2023 Cooperative Business Teen Conference Registration Form

SUBMIT THIS FORM ALONG WITH PAYMENT TO THE ST. JOHN 4-H OFFICE BY FRIDAY, APRIL 21, 2023

4-H Member Name (First & Last): ______________________________

Mailing Address (City, State, Zip Code): ______________________________

4-H Member Phone Number: ______________________________

Gender: ________ **T-Shirt Size:** ________ **Grade:** ________ **Age:** ______

Will Transportation Need to be Provided **Yes:** ________ **No:** ________

Mother/Guardian Name (First & Last): ______________________________

Phone Number: ______________________________

Father/Guardian Name (First & Last): ______________________________

Phone Number: ______________________________

Emergency Contact Name (First & Last): ______________________________

Phone Number: ______________________________

Emergency Contact Email Address: ______________________________

Registration Fee: $30.00

Submit this form to Mr. Xavier by Friday, April 21, 2023 to guarantee a t-shirt.

Make all checks and money orders payable to: St. John 4-H Foundation

If you would like to use a credit/debit card, please complete the information on the backside

Should you need an ADA accommodation, please contact Xavier Bell, St. John the Baptist 4-H Agent at **985-497-3261** or by email at **XBell@agcenter.lsu.edu**.

The LSU AgCenter and LSU provide equal opportunities in programs and employment

CAMPERS LAST NAME ____________________ CAMPERS FIRST NAME ____________________

RESTRICTIONS

Please list any restrictions for the following.

YES	NO	CONDITION	IF YES, EXPLAIN
		List Any Dietary Restrictions	
		List Any Medical Restrictions	
		List Any Physical Restrictions	
		List Any Other Restrictions	

VACCINATIONS

In pursuant with the rules set forth by Louisiana law (Louisiana Revised 17:170 Sec E) to the Louisiana Department of Education, the Louisiana 4-H Youth Development Program will use LDE's exemption process (with modifications) from immunizations for all 4-H members/volunteers attending 4-H functions where immunization records are required. Although Louisiana has vaccination requirements for children entering daycare or school, these requirements can be waived. The child's parent or guardian may request an exemption in writing for medical or religious/ philosophical reasons. The parent or guardian simply provides their child's name, date of birth and states their decision to exempt their child from the school vaccination requirements, and files this with the 4-H Agent, Camp Director, or 4-H Event Manager. Medical exemptions are completed by the child's healthcare provider. Those requesting an exemption must complete the Louisiana 4-H Form entitled: "Statement of Exemption from Immunization." Please indicate if you have received any of the vaccinations.

Date of last Hepatitis B ____________________

Date of last Tetanus Shot. (Leave blank if not current or unknown.) ____________________

List Any Other Vaccinations

____ YES

____ NO

If yes, provide details

CARE

Please enter your Family Physician's name, address, and telephone number.

Primary Physician Name ____________________

Primary Physician Phone ____________________

Clinic Name ____________________

Clinic Phone ____________________

Clinic Address (Address, City, Zip) ____________________

REMARKS

When completing this section please thoroughly explain any "Yes" items. Please include any ways we can provide support and/or encouragement to assist them while participating. ATTENTION: BY LAW, IF CHILD/MINOR ABUSE IS LISTED/MENTIONED, THE LSU AGCENTER IS MANDATED TO REPORT TO THE DEPARTMENT OF CHILDREN AND FAMILY SERVICES.

YES	NO	CONDITION	IF YES, EXPLAIN
		Does this individual have any health diagnosis that is important for staff to know in order to maximize participation and ensure safety and well-being?	
		Does this individual have a learning disability, emotional or behavioral disorder and/or mental health diagnosis?	
		Does this individual have a physical disability?	
		Any Recent Life Events Affecting Participation	

CAMPERS LAST NAME ______________________ CAMPERS FIRST NAME ______________________

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YES	NO	CONDITION	IF YES, EXPLAIN
		Instructions To Assist In Case Of Emergency	
		Other Issues Not Already Addressed	

HISTORY

Please indicate if you have had any history of the following.

YES	NO	CONDITION	IF YES, EXPLAIN
		Acute Chronic Illness	
		Concussions	
		Prior Activity Restriction	
		Recent Infections	
		Recent Surgeries/Fractures/Hospitalization	

HEALTH INSURANCE

Please fill out the following for insurance and contact information.

Company Name ______________________

Company Address ______________________

Policy Number ______________________

Group Number ______________________

CONDITIONS

Is there past or present history of the following? Please indicate YES or NO on each. Explain any "Yes" items and list any other problems, including the diagnosis, date of injury or illness, hospital, length of hospitalization, name of the doctor, etc. in the box provided. *NOTE: Localized redness/swelling does not constitute insect allergy. Body-wide rash, swelling, and difficulty breathing do constitute insect allergy (anaphylaxis).*

YES	NO	CONDITION	IF YES, EXPLAIN
		Abnormal Menstrual History	
		ADD-ADHD	
		Allergies	
		Appendicitis	
		Arthritis	
		Asthma	
		Back/Joint	

CAMPERS LAST NAME ________________ CAMPERS FIRST NAME ________________

CONDITIONS

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YES	NO	CONDITION	IF YES, EXPLAIN
		Bleeding/Clotting Disorder	
		Chronic Bone/Muscle Or Joint Injuries	
		Diabetes	
		Diarrhea/Constipation	
		Dizziness During Or After Exercise	
		Ear/Sinus Infection	
		Fainting	
		Headaches	
		Head Injury	
		Hernia	
		Hypertension	
		Insect Bites	
		Nervous Disorders	
		Nose Bleeds	
		Sleepwalking	
		Tuberculosis	
		Ulcers	
		Bedwetting	
		Depression	
		Eye, Ear, Nose, & Throat	
		Gall Bladder Problems	
		Mental , Emotional, or Behavioral Disorders	
		Skin Problems	

