



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

Birthday: \_\_\_\_\_

## Camper/Parent Authorizations – CrossWoods Adventure Camp, Inc.

**\*PLEASE REMEMBER TO INCLUDE A COPY OF YOUR HEALTH INSURANCE CARD WITH THIS COMPLETED PACKET**

### Section A: Camper Authorization

- I understand and agree to cooperate with all regulations regarding behavior, health, special qualifications and age.
- I authorize an adult, in whose care I have been entrusted, to consent to X-ray examination, anesthetic, medical, surgical or dental diagnosis and treatment or hospital care, to be rendered to me under the general or specific supervision and on the advice of any physician or dentist licensed under the provisions of the Medical Practice Act. If I am not a minor, I will be liable and agree to pay all costs and expenses incurred in connection with such medical and dental services rendered to me pursuant to this authorization.
- I understand the general guidelines of behavior: I must respect and obey instructions of the adult(s) in charge and that no smoking, alcohol, illegal drugs, possession of weapons, or sexual misconduct is tolerated. I will assume all transportation costs if problems occur during any event or activity.
- I will take no civil action against the CrossWoods staff, any associated agencies, or persons in whose care I have been entrusted, for my normal care.
- I give my permission for photographs or video footage of me to be used by CrossWoods, for promotional purposes, unless I initial here \_\_\_\_\_ (*initialing means you do NOT give permission*).
- I give my permission for my address/phone number/email address to be included on a participant roster of the camp for use of campers and staff only, unless I initial here \_\_\_\_\_ (*initialing means you do NOT give permission*).

\_\_\_\_\_  
Signature of Camper

\_\_\_\_\_  
Printed Name of Camper

\_\_\_\_\_  
Date

### Section B: Parent/Guardian Authorization and Authorized Rides (Must be signed by the camper's parent/guardian if the camper is under the age of 18 on the first day of camp)

- I give full permission to this minor to attend the youth event at CrossWoods Camp.
- I give full permission to this minor to participate in all activities at CrossWoods Camp, unless otherwise specified on the Health History Form.
- I authorize an adult, in whose care the minor has been entrusted, to consent to X-ray examination, anesthetic, medical, surgical or dental diagnosis and treatment or hospital care, to be rendered to the minor under the general or specific supervision and on the advice of any physician or dentist licensed under the provisions of the Medical Practice Act, if there is insufficient time or inability to contact me. I will be liable and agree to pay all costs and expenses incurred in connection with such medical and dental services rendered to the above named minor pursuant to this authorization.
- I give permission for this minor to ride in any vehicle designated by the adult in whose care the minor has been entrusted while participating in events at CrossWoods Camp.
- I understand the general guidelines of behavior: the minor must respect and obey instructions of the adult(s) in charge and that no smoking, alcohol, illegal drugs, possession of weapons or sexual misconduct is tolerated. I will assume all transportation costs for this minor if problems occur during any event or activity.
- I will take no civil action against CrossWoods staff, any associated agencies, or persons in whose care the minor has been entrusted, for normal care of the minor in their charge.
- I give my permission for photographs or video footage of my child to be used by CrossWoods, for promotional purposes, unless I initial here \_\_\_\_\_ (*initialing means you do NOT give permission*).
- I give my permission for my child's address/phone number to be included on a participant roster of the camp for use of campers and staff only, unless I initial here \_\_\_\_\_ (*initialing means you do NOT give permission*).
- I have also read and consent to all the items printed in Section A of this form.

**Authorized Rides: Please check one or more of the following boxes as appropriate.**

☐ Only the following people may pick up the above named camper: \_\_\_\_\_

☐ The following people may NOT pick up the above named camper: \_\_\_\_\_

☐ By checking this box I am authorizing anyone to pick up the above named camper.

