

Delegate Health Update

To be completed immediately prior to travel

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

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

1. Original health forms were submitted in March with your trip request and Behavior Expectation forms. 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 on your Citizenship Washington Focus trip such as mononucleosis, hepatitis, chicken pox, influenza, etc.?

Yes No

Type of illness _____

3. List all prescriptions and medications you will bring on the CWF trip.

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

Delegate name _____
(print)

Delegate signature _____ Date _____

Parent/Guardian signature _____ Date _____

**Bring this form with you to the boarding site and give it to the Group Coordinator
(only if there has been a change in your health/medication status).**

2008 Citizenship Washington Focus Pre-Departure Brain Busting Prep

In order to be prepared for the CWF experience, you need to be aware of some of the current political issues that are on the state's and the nation's agenda. In addition, you should be prepared to discuss your own thoughts and viewpoints on those issues. Below is a discussion preparation guide that will be helpful to get your mind moving on political events in our state and our nation. Think critically about each question. Then take time to answer each question fully. The chaperones will collect your brain-busting prep on the bus.



1. **The U.S. Electoral College chooses a new President of the United States every four years. In order to win support of the popular vote, the candidates must focus on the major issues such as education, agriculture, health care, Social Security, the Iraq War, terrorism, and the United States' place in a global community. How could a new President's beliefs on these issues and/or others affect you and your family in Wisconsin?**



2. **If you were a U.S. Senator from Wisconsin, what would be the first bill you would bring to the Senate floor? What information would you include in your bill? What suggestions or criticisms might other Senators have of your bill?**



3. **Senator Russ Feingold and Senator Herb Kohl are coming to your town for a listening session. What questions would you raise in order to interest the senators in specific issues in your own community? Prepare two specific questions for the senators.**

Senator Kohl:

- 1.
- 2.

Senator Feingold

- 1.
- 2.

Some websites you may want to investigate for more information are:

<http://www.senate.gov/>

<http://thomas.loc.gov/home/thomas.html>

<http://www.house.gov/>

<http://feingold.senate.gov/>

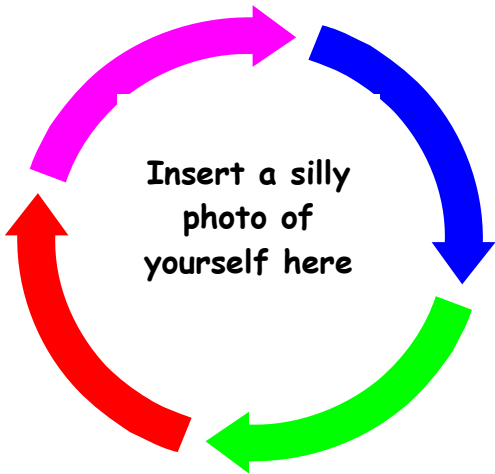
http://www.house.gov/house/Tying_it_all.html

<http://www.senate.gov/~kohl/>

Bring this form with you to the boarding site and give it to the Group Coordinator.

LET'S GET TO KNOW YOU

Hi! My name is _____



Nicknames _____

Hometown _____

4-H Club/County _____

High school _____ Grade _____

Favorite movie _____

Favorite book _____

Favorite childhood toy _____

Birthday/Zodiac sign _____

Hobbies _____

School activities _____

4-H activities/projects _____

Places you have traveled _____

Favorite songs _____

Favorite school subject _____ Least favorite _____

Embarrassing moment _____

Proudest moment _____

Pet peeves _____

Future goals/aspirations _____

What do you want to get out of CWF? _____

Favorite quote _____

Any other info to help us know you better _____

Return to Your Group Coordinator by June 1, 2008

(See roster for name/address)

2008 CITIZENSHIP WASHINGTON FOCUS

HEALTH INFORMATION & CONSENT FOR EMERGENCY TREATMENT

Attach
photo
here
(Write
name on
the back)

This information is confidential and necessary for proper care by staff advisors and medical personnel.

Information must be typed or legibly printed in black ink .

Do not leave empty blanks; enter N/A if not applicable.

Keep this copy to carry with you at all times while on the trip.

Participant Information:

Last Name _____ First name _____ MI _____
 Address _____ City _____ WI Zip _____
 Birth Date _____ Height _____ Weight _____ Female Male
 County _____
 (Name of County Where Your 4-H Office is Located.)

