<input type="checkbox"/>	Emotional or mental (reaction to stress, frequent anxiety, excessive fears, etc.). Explain _____
<input type="checkbox"/>	<input type="checkbox"/>	Exposure to a contagious or serious disease within last 12 months. Explain _____
<input type="checkbox"/>	<input type="checkbox"/>	Eye or ear (color blindness, peripheral vision, depth perception, near or farsightedness, ear infection, impaired hearing or other). Explain _____
<input type="checkbox"/>	<input type="checkbox"/>	Heart (high/low blood pressure, murmurs, chest pain, rheumatic fever, etc.). Explain _____
<input type="checkbox"/>	<input type="checkbox"/>	Kidney or gall bladder. Explain _____
<input type="checkbox"/>	<input type="checkbox"/>	Limiting physical conditions (sitting, standing, walking). Is special equipment or assistance needed? Explain _____
<input type="checkbox"/>	<input type="checkbox"/>	Muscular/skeletal (arthritis, recent fractures, etc.). Explain _____
<input type="checkbox"/>	<input type="checkbox"/>	Nervous system (breakdown, convulsions, dizziness, epilepsy, loss of consciousness, paralysis, etc.). Explain _____
<input type="checkbox"/>	<input type="checkbox"/>	Nose or throat (thyroid, lymph nodes, carotid arteries, other). Explain: _____
<input type="checkbox"/>	<input type="checkbox"/>	Reproductive (menstrual difficulties, other). Explain: _____
<input type="checkbox"/>	<input type="checkbox"/>	Respiratory (asthma, persistent/chronic cough, abnormal chest x-ray, tuberculosis, or any other lung problems). Explain _____
<input type="checkbox"/>	<input type="checkbox"/>	Skin (rash, other). Explain _____
<input type="checkbox"/>	<input type="checkbox"/>	Sleep (sleep apnea, sleepwalking, recurrent nightmares, other). Explain: _____
<input type="checkbox"/>	<input type="checkbox"/>	Stomach, liver or intestinal (ulcers, jaundice, hernia, colitis, indigestion, etc.). Explain _____
<input type="checkbox"/>	<input type="checkbox"/>	Surgical operations, accidents or injuries in the past 2 years. Explain _____
<input type="checkbox"/>	<input type="checkbox"/>	Vascular and blood (anemia; Hepatitis B or C; hemophilia, HIV positive; HBV; migraines, nosebleeds, transfusions, unconsciousness/fainting, other). Explain _____ (over)

Continued explanations of "yes" answers:

Dietary needs/restrictions: _____

General attitude/mood/alertness (shyness, energy level, cooperation) _____

Immunizations -- list dates of last vaccines:

Hepatitis _____ Influenza _____ Tetanus _____

Medications:

List all prescriptions/non-prescription medications participant will require during the program, listing dosages, time medications are taken, and sensitivity to them: _____

Social habits (smoking or chewing tobacco, alcohol consumption, illicit drug use) Explain: _____

Insurance information: Currently covered by insurance: ___ Yes ___ No

Insurance Co. _____ Policy Number _____
Address _____ City _____ State ___ Zip ___
Telephone number: _____

Physician information:

Family Physician or Clinic _____ Phone _(_____) _____
Date of last medical examination: _____ Is participant under a doctor's care now? yes no

Emergency Contact:

Last Name _____ First name _____ MI _____
Address _____ City _____ State ___ Zip ___
Day phone _(_____) _____ Evening phone _(_____) _____
Relationship _____

Alternate contact in case of emergency:

Name _____ Relationship _____
Day phone _(_____) _____ Evening phone _(_____) _____

I understand that failure to provide complete information on this health form could hinder staff's ability to provide adequate care and could result in termination of my participation in this event.

*I consider my health to be: Excellent Good Fair Poor. I believe that I can **safely participate** in this program. I further declare that I have no physical, mental, or communicable conditions that will interfere with participation in this program.*

I will notify the WI 4-H Youth Development Office of any changes in health or prescriptions between now and departure. I understand that if a serious illness or injury develops, medical and/or hospital care will be given but Wisconsin 4-H and program staff are not responsible in case of accidental injury or illness. The person noted above will be notified as soon as possible in case of medical emergency while I am participating in this program. If a medical emergency arises, I give permission for emergency treatment or surgery as recommended by an attending physician. I agree to cover cost of prescriptions and emergency transportation to medical facilities or home, if necessary.

Signature _____ **Date** _____

**Postmark by September 2, 2008 to
Wisconsin 4-H Outreach, 431 Lowell Center, 610 Langdon St., Madison WI 53703-1195**

ADULT HEALTH INFORMATION & CONSENT FOR EMERGENCY TREATMENT

Attach photo here with name on back.

NATIONAL 4-H DAIRY CONFERENCE September 28- October 1, 2008 University of Wisconsin - Madison

This information is confidential and necessary for proper care by staff advisors and medical personnel. Information must be legibly printed in black ink or typed. Do not leave empty blanks; enter N/A if not applicable.