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

\_\_\_\_\_  
Printed Name of Parent/Legal Guardian

\_\_\_\_\_  
Date

### **Section C: Release of Liability and Acknowledgment of Risk**

Having carefully read the policies description above, I agree to abide by the expectations, payment, and benefits stated therein. I understand that CrossWoods likewise agrees to abide by the same. I understand that participating in Adventure Activities at CrossWoods could potentially cause injury. I certify that I am physically and emotionally able to do any activities I choose to participate in. I accept all risks associated with participating in said activities and agree to comply with all the safety rules and instructions provided by CrossWoods. I, my heirs, my personal representative, or anyone entitled to act on my behalf hereby release and discharge CrossWoods, its staff and corporate officers, their agents, representatives and successors from all claims or liabilities of any kind or nature resulting from, or arising out of activities associated with participating in any activities at CrossWoods, even though that liability may arise out of negligence or carelessness on the part of the entities named herein. In addition, I agree to release, forever discharge, and to forever hold harmless CrossWoods, from any and all claims for property damage and expenses of any nature whatsoever which may be incurred by the undersigned (including travel between the undersigned's home and CrossWoods Camp, excursions from CrossWoods Camp, and time spent at CrossWoods Camp. I acknowledge that while staying at CrossWoods, I am free to leave at any time for any reason, and that the camp directors similarly retain the right to terminate my residence at CrossWoods at will. I represent that I am of lawful age and legally competent to execute this statement and that before signing it, I have read and understand its contents completely.

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Signature

Date

Print Name Here

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Signature of Parent if Guest is under 18

Date

Print Name Here

CrossWoods Health History Form
For Campers & Adults

Bring when you register:
This Completed Form
Copy of Insurance Card
Any medications in labeled containers

Camper Name Birth Date / / Age at Camp
Home Mailing Address

Table with 3 columns: Custodial parent/guardian, Second parent/guardian or other contact, If neither available, in an emergency notify. Rows include Name, Home Phone, Work Phone, and Cell Phone.

Insurance Information

Is this camper covered by medical/hospital/health insurance? Yes No
If yes, please attach a photocopy of the front and back of the insurance card. And provide the following:
Insurance Carrier Phone
Group/Policy Number Name of insured

Health History – A parent, legal guardian, physician or nurse practitioner may complete this section.

Physician's Name Phone

This individual is under the care of a physician for the following:

Provide month and year Tetanus booster Hepatitis B Polio
for each immunization. Haemophilus b (HIB) MMR Varicella (Chicken Pox)

This individual has had chicken pox? Yes No This individual has had mononucleosis in the past 12 months? Yes No
This individual has a history of illness, injury or surgery that will affect participation? Yes No

If yes, explain:

Allergies - List all known Describe reaction and management of the reaction:
Medication allergies
Food allergies
Other allergies –include insect stings, hay fever, asthma, animal dander, etc...

DIET: No red meat No pork No eggs No poultry
No seafood No dairy products Other

**Medications:** List **All** medications (*include over the counter/nonprescription*) taken routinely. Bring enough medication for entire camp in original bottle/packaging that identifies prescribing physician (*if prescription*), name of medication, dosage, and frequency. Medications dispensed according to label instructions. If the camper is not taking medication as indicated on the label, get the medication into a container properly labeled by a physician or pharmacist for current dosage. Campers are not allowed to self-medicate, except by necessity (*i.e. inhalers and the like*).

☐ This person takes **NO** medications on a regular basis.      ☐ This person **takes** medications on a regular basis (*include over the counter medications*)

Medication Name \_\_\_\_\_ Dosage \_\_\_\_\_ Taken daily ☐ Yes ☐ No

Reason taking \_\_\_\_\_ Date started \_\_\_\_\_

Medication Name \_\_\_\_\_ Dosage \_\_\_\_\_ Taken daily ☐ Yes ☐ No

Reason taking \_\_\_\_\_ Date started \_\_\_\_\_

Medication Name \_\_\_\_\_ Dosage \_\_\_\_\_ Taken daily ☐ Yes ☐ No

Reason taking \_\_\_\_\_ Date started \_\_\_\_\_

Medication Name \_\_\_\_\_ Dosage \_\_\_\_\_ Taken daily ☐ Yes ☐ No

Reason taking \_\_\_\_\_ Date started \_\_\_\_\_

**- - - List any additional medications on a separate sheet. - - -**

**Ongoing Health Concerns:** Check all that pertain to this individual, and provide information about supportive healthcare.