CAMPERS LAST NAME

CAMPERS FIRST NAME

CONDITIONS

Is there past or present history of the following? Please indicate YES or NO on each. Explain any "Yes" items and list any other problems, including the diagnosis, date of injury or illness, hospital, length of hospitalization, name of the doctor, etc. in the box provided. *NOTE: Localized redness/swelling does not constitute insect allergy. Body-wide rash, swelling, and difficulty breathing do constitute insect allergy (anaphylaxis).*

YES	NO	CONDITION	IF YES, EXPLAIN
		Sleep Problems	
		Stomach Problems	
		Does this individual have any other health-related conditions, including those requiring medication?	
		List any exposure to infectious disease in the two weeks prior to event.	

DEVICES

Please indicate if you use any of the following. Explain any "Yes" items and list any other problems, including the diagnosis, date of injury or illness, hospital, length of hospitalization, name of doctor, etc.

YES	NO	CONDITION	IF YES, EXPLAIN
		Contact Lenses	
		Epi-Pen	
		Glasses	
		Hearing Aid	
		Inhaler	
		List Any Other Devices	

ALLERGIES

Please indicate any allergies.

YES	NO	CONDITION	IF YES, EXPLAIN
		List Any Allergies to Medicines	
		List Any Allergies to Environment	
		Does this individual have any specific dietary needs, food allergies or restrictions (e.g. peanuts, gluten-free), or other health-related conditions, including those requiring medication?	
		Does the individual require any dietary modifcations? If so please explain. Note that dietary modifications require a physician's written instructions to be given to 4-H staff two (2) weeks prior to the event. Dietary requests will not be honored for food preferences, personal taste, or for "picky eaters".	
		List any other allergies not listed	
		List any allergy reactions or treatments not listed above.	

CAMPERS LAST NAME ____________________ CAMPERS FIRST NAME ____________________

AUTHORIZED MEDICATIONS

At times over-the-counter medication(s) need to be administered if approval is indicated by the 4-H member's parent or guardian. Please complete the following section if your child may need any of these over-the-counter medications during his/her stay. NOTE: Unless we have parental authorization, we cannot administer ANY medications. OVER-THE-COUNTER MEDICATION NOTE(S): • Staff reserves the right to use generic equivalents when available for the name-brand over-the-counter medications listed above. • O-T-C Medication may or may not be available at all 4-H events based on location, length of the event, and/or other rules/guidelines. The following over-the-counter, non-prescription, medications may be administered to my child, without contacting me.

YES	NO	MEDICATION
		Acetaminophen (such as Tylenol)
		Allergy Medication
		Aloe Vera Gel
		Antacid (such as Tums or Pepto Bismol)
		Polysporin (topical antibiotics such as Neosporin)
		Antihistamine (such as Benadryl
		Aspirin
		Calamine Lotion
		Cough Syrup
		Decongestant
		Eye Drops
		Ibuprofen (such as Advil)
		Imodium

YES	NO	MEDICATION
		Insect Bite Medication
		Insect Repellant
		Medicated Lip Ointment
		Milk Of Magnesia
		Pepto Bismol
		Robitussin
		Skin Irritation Medication
		Solarcaine
		Sore Throat Lozenges
		Sore Throat Spray
		Swimmers Ear Drops
		Sunscreen

YES	NO	MEDICATION	MEDICATION INSTRUCTIONS
		List Any Other Over the Counter Medications	
		List Any Prescription Medications	

OVERNIGHT MEDICAL RELEASE

I, THE SIGNED PARENT/GUARDIAN/VOLUNTEER BELOW AGREE TO MY CHILD (OR MYSELF) PARITICIPATING IN THIS LOUISIANA 4-H EVENT. I FURTHERMORE, ATEST THAT ALL INFORMATION PROVIDED ON THIS REGISTRATION IS COMPLETE, CORRECT, AND CURRENT ON THE DATE BELOW.

Parent/Guardian/Volunteer Signature ____________________ Date ____________________

St. John the Baptist Cooperative Extension Service
4-H Youth Development
P.O. Box 250
151 East 3rd St.
Edgard, LA 70049
(985) 497-3261
Fax: (985) 497-3409
Website: www.lsuagcenter.com

St. John the Baptist Parish 4-H
Debit/Credit Card Authorization Form

Please complete all fields. You may cancel this authorization at any time by contacting us. This authorization will remain in effect until canceled.

Credit/Debit Card Information
Cardholder Name *(as shown on the card)*:
Card Number:
Expiration Date *(mm/yy)*:
CVV # *(found on the back of the card)*:
Email Address:

Select Payment Option	
	Pay total amount: **$30**

I, ______________________________, authorize St. John the Baptist 4-H to charge my card above for the agreed amount above and acknowledge that I will be charged a 3.5% +15¢ processing fee.

______________________________ ______________
Cardholder Signature Date

A State Partner in the Cooperative Extension System
The LSU Agricultural Center is a statewide campus of the LSU System and provides equal opportunities in programs and employment. Louisiana State University and A. & M. College, Louisiana parish governing bodies, Southern University, and United States Department of Agriculture cooperating.