Participant Information:

Last Name _____ First name _____ MI _____
Address _____ City _____ State _____ Zip _____
Birth Date _____ Height _____ Weight _____ Female Male

Health: Have you experienced any of the following illnesses/injuries/diseases/disorders/problems or symptoms? If you check "yes" to any of the following, **enter the details below** including diagnosis, treatment, date of illness or injury, name of hospital, name of physician and telephone number. Continue on reverse side of page, if necessary.

YES	NO	CONDITION
<input type="checkbox"/>	<input type="checkbox"/>	Allergies to bee stings. Explain _____
<input type="checkbox"/>	<input type="checkbox"/>	Allergies to dyes (red dye, food coloring). Explain _____
<input type="checkbox"/>	<input type="checkbox"/>	Allergies to environmental factors (pollen, mold, dust, hay fever). Explain _____
<input type="checkbox"/>	<input type="checkbox"/>	Allergies to foods: Explain _____
<input type="checkbox"/>	<input type="checkbox"/>	Allergies to latex. Explain _____
<input type="checkbox"/>	<input type="checkbox"/>	Allergies to medicines including penicillin, tetanus, etc. Explain _____ How do you react to the(se) allergy(ies)? _____ Normal treatment? _____
<input type="checkbox"/>	<input type="checkbox"/>	Bladder or bowel control problems. Explain _____
<input type="checkbox"/>	<input type="checkbox"/>	Diabetes or hypoglycemia (low blood sugar). Explain _____
<input type="checkbox"/>	<input type="checkbox"/>	Eating disorders (anorexia, bulimia or other). Explain _____
<input type="checkbox"/>	<input type="checkbox"/>	Emotional or mental (reaction to stress, frequent anxiety, excessive fears, etc.). Explain _____
<input type="checkbox"/>	<input type="checkbox"/>	Exposure to a contagious or serious disease within last 12 months. Explain _____
<input type="checkbox"/>	<input type="checkbox"/>	Eye or ear (color blindness, peripheral vision, depth perception, near or farsightedness, ear infection, impaired hearing or other). Explain _____
<input type="checkbox"/>	<input type="checkbox"/>	Heart (high/low blood pressure, murmurs, chest pain, rheumatic fever, etc.). Explain _____
<input type="checkbox"/>	<input type="checkbox"/>	Kidney or gall bladder. Explain _____
<input type="checkbox"/>	<input type="checkbox"/>	Limiting physical conditions (sitting, standing, walking). Is special equipment or assistance needed? Explain _____
<input type="checkbox"/>	<input type="checkbox"/>	Muscular/skeletal (arthritis, recent fractures, etc.). Explain _____
<input type="checkbox"/>	<input type="checkbox"/>	Nervous system (breakdown, convulsions, dizziness, epilepsy, loss of consciousness, paralysis, etc.). Explain _____
<input type="checkbox"/>	<input type="checkbox"/>	Nose or throat (thyroid, lymph nodes, carotid arteries, other). Explain: _____
<input type="checkbox"/>	<input type="checkbox"/>	Reproductive (menstrual difficulties, other). Explain: _____
<input type="checkbox"/>	<input type="checkbox"/>	Respiratory (asthma, persistent/chronic cough, abnormal chest x-ray, tuberculosis, or any other lung problems). Explain _____
<input type="checkbox"/>	<input type="checkbox"/>	Skin (rash, other). Explain _____
<input type="checkbox"/>	<input type="checkbox"/>	Sleep (sleep apnea, sleepwalking, recurrent nightmares, other). Explain: _____
<input type="checkbox"/>	<input type="checkbox"/>	Stomach, liver or intestinal (ulcers, jaundice, hernia, colitis, indigestion, etc.). Explain _____
<input type="checkbox"/>	<input type="checkbox"/>	Surgical operations, accidents or injuries in the past 2 years. Explain _____
<input type="checkbox"/>	<input type="checkbox"/>	Vascular and blood (anemia; Hepatitis B or C; hemophilia, HIV positive; HBV; migraines, nosebleeds, transfusions, unconsciousness/fainting, other). Explain _____ (over)

Continued explanations of "yes" answers:

Dietary needs/restrictions: _____

General attitude/mood/alertness (shyness, energy level, cooperation) _____

Immunizations -- list dates of last vaccines:

Hepatitis _____ Influenza _____ Tetanus _____

Medications:

List all prescriptions/non-prescription medications participant will require during the program, listing dosages, time medications are taken, and sensitivity to them: _____

Social habits (smoking or chewing tobacco, alcohol consumption, illicit drug use) Explain: _____

Insurance information: Currently covered by insurance: ___ Yes ___ No

Insurance Co. _____ Policy Number _____
Address _____ City _____ State ___ Zip ___
Telephone number: _____

Physician information:

Family Physician or Clinic _____ Phone _(_____) _____
Date of last medical examination: _____ Is participant under a doctor's care now? yes no

Emergency Contact:

Last Name _____ First name _____ MI _____
Address _____ City _____ State ___ Zip ___
Day phone _(_____) _____ Evening phone _(_____) _____
Relationship _____

Alternate contact in case of emergency:

Name _____ Relationship _____
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I understand that failure to provide complete information on this health form could hinder staff's ability to provide adequate care and could result in termination of my participation in this event.