☐ This individual has no ongoing health concerns

☐ This individual has the following ongoing health concerns

☐ Asthma      ☐ Headaches      ☐ Sleepwalking      ☐ Diabetes      ☐ Frequent ear infections

☐ Bedwetting      ☐ Pregnancy      ☐ Menstrual cramps or related concerns      ☐ Other \_\_\_\_\_

Provide information about supportive health care for each checked item \_\_\_\_\_

If your child receives care/ medication for emotional, learning and/or psychological concerns, provide background information to help us work with this camper \_\_\_\_\_

Person completing this form \_\_\_\_\_ Date \_\_\_\_\_

*Parent Initials*

\_\_\_\_\_ I authorize an adult, in whose care the minor has been entrusted, to consent to X-ray examination, anesthetic, medical, surgical or dental diagnosis and treatment or hospital care for the above named minor. Such care is to be rendered under the general or specific supervision and on the advice of any physician or dentist licensed under the provisions of the Medical Practice Statutes of the State of Wisconsin, if there is insufficient time or inability to contact me. I will be liable and agree to pay all costs and expenses incurred in connection with such medical and dental services rendered pursuant to this authorization.

\_\_\_\_\_ I give permission for this minor to ride in any vehicle designated by the adult in whose care the minor has been entrusted.

\_\_\_\_\_ I will take no civil action against CrossWoods, any associated agencies, or persons in whose care the minor has been entrusted, for normal care of the minor in their charge.

\_\_\_\_\_ I give permission for this minor to receive non-prescription medications for non-emergency situations from a designated health-care provider.

\_\_\_\_\_ If my child has a headache, I usually give them \_\_\_\_\_ (*example: Tylenol, Ibuprofen, etc...*)

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

## Medication Consent Form

Child's Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_  
 Grade Level: \_\_\_\_\_ Teacher/catechist: \_\_\_\_\_  
 Parent(s) Names: \_\_\_\_\_  
 Home Phone: \_\_\_\_\_ Cell: \_\_\_\_\_ Work: \_\_\_\_\_

In the event that your child becomes ill or needs medication provided while at CrossWoods Adventure Camp, Inc. or participating in a CrossWoods Adventure Camp, Inc. event, this consent form needs to be completed and signed by a parent. This includes all prescription medication and all over-the-counter products including pain reliever, cough syrup, cough drops, etc. **Absolutely no medication will be administered to a minor without written medication order from a parent or physician.**

**Prescription Medication:** All prescription medications need to be brought to the appropriate parish staff in a legible pharmacy labeled container with specific instructions for the correct dosage.

**Over-the-Counter (OTC) Products:** Parents must supply the child's over-the-counter products in their original manufacturer's packaging with ingredients and recommended therapeutic dose listed and with their child's name written on it. Minors cannot carry these on their person or in their backpack. These products must be turned in to the CrossWoods Adventure Camp, Inc. camp nurse.

				Contact parent for the following reasons:
Medication Name	Dose	Frequency/Time	Duration	

				Contact parent for the following reasons:
Medication Name	Dose	Frequency/Time	Duration	

Parent/Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_  
 Staff Receiving Form & Medication: \_\_\_\_\_



UW-MADISON EXTENSION

## Wisconsin 4-H Code of Conduct for Members and Participants

The opportunity to participate in 4-H programs is a privilege. Everyone who participates in any 4-H programs are expected to follow these standards. This Code of Conduct applies to all 4-H activities (i.e. in-person, social media, virtual meetings, etc.).

**Participate** - I will do my best to participate in 4-H programs as my abilities allow. I will do my best to meet new friends, try new things, and explore new opportunities and have fun!

**Create a Welcoming Environment for All** - I will help create a safe, inclusive space for learning, sharing and cooperating. I will welcome people from diverse backgrounds, cultures, and perspectives.

**Bring Your Best Self** - I will conduct myself in a manner that reflects honesty, integrity, awareness and self-control. I will accept responsibility for my decisions and actions. I will be open to new ideas, suggestions, and opinions. I will use appropriate language, exhibit good sportsmanship and have empathy for others.

