

4-H ON THE WILD SIDE ADULT STAFF APPLICATION

WEEKEND 1—MAY 31-JUNE 1, 2008 WEEKEND 2—JUNE 7-8, 2008

Name _____ Phone _____
Address _____ City _____ Zip _____
Position _____ Male _____ Female _____

Ethnicity: White African American Hispanic Indian/Eskimo Asian

I am currently registered as a 4-H Leader: Yes No

4-H Club Name _____ Other Affiliation _____

List past experience you have had with children or camping:

What strengths and skills would you bring to the 4-H On the Wild Side Camp staff?

I am interested in being an adult staff at 4-H On the Wild Side Camp because:

I have read and understand the conditions of participation in the **SACRAMENTO COUNTY 4-H ON THE WILD SIDE CAMP** and I am signing below as an indication of my intent to participate.

Applicant's Signature _____ Date _____

Please be sure to fill out all pages of this application, including the Medical Treatment Form (2 pages).

Send this completed application to: **SACRAMENTO 4-H OFFICE
4145 BRANCH CENTER ROAD
SACRAMENTO, CA 95827-3898**

MEDICAL TREATMENT FORM - ADULT University of California 4-H Youth Development Program

Name: _____ County: SACRAMENTO

Event: 4-H ON THE WILD SIDE CAMP Site: NORTHERN CALIFORNIA

County/State: SACRAMENTO, CA Dates: 03/08/08 to 06/30/08

I hereby certify that I am in good health and can travel to and participate in this 4-H function.

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, medial 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 under the provisions of the Dental Practices Act, California Business and Professions Code section 1600 et seq.

AUTHORIZATION AND CONSENT

_____ In the event of an emergency,
DATE SIGNATURE

please contact the following person: _____

ADDRESS: _____
MAILING ADDRESS CITY ZIP CODE

DAY PHONE: (____) _____ NIGHT PHONE: (____) _____

NON-CONSENT

I do not desire to sign this authorization and understand that this will prohibit my receiving any medical attention in the event of illness or accident.

_____ DATE SIGNATURE

PLEASE COMPLETE THE HEALTH HISTORY INFORMATION ON REVERSE SIDE.

University policy and the State of California Information Practices Act of 1977 requires the following information be provided when collecting personal information from you about your child: 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 the signature line above. Failure to provide the medical information and authorization may result in our inability to provide needed 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 at the Division of Agriculture and Natural Resources, 4-H, DANR, North Central Region, University of California, Davis, California, 95616. Only your own/your child's records are open to your review. Any known or foreseeable intergovernmental transfer which may be made of the information is as follows: None.