*I consider my health to be: Excellent Good Fair Poor. I believe that I can **safely participate** in this program. I further declare that I have no physical, mental, or communicable conditions that will interfere with participation in this program.*

I will notify the WI 4-H Youth Development Office of any changes in health or prescriptions between now and departure. I understand that if a serious illness or injury develops, medical and/or hospital care will be given but Wisconsin 4-H and program staff are not responsible in case of accidental injury or illness. The person noted above will be notified as soon as possible in case of medical emergency while I am participating in this program. If a medical emergency arises, I give permission for emergency treatment or surgery as recommended by an attending physician. I agree to cover cost of prescriptions and emergency transportation to medical facilities or home, if necessary.

Signature _____ **Date** _____

**Submit this second completed original form to
your State/Provincial Coordinator by Sept. 2, 2008**

2008 National 4-H Dairy Conference Youth and Adult Health Update

To be completed immediately prior to Conference for health changes since submitting your medical form.

(IF THERE ARE NO CHANGES, THIS FORM IS NOT NEEDED)

This information is required for your safety and will be shared with emergency medical personnel.

1. Original health forms were submitted in August. Since then, have you incurred an illness or injury that required hospitalization? Yes No

Nature of illness or injury _____

2. Have you been exposed to any communicable disease within the two weeks prior to departing for National 4-H Dairy Conference, such as mononucleosis, hepatitis, chicken pox, influenza, etc.?

Yes No

Type of illness _____

3. List all prescriptions and medications you will bring to National 4-H Dairy Conference.

Medication	for:	Special instructions:
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Delegate name _____ (print) _____ (State)