**Follow the Rules** - I will obey federal, state and local laws. I will follow the policies, guidelines and procedures of the University of Wisconsin Division of Extension. I will not possess, offer to others, or use alcohol, illicit drugs, nicotine or any vaping products during any 4-H program. I will not attend 4-H activities under the influence of alcohol or illegal substances. Possession or use of a weapon or look-alike or other item that might cause bodily harm is not allowed unless it is authorized as part of the educational program.

**Honor Diversity** – Mine and Others'. I respect and uphold the rights and dignity of all persons who participate in 4-H programs. I recognize that all people have skills and talents to contribute.

**Create a Safe Environment** - I will keep myself and others safe from harm (verbal, mental, physical, or emotional). I will be kind, considerate and courteous of all persons and their property. I will not insult, harass, or bully others or engage in other hostile behaviors. I will not engage in romantic displays or sexual activities during 4-H activities.

**Be a Team Player** - I will work cooperatively with all individuals involved in 4-H activities. I will accept appropriate guidance from staff and volunteers. I will respect the integrity of the group and the group's decisions. I will be aware that my words and actions have an impact on others. Though I may not always agree with others, I will disagree respectfully and seek mutual understanding.

**Treat Animals Humanely** - Treat animals humanely and provide appropriate animal care.

**Follow the Dress Code** - I will wear clothing that promotes safety and inclusion for all. I will wear clothing that is practical for the activity occurring. I will wear clothing that is free of promoting violence, obscenity, illegal activities, discrimination, or intimidation. When participating in 4-H, I recognize I am representing myself and the organization. Individual programs may have more specific requirements.

**Be a Positive Role Model** - I will act in a mature, responsible manner, recognizing I am a role model for others and am representing both myself and the Wisconsin 4-H Program. I will be responsible for my behavior, use positive and supportive language, and work to Make the Best, Better!

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Violations of the code of conduct may lead to a restorative process focused on repairing the harm done and rebuilding relationships in the community. This process may also include temporary or permanent limits to participation in 4-H.

We have read, understand, and agree to the above.

Member Name (printed) \_\_\_\_\_

Member Signature \_\_\_\_\_ Date \_\_\_\_\_

Parent (Guardian) Name (printed) \_\_\_\_\_

Parent (Guardian) Signature \_\_\_\_\_ Date \_\_\_\_\_

## Agreement for Assumption of Risk and Consent for Emergency Treatment - Minors

I, \_\_\_\_\_ (print name of Parent/Guardian), desire to allow \_\_\_\_\_ (print name of minor child) my minor child/ward to participate voluntarily in the programs conducted by the University of Wisconsin-Madison Division of Extension.

Parent Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_

I UNDERSTAND THAT I AM BEING ASKED TO READ EACH OF THE FOLLOWING PARAGRAPHS CAREFULLY. I UNDERSTAND THAT IF I WISH TO DISCUSS ANY OF THE TERMS CONTAINED IN THIS AGREEMENT, I MAY CONTACT THE WISCONSIN 4-H PROGRAM LEADER AT TELEPHONE NUMBER 608-262-2391.

### **ASSUMPTION OF RISKS:**

I understand that not all risks can be foreseen and there are some risks which are unpredictable. I understand that certain inherent risks cannot be eliminated regardless of the care taken to avoid injuries. Some of these involve food-borne illness or allergens, strenuous exertions of strength using various muscle groups, and exposure to infectious disease. The specific risks vary from one activity to another, but in each activity the risks range from: 1) minor injuries such as scratches, bruises, and cuts, to 2) major injuries and illness such as severe cuts, injuries, allergic reactions, or severe illness, to 3) catastrophic injuries including anaphylaxis, paralysis, and death. I understand that the University of Wisconsin – Madison Division of Extension has advised me to seek the advice of my child/ward's physician before participating in the program. I understand that I have been advised to have health and accident insurance in effect for my child/ward and that no such coverage is provided for me by the University or the State of Wisconsin. **I KNOW, UNDERSTAND, AND APPRECIATE THE RISKS THAT ARE INHERENT IN THE ABOVE-LISTED PROGRAMS AND ACTIVITIES, I HEREBY ASSERT THAT MY CHILD/WARD'S PARTICIPATION IS VOLUNTARY AND THAT I KNOWINGLY ASSUME ALL SUCH RISKS. I FURTHER AGREE TO ASSUME RESPONSIBILITY FOR EXPENSE OF REPAIR OR REPLACEMENT OF UNIVERSITY OF WISCONSIN PROPERTY THAT IS ATTRIBUTABLE TO MY CHILD'S OR WARD'S NEGLIGENT ACTS OR WILLFUL MISCONDUCT.**