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 _____
How does this person react to the(se) allergy(ies)? _____
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.).
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/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"/> | Learning or attention disorders. 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 (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 x-ray, tuberculosis, other lung problems).
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.).
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 _____ |

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:

List special dietary needs or 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 am of the opinion that _____ can safely participate in this program. I consider his/her health to be: : Excellent Good Fair Poor. 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 an 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 injury or illness. I, or the person noted above, will be notified as soon as possible in case of medical concerns while my son/daughter is participating in this program. If medical care is needed, I give permission for treatment or surgery as recommended by an attending physician. I agree to cover cost of medical care, prescriptions and emergency transportation to medical facilities or home, if necessary.

Signature of Parent/Guardian _____ **Date** _____

**Do not return this copy to the WI 4-H Youth Development Office.
This form must be carried by the delegate throughout the CWF trip.**

2008 CITIZENSHIP WASHINGTON FOCUS HEALTH INFORMATION & CONSENT FOR EMERGENCY TREATMENT

Attach photo here
(write name on the back)

This information is confidential and necessary for proper care by staff advisors and medical personnel.
Information must be typed or legibly printed in black ink .

Do not leave empty blanks; enter N/A if not applicable. Incomplete forms will be returned!

Participant Information:

Last Name _____ First name _____ MI _____
 Address _____ City _____ WI Zip _____
 Birth Date _____ Height _____ Weight _____ Female Male
 County _____
 (Name of County Where Your 4-H Office is Located.)

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 _____ How does this person react to the(se) allergy(ies)? _____ 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.). Explain concern and suggested method of handling it _____
<input type="checkbox"/>	<input type="checkbox"/>	Exposure to a contagious or serious disease recently. Explain _____
<input type="checkbox"/>	<input type="checkbox"/>	Eye or ear (color blindness, peripheral vision, depth perception, near/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"/>	Learning or attention disorders. 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 (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 x-ray, tuberculosis, other lung problems). 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.). 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 _____

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:

List special dietary needs or 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:

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 (_____) _____

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Signature of Parent/Guardian _____ Date _____

You will jeopardize your position in your preferred week if you do not send all forms on time.

Must be postmarked by April 1, 2008 to

WI 4-H Outreach, 431 Lowell Hall, 610 Langdon St., Madison WI 53703



2008 Citizenship Washington Focus MEDIA AND INFORMATION RELEASE

Participant Name: _____

I give to the National 4-H Youth Conference Center and National 4-H Council, 4-H clubs and programs, its nominees, agents, and assigns unlimited permissions to copyright and use, publish, and republish for purposes of advertising, public relations, trade, or any other lawful use, information about me and reproductions of my likeness (photographic or otherwise) and my voice, whether or not related to any affiliation with 4-H, with or without my name. I hereby waive any right that I may have to inspect or approve the copy and/or finished product or products that may be used in connection therewith or the use to which it may be applied.

Participant's Signature: _____ **Date:** _____

Consent of parent or legal guardian if above individual is a minor:

I consent and agree, individually and, as parent or legal guardian of the minor named above, to the foregoing terms and provisions. I hereby warrant that I am of full age and have every right to contract for the minor in the above regard. I state further that I have read the above information release and that I am fully familiar with the contents.

Parent/Guardian's Name: _____ **Relationship:**

Signature: _____ **Date:** _____

Questions? Contact Jeunice Salita-Lim:

Jeunice Salita-Lim
Program Planner
7100 Connecticut Avenue
Chevy Chase, MD 20815
301-961-2892
jsalita@fourhcouncil.edu

**Postmark by April 1, 2008 to
Wisconsin 4-H Outreach, 431 Lowell Hall, 610 Langdon St., Madison WI 53703**

Name: _____
2008 Citizenship Washington Focus

County: _____
Trip Week # _____ (to be completed by the WI 4-H YD Office)

**University of Wisconsin Extension
4-H Youth Development Programs
Expectation Statement for Youth on
UW-Extension Sponsored Trips and Events**

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.

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 chaperone 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.

Note: National 4-H Center also requests that you not burn candles or incense in the Center buildings; not bring pets or animals, except trained guide dogs, to the program; not sell merchandise in public areas or to others outside the group; not bring food into the Center; do wear shoes and shirts inside all buildings at all times; observe quiet hours of 11:00 p.m-7:00 a.m. and that you pay for personal phone calls.

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: _(_____) _____

You will jeopardize your position in your preferred week if you do not send all forms on time.

Must be postmarked by April 1, 2008!

Send to

WI 4-H Outreach, 431 Lowell Hall, 610 Langdon St., Madison WI 53703