Delegate signature _____ Date _____

Parent/Guardian signature _____ Date _____

**Bring this form with you to National 4-H Dairy Conference to give to your chaperone
(only if there have been changes in your health or medication status).**

~~~~~  
**Chaperones: bring to Conference at registration on Sunday, September 28, 2008.**



Name: \_\_\_\_\_ State/Province \_\_\_\_\_

## National 4-H Dairy Conference Youth Expectation of Conduct Form

**September 28- October 1, 2008**

**University of Wisconsin- Madison**

This form applies to all youth on UW-Extension sponsored trips or events. The youth, by signing this form, agrees to conduct him/herself in a responsible manner and abide by all expectations as stated.

### **Youth responsibilities:**

1. Attend and participate in program orientation; prepare for the program in advance.
2. Be on time and participate in all scheduled sessions including workshops, recreation, evening activities and delegation meetings. Those not feeling well or having a schedule conflict must inform an adult leader.
3. Bring back ideas and experiences to share with county's youth and/or adult leader groups.
4. Cooperate with the adult advisors' and program staff's leadership. Contact the adult advisor in regard to any conflict or problems during the event.
5. Show respect and courtesy for programs and speakers in progress by remaining for the entire program and be courteous when taking flash photos during speeches and entertainment.
6. Be respectful of public property and the facilities used during the activity or event. Be responsible for your own property.
7. Behave in accordance with applicable federal, state and municipal laws.
8. Behave in ways that are acceptable to other delegates, adult advisors and hosting organizations and uphold high standards for the group by respecting the ideas, abilities and bodies of others. Use of language and gestures found to be objectionable to others is not permitted.
9. Refrain from participating in initiation ceremonies, hazing, harassment, and other behaviors that involve humiliation or embarrassing another person. Such activities will not be tolerated.
10. Remain on the premises or assigned program area throughout the program; unauthorized absence is not permitted.
11. Visiting or leaving the premises with non-registered persons is discouraged. Adults in charge must be notified in advance by the participant's parent/guardian if guests are expected.
12. Refrain from driving any vehicle during the event without expressed permission of the group advisor.
13. Wear program nametag to all program activities unless removal is specified. Use good judgement in selecting clothing appropriate for weather and occasion, abiding by any established dress code. Clothing that is revealing or with obscene language/pictures or with drug, tobacco or alcohol advertising is never allowed.
14. Abide by the lodging assignments for the entire event for easy location in emergency. No room switching is allowed.
15. Abide by established written curfew and quiet times or by adult advisor's spoken word. (Curfew means being in the assigned room with the lights out.) Be quiet and considerate of others when they wish to sleep. Do not order food to be delivered after curfew.
16. Respect the privacy of others. Visiting sleeping rooms of any member of the opposite sex is forbidden.
17. Youth are encouraged to interact with all members of the group and not pair up with another person. Necking, kissing and other displays of personal affection are in poor taste and will not be tolerated. Refrain from all sexual activity during the program.
18. Possessing, using and/or being in the presence of alcohol, tobacco, fireworks, weapons, illicit drugs or medication(s) unapproved by program staff will result in disciplinary action for the offender(s). Adult advisors must be informed of all prescription medications present during the program.

### **Participants and their families understand the adult chaperone's role is:**

1. To serve as an advocate for the participants;
2. To maintain regular contact with participants to monitor health, attitude, problem situations, behavior, etc.;
3. To be aware of all prescription medication but do not dispense medication;
4. To make appropriate decisions in emergency situations to enhance the health and well-being of the participants;
5. To have responsibility to determine the occurrence of inappropriate behavior and take appropriate actions as follows.

(over)

**Chaperones will take the following steps for violations of this Expectation Agreement:**

1. Counsel involved participants to reach an understanding and stop the inappropriate behavior;
2. Take disciplinary actions at the time of occurrence. This will not include physical punishment but might consist of restriction of privileges, restriction to an assigned area, apology to the group, additional duties, etc.;
3. Inform parents and local Extension personnel of misbehavior at time of occurrence if chaperon feels severity of situation warrants such immediate notification; and
4. When the infraction is serious, decide as part of a committee of at least two adults to remove a participant from the program and send him/her home immediately. (Participants removed from the program will wait for transportation at the General Headquarters or other area designated by program representatives.)
5. Write a letter describing disruptive behavior to be sent to the participant's parents, the WI 4-H Youth Development Office and the county 4-H office within ten (10) days after the event concludes.

**Consequences of disciplinary action:**

1. Families of participants removed from the program will be responsible for the participants' transportation, including bus/plane fares and supplemental "Unaccompanied Child" fares or expenses for a chaperone. Event registration, lodging or other participant fees will not be reimbursed.
2. If damage/destruction of property occurred, participants will be assessed for the cost of damages and repairs.
3. Participants removed from the program may be required to relinquish all funds donated to help meet his/her financial obligations for the event.
4. Youth who do not follow the guidelines in this Expectation Agreement while participating in a 4-H event may be required to appear before a county Disciplinary Review Committee in addition to consequences that occur during the event.
5. Disciplinary action may result in restricted opportunity to participate in future 4-H related activities for the involved members.
6. Youth who break public laws will be dismissed from the program and will be subject to legal action by law enforcement authorities.

**Youth Statement of Agreement:**

I have read and understand this Expectation Agreement and will abide by it.

\_\_\_\_\_  
Youth Participant's Signature

\_\_\_\_\_  
Date