Parent Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_

### **HOLD HARMLESS, INDEMNITY AND RELEASE:**

In consideration of permission for my child/ward to voluntarily participate in these activities, I, and on behalf of my spouse, heirs, personal representatives, estate or assigns, agree to hold harmless and release the Board of Regents of the University of Wisconsin System and its officers, employees, agents and volunteers, from and against any and all claims, demands, actions, or causes of action of any sort on account of damage to personal property, or personal injury, or death which may result from my child/ward's participation in the above-listed program, except where such loss arises from the Board's or its officers', employees', agents', or volunteers' gross negligence of willful misconduct. I understand that by agreeing to this clause I am releasing claims and giving up substantial rights, including my right to sue. Furthermore, I, and on behalf of my spouse, heirs, personal representatives, estate or assigns, agree to defend and indemnify the Board of Regents of the University of Wisconsin System and its officers, employees, agents and volunteers from and against any and all claims, demands, actions, or causes of action of any sort arising from damage to personal property, or personal injury, or death where such loss arises from my or my child's/ward's negligent acts or willful misconduct while participating in the above-listed program.

Parent Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_

### **CONSENT FOR EMERGENCY TREATMENT:**

I authorize the University of Wisconsin – Madison Division of Extension and its designated representatives to consent, on my behalf, to any emergency medical/hospital care or treatment to be rendered upon the advice of any licensed physician to my child/ward. **I AGREE TO BE RESPONSIBLE FOR ALL NECESSARY CHARGES INCURRED BY ANY HOSPITALIZATION OR TREATMENT REQUIRED PURSUANT TO THIS AUTHORIZATION.**

Parent Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Final April 24, 2023 (reviewed by UW Madison Risk Management, Office of Legal Affairs, Extension Policy Advisor)



## Extension

UNIVERSITY OF WISCONSIN-MADISON

### Video, Image, Testimonial Consent Form

#### Adult participants:

I recognize and acknowledge that the University of Wisconsin may record my participation and appearance on any recorded medium including, but not limited to video, audio, photos (collectively, “recordings”) for use in any form (including, but not limited to print, websites, blogs, internet, and social media). I authorize such recording and release the University of Wisconsin to use my name, likeness, voice, and biographical material to exhibit or distribute such recordings in whole or in part without restrictions or limitations for any educational or promotional purpose. I further authorize the University to distribute such recording to third parties (e.g., newspapers) and release such third parties to use my name, likeness, voice, and biographical material to exhibit or distribute such recordings in whole or in part without restrictions or limitations for any educational, promotional, editorial, or news reporting purpose.

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Name

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Signature

Date

#### Minor participants:

I recognize and acknowledge that the University of Wisconsin may record my child's participation and appearance on any recorded medium including, but not limited to video, audio, photos (collectively, “recordings”) for use in any form (including, but not limited to print, websites, blogs, internet, and social media). I authorize such recording and release the University of Wisconsin to use my child's name, likeness, voice, and biographical material to exhibit or distribute such recordings in whole or in part without restrictions or limitations for any educational or promotional purpose. I further authorize the University to distribute such recording to third parties (e.g., newspapers) and release such third parties to use my child's name, likeness, voice, and biographical material to exhibit or distribute such recordings in whole or in part without restrictions or limitations for any educational, promotional, editorial, or news reporting purpose.

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Name of minor

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Name of guardian or parent

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Signature

Date