**Parent/Guardian Statement of Agreement:**

I have read and understand the rules and penalties in this agreement and agree to be bound by them. In addition, I understand that participants of this event are occasionally photographed and/or videotaped for 4-H promotional or educational materials. I also understand that no personal information about the participant, such as name, age or address, will be used with photos or videos in state promotional program materials. However, photos may be released to county Extension staff for local publication where participants may be identified. I give my permission to U.W.-Extension to use such images of this participant without any expectation of compensation.

\_\_\_\_\_  
Parent/Guardian's Signature

\_\_\_\_\_  
Date

Address and telephone where parent or guardian can be reached during this program:

Name: \_\_\_\_\_

Address: \_\_\_\_\_

City, State, Zip Code: \_\_\_\_\_

Daytime phone: \_( \_\_\_\_\_ ) \_\_\_\_\_ Night phone: \_( \_\_\_\_\_ ) \_\_\_\_\_

**Postmark by September 2, 2008 to**

**Wisconsin 4-H Outreach, 431 Lowell Center, 610 Langdon St., Madison WI 53703-1195**

# YOUTH HEALTH INFORMATION & CONSENT FOR EMERGENCY TREATMENT

**Attach photo here with name on back.**

## NATIONAL 4-H DAIRY CONFERENCE September 28- October 1, 2008 University of Wisconsin - Madison

This information is confidential and necessary for proper care by staff advisors and medical personnel.  
Information must be legibly printed in black ink or typed.  
Do not leave empty blanks; enter N/A if not applicable.

### Participant Information:

Last Name \_\_\_\_\_ First name \_\_\_\_\_ MI \_\_\_\_\_  
Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
Birth Date \_\_\_\_\_ Height \_\_\_\_\_ Weight \_\_\_\_\_  Female  Male

**Health:** Has this delegate experienced any of the following illnesses/injuries/diseases/disorders/problems or symptoms? If you check "yes" to any of the following, **enter the details below** including diagnosis, treatment, date of illness or injury, name of hospital, name of physician and telephone number. Continue on reverse side of page, if necessary.

| YES                      | NO                       | CONDITION                                                                                                                                                            |
|--------------------------|--------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <input type="checkbox"/> | <input type="checkbox"/> | Allergies to bee stings. Explain _____                                                                                                                               |
| <input type="checkbox"/> | <input type="checkbox"/> | Allergies to dyes (red dye, food coloring). Explain _____                                                                                                            |
| <input type="checkbox"/> | <input type="checkbox"/> | Allergies to environmental factors (pollen, mold, dust, hay fever). Explain _____                                                                                    |
| <input type="checkbox"/> | <input type="checkbox"/> | Allergies to foods: Explain _____                                                                                                                                    |
| <input type="checkbox"/> | <input type="checkbox"/> | Allergies to latex. Explain _____                                                                                                                                    |
| <input type="checkbox"/> | <input type="checkbox"/> | Allergies to medicines including penicillin, tetanus, etc. Explain _____<br>How does this person react to the(se) allergy(ies)? _____<br>Normal treatment? _____     |
| <input type="checkbox"/> | <input type="checkbox"/> | Bladder or bowel control, bedwetting. Explain _____                                                                                                                  |
| <input type="checkbox"/> | <input type="checkbox"/> | Diabetes or hypoglycemia (low blood sugar). Explain _____                                                                                                            |
| <input type="checkbox"/> | <input type="checkbox"/> | Eating disorders (anorexia, bulimia or other). Explain _____                                                                                                         |
| <input type="checkbox"/> | <input type="checkbox"/> | Emotional or mental (severe homesickness, reaction to stress, frequent anxiety, excessive fears, etc.).<br>Explain concern and suggested method of handling it _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Exposure to a contagious or serious disease within last 12 months. Explain _____                                                                                     |
| <input type="checkbox"/> | <input type="checkbox"/> | Eye or ear (color blindness, peripheral vision, depth perception, near or farsightedness, ear infection, impaired hearing or other). Explain _____                   |
| <input type="checkbox"/> | <input type="checkbox"/> | Heart (high/low blood pressure, murmurs, chest pain, rheumatic fever, etc.).<br>Explain _____                                                                        |
| <input type="checkbox"/> | <input type="checkbox"/> | Kidney or gall bladder. Explain _____                                                                                                                                |
| <input type="checkbox"/> | <input type="checkbox"/> | Learning or attention disorders. Explain _____                                                                                                                       |
| <input type="checkbox"/> | <input type="checkbox"/> | Limiting physical conditions (sitting, standing, walking). Is special equipment or assistance needed?<br>Explain _____                                               |
| <input type="checkbox"/> | <input type="checkbox"/> | Muscular/skeletal (arthritis, recent fractures, etc.). Explain _____                                                                                                 |
| <input type="checkbox"/> | <input type="checkbox"/> | Nervous system (convulsions, epilepsy, dizziness, etc.). Explain _____                                                                                               |
| <input type="checkbox"/> | <input type="checkbox"/> | Nose or throat (thyroid, lymph nodes, carotid arteries, other). Explain: _____                                                                                       |
| <input type="checkbox"/> | <input type="checkbox"/> | Reproductive (menstrual difficulties, other). Explain: _____                                                                                                         |
| <input type="checkbox"/> | <input type="checkbox"/> | Respiratory (asthma, persistent/chronic cough, abnormal chest x-ray, tuberculosis, or any other lung problems).<br>Explain _____                                     |
| <input type="checkbox"/> | <input type="checkbox"/> | Skin (rash, other). Explain _____                                                                                                                                    |
| <input type="checkbox"/> | <input type="checkbox"/> | Sleep (sleepwalking, recurrent nightmares, other). Explain: _____                                                                                                    |
| <input type="checkbox"/> | <input type="checkbox"/> | Stomach, liver or intestinal (ulcers, jaundice, hernia, colitis, indigestion, etc.).<br>Explain _____                                                                |
| <input type="checkbox"/> | <input type="checkbox"/> | Surgical operations, accidents or injuries in the past 2 years. Explain _____                                                                                        |
| <input type="checkbox"/> | <input type="checkbox"/> | Vascular and blood (anemia; Hepatitis B or C; hemophilia, HIV positive; HBV; migraines, nosebleeds, transfusions, unconsciousness/fainting, other). Explain _____    |

(over)

**Continued explanations of "yes" answers:**

**Other important health information** that the Adult Advisors should know? \_\_\_\_\_

**Contagious diseases:** list dates of exposure and occurrence of the following: Measles, Mumps, Rubella, Chicken Pox, Mononucleosis, Tuberculosis, Pneumonia \_\_\_\_\_

**Dietary needs/restrictions:** \_\_\_\_\_

**General attitude/mood/alertness** (shyness, energy level, cooperation) \_\_\_\_\_

**Immunizations -- list dates of last vaccines:**

Hepatitis \_\_\_\_\_ Influenza \_\_\_\_\_ Tetanus \_\_\_\_\_ MMR (Measles/Mumps/Rubella) \_\_\_\_\_

Was this a second MMR immunization? \_\_\_\_\_

**Medications:**

List all prescriptions/non-prescription medications participant will require during the program, listing dosages, time medications are taken, and sensitivity to them: \_\_\_\_\_

Do you want an adult advisor to collect and dispense medications?  yes  no

**Social habits** (smoking or chewing tobacco, alcohol consumption, illicit drug use) Explain: \_\_\_\_\_

**Insurance information:** Currently covered by insurance: \_\_\_ Yes \_\_\_ No

Insurance Co. \_\_\_\_\_ Policy Number \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Telephone number: \_\_\_\_\_

**Physician information:**

Family Physician or Clinic \_\_\_\_\_ Phone (\_\_\_\_\_) \_\_\_\_\_

Date of last medical examination: \_\_\_\_\_ Is participant under a doctor's care now?  yes  no

**Parent/Guardian information:**

Last Name \_\_\_\_\_ First name \_\_\_\_\_ MI \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Day phone (\_\_\_\_\_) \_\_\_\_\_ Evening phone (\_\_\_\_\_) \_\_\_\_\_

**Alternate contact in case of emergency:**

Name \_\_\_\_\_ Relationship to participant \_\_\_\_\_

Day phone (\_\_\_\_\_) \_\_\_\_\_ Evening phone (\_\_\_\_\_) \_\_\_\_\_

*I understand that failure to provide complete information on this health form could hinder chaperones' and staff's ability to provide adequate care and could result in termination of my son/daughter's participation in this event.*

*I consider his/her health to be:  Excellent  Good  Fair  Poor. I am of the opinion that \_\_\_\_\_ can **safely participate** in this program I further declare that he/she has no physical, mental, or communicable conditions that will interfere with participation in this program.*

I will notify the WI 4-H Youth Development Office of any changes in health or prescriptions between now and departure. I understand my son/daughter will be supervised and that if a serious illness or injury develops, medical and/or hospital care will be given but Wisconsin 4-H and program staff are not responsible in case of accidental injury or illness. I, or the person noted above, will be notified as soon as possible in case of medical emergency while my son/daughter is participating in this program. If a medical emergency arises, I give permission for emergency treatment or surgery as recommended by an attending physician. I agree to cover cost of prescriptions and emergency transportation to medical facilities or home, if necessary.

**Signature of Parent/Guardian** \_\_\_\_\_ **Date** \_\_\_\_\_

**Postmark by September 2, 2008 to  
Wisconsin 4-H Outreach, 431 Lowell Center, 610 Langdon St., Madison WI 53703-1195**

# YOUTH HEALTH INFORMATION & CONSENT FOR EMERGENCY TREATMENT

Attach photo  
here with  
name on  
back.

## NATIONAL 4-H DAIRY CONFERENCE

September 28- October 1, 2008  
University of Wisconsin - Madison

This information is confidential and necessary for proper care by staff advisors and medical personnel.  
Information must be legibly printed in black ink or typed.  
Do not leave empty blanks; enter N/A if not applicable.

### Participant Information:

Last Name \_\_\_\_\_ First name \_\_\_\_\_ MI \_\_\_\_\_  
Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
Birth Date \_\_\_\_\_ Height \_\_\_\_\_ Weight \_\_\_\_\_  Female  Male

**Health:** Has this delegate experienced any of the following illnesses/injuries/diseases/disorders/problems or symptoms? If you check "yes" to any of the following, **enter the details below** including diagnosis, treatment, date of illness or injury, name of hospital, name of physician and telephone number. Continue on reverse side of page, if necessary.

| YES                      | NO                       | CONDITION                                                                                                                                                            |
|--------------------------|--------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <input type="checkbox"/> | <input type="checkbox"/> | Allergies to bee stings. Explain _____                                                                                                                               |
| <input type="checkbox"/> | <input type="checkbox"/> | Allergies to dyes (red dye, food coloring). Explain _____                                                                                                            |
| <input type="checkbox"/> | <input type="checkbox"/> | Allergies to environmental factors (pollen, mold, dust, hay fever). Explain _____                                                                                    |
| <input type="checkbox"/> | <input type="checkbox"/> | Allergies to foods: Explain _____                                                                                                                                    |
| <input type="checkbox"/> | <input type="checkbox"/> | Allergies to latex. Explain _____                                                                                                                                    |
| <input type="checkbox"/> | <input type="checkbox"/> | Allergies to medicines including penicillin, tetanus, etc. Explain _____<br>How does this person react to the(se) allergy(ies)? _____<br>Normal treatment? _____     |
| <input type="checkbox"/> | <input type="checkbox"/> | Bladder or bowel control, bedwetting. Explain _____                                                                                                                  |
| <input type="checkbox"/> | <input type="checkbox"/> | Diabetes or hypoglycemia (low blood sugar). Explain _____                                                                                                            |
| <input type="checkbox"/> | <input type="checkbox"/> | Eating disorders (anorexia, bulimia or other). Explain _____                                                                                                         |
| <input type="checkbox"/> | <input type="checkbox"/> | Emotional or mental (severe homesickness, reaction to stress, frequent anxiety, excessive fears, etc.).<br>Explain concern and suggested method of handling it _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Exposure to a contagious or serious disease within last 12 months. Explain _____                                                                                     |
| <input type="checkbox"/> | <input type="checkbox"/> | Eye or ear (color blindness, peripheral vision, depth perception, near or farsightedness, ear infection, impaired hearing or other). Explain _____                   |
| <input type="checkbox"/> | <input type="checkbox"/> | Heart (high/low blood pressure, murmurs, chest pain, rheumatic fever, etc.).<br>Explain _____                                                                        |
| <input type="checkbox"/> | <input type="checkbox"/> | Kidney or gall bladder. Explain _____                                                                                                                                |
| <input type="checkbox"/> | <input type="checkbox"/> | Learning or attention disorders. Explain _____                                                                                                                       |
| <input type="checkbox"/> | <input type="checkbox"/> | Limiting physical conditions (sitting, standing, walking). Is special equipment or assistance needed?<br>Explain _____                                               |
| <input type="checkbox"/> | <input type="checkbox"/> | Muscular/skeletal (arthritis, recent fractures, etc.). Explain _____                                                                                                 |
| <input type="checkbox"/> | <input type="checkbox"/> | Nervous system (convulsions, epilepsy, dizziness, etc.). Explain _____                                                                                               |
| <input type="checkbox"/> | <input type="checkbox"/> | Nose or throat (thyroid, lymph nodes, carotid arteries, other). Explain: _____                                                                                       |
| <input type="checkbox"/> | <input type="checkbox"/> | Reproductive (menstrual difficulties, other). Explain: _____                                                                                                         |
| <input type="checkbox"/> | <input type="checkbox"/> | Respiratory (asthma, persistent/chronic cough, abnormal chest x-ray, tuberculosis, or any other lung problems).<br>Explain _____                                     |
| <input type="checkbox"/> | <input type="checkbox"/> | Skin (rash, other). Explain _____                                                                                                                                    |
| <input type="checkbox"/> | <input type="checkbox"/> | Sleep (sleepwalking, recurrent nightmares, other). Explain: _____                                                                                                    |
| <input type="checkbox"/> | <input type="checkbox"/> | Stomach, liver or intestinal (ulcers, jaundice, hernia, colitis, indigestion, etc.).<br>Explain _____                                                                |
| <input type="checkbox"/> | <input type="checkbox"/> | Surgical operations, accidents or injuries in the past 2 years. Explain _____                                                                                        |
| <input type="checkbox"/> | <input type="checkbox"/> | Vascular and blood (anemia; Hepatitis B or C; hemophilia, HIV positive; HBV; migraines, nosebleeds, transfusions, unconsciousness/fainting, other). Explain _____    |

(over)

**Continued explanations of "yes" answers:**

**Other important health information** that the Adult Advisors should know? \_\_\_\_\_

**Contagious diseases:** list dates of exposure and occurrence of the following: Measles, Mumps, Rubella, Chicken Pox, Mononucleosis, Tuberculosis, Pneumonia \_\_\_\_\_

**Dietary needs/restrictions:** \_\_\_\_\_

**General attitude/mood/alertness** (shyness, energy level, cooperation) \_\_\_\_\_

**Immunizations -- list dates of last vaccines:**

Hepatitis \_\_\_\_\_ Influenza \_\_\_\_\_ Tetanus \_\_\_\_\_ MMR (Measles/Mumps/Rubella) \_\_\_\_\_

Was this a second MMR immunization? \_\_\_\_\_

**Medications:**

List all prescriptions/non-prescription medications participant will require during the program, listing dosages, time medications are taken, and sensitivity to them: \_\_\_\_\_

Do you want an adult advisor to collect and dispense medications?  yes  no

**Social habits** (smoking or chewing tobacco, alcohol consumption, illicit drug use) Explain: \_\_\_\_\_

**Insurance information:** Currently covered by insurance: \_\_\_ Yes \_\_\_ No

Insurance Co. \_\_\_\_\_ Policy Number \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Telephone number: \_\_\_\_\_

**Physician information:**

Family Physician or Clinic \_\_\_\_\_ Phone (\_\_\_\_\_) \_\_\_\_\_

Date of last medical examination: \_\_\_\_\_ Is participant under a doctor's care now?  yes  no

**Parent/Guardian information:**

Last Name \_\_\_\_\_ First name \_\_\_\_\_ MI \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Day phone (\_\_\_\_\_) \_\_\_\_\_ Evening phone (\_\_\_\_\_) \_\_\_\_\_

**Alternate contact in case of emergency:**

Name \_\_\_\_\_ Relationship to participant \_\_\_\_\_

Day phone (\_\_\_\_\_) \_\_\_\_\_ Evening phone (\_\_\_\_\_) \_\_\_\_\_

*I understand that failure to provide complete information on this health form could hinder chaperones' and staff's ability to provide adequate care and could result in termination of my son/daughter's participation in this event.*

*I consider his/her health to be:  Excellent  Good  Fair  Poor. I am of the opinion that \_\_\_\_\_ can **safely participate** in this program I further declare that he/she has no physical, mental, or communicable conditions that will interfere with participation in this program.*

I will notify the WI 4-H Youth Development Office of any changes in health or prescriptions between now and departure. I understand my son/daughter will be supervised and that if a serious illness or injury develops, medical and/or hospital care will be given but Wisconsin 4-H and program staff are not responsible in case of accidental injury or illness. I, or the person noted above, will be notified as soon as possible in case of medical emergency while my son/daughter is participating in this program. If a medical emergency arises, I give permission for emergency treatment or surgery as recommended by an attending physician. I agree to cover cost of prescriptions and emergency transportation to medical facilities or home, if necessary.

**Signature of Parent/Guardian** \_\_\_\_\_ **Date** \_\_\_\_\_

**Submit this second completed original form to  
your State/Provincial Coordinator  
by Sept. 2, 2008 for your chaperone's use during travel.**

# 2008 NATIONAL 4-H DAIRY CONFERENCE REGISTRATION AND LODGING RESERVATION FORM

Note: delegates must be at least 15 but not more than 18 as of January 1, 2008; chaperone must be at least 21 at Conference.  
Delegates: Complete this form and return it to the Contact Person for your State or Province.  
Please TYPE OR PRINT CLEARLY. The address you provide will be printed in the conference roster.

|                                                                                                                                                                   |                   |                 |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------|-----------------|
| Last Name                                                                                                                                                         | First Name        |                 |
| Nickname for Nametag (if different from above)                                                                                                                    | E-mail address    |                 |
| Address (Street/Rural Route/Box Number)                                                                                                                           |                   |                 |
| City<br>( )                                                                                                                                                       | State/Province    | Zip/Postal Code |
| Daytime Telephone                                                                                                                                                 | Best time to call |                 |
| T-shirt size ( <i>subject to availability</i> ): ___ sm ___ med ___ lg ___ XL ___ 2X ___ 3X                                                                       |                   |                 |
| Ethnic Code (check one): ___ Hispanic ___ Non-Hispanic                                                                                                            |                   |                 |
| Race Code (check all that apply): ___ American Indian/Alaskan Native ___ Asian ___ Black/African American<br>___ Native Hawaiian/Other Pacific Islander ___ White |                   |                 |
| Roommate Preference: _____                                                                                                                                        |                   |                 |
| (If no preference is indicated, a roommate will be randomly assigned.)                                                                                            |                   |                 |
|                                                                                                                                                                   | Last Name         | First Name      |
| Adult: <input type="checkbox"/> Chaperone ___ Planning Committee ___ female ___ male                                                                              |                   |                 |
| Youth Delegate: Birth date _____ ___ female ___ male                                                                                                              |                   |                 |
| Chaperone's name _____ from _____ state/province.                                                                                                                 |                   |                 |

**ARRIVAL INFORMATION-** I will travel by:

\_\_\_ van or car \_\_\_ charter bus \_\_\_ Greyhound \_\_\_ bus from Chicago \_\_\_ bus from Milwaukee \_\_\_ airline to Madison  
Arrival at Lowell Hall: \_\_\_ Saturday, Sept. 27 \_\_\_ Sunday, Sept. 28 Time of Arrival: \_\_\_\_\_  a.m.  p.m.

**DEPARTURE INFORMATION:**

Departure from Lowell Hall: \_\_\_ Thursday, October 1 \_\_\_ Friday, October 2 \_\_\_ other: \_\_\_\_\_  
Approximate Time of Departure: \_\_\_\_\_  a.m.  p.m. Airline: \_\_\_\_\_ Flight Number: \_\_\_\_\_

**SEMINAR PREFERENCE:** Please refer to the Delegate and Chaperone Registration Materials and Handbook for seminar descriptions. Rank in order of your preference (1 being first choice and 7 being last choice).

- \_\_\_\_\_ A. "How to Artificially Inseminate Dairy Cattle"
- \_\_\_\_\_ B. "Dairy Foods Evaluation"
- \_\_\_\_\_ C. "Marketing Dairy Products"
- \_\_\_\_\_ D. "Trek in Biotech"
- \_\_\_\_\_ E. "Roaming through the Rumen"
- \_\_\_\_\_ F. "Developing a Comprehensive Dairy Herd Mating Strategy"
- \_\_\_\_\_ G. "Forages: Making Food from the Sun"

**LEADERSHIP TEAM PREFERENCE:** Please refer to the Delegate and Chaperone Registration Materials and Handbook for committee descriptions. Rank in order of your preference (1 being first choice and 8 being last choice).

- |                             |                                         |
|-----------------------------|-----------------------------------------|
| _____ 1. Recreation/Fitness | _____ 4. News and Weather Reports       |
| _____ 2. Hospitality        | _____ 5. Head Table                     |
| _____ 3. Transportation     | _____ 6. Sponsor Appreciation           |
|                             | _____ 7. Dairy Cattle Linear Evaluation |

**TOUR OPTION:**

I am interested in attending the tour of a goat farm on Tuesday afternoon Yes \_\_\_\_\_ No \_\_\_\_\_  
(Delegates will be assigned on a first-come, first-serve basis. Due to travel time, this tour if is offered as an alternate option to both oppositely scheduled tours: the replacement heifer farm and the organic dairy farm tours.)

**Deadline:** \_\_\_\_\_

**To:** \_\_\_\_\_

**(Coordinator: register delegates on-line between July 10-Aug. 22, 2008)**