



August 10- 14th from 8 a.m. -4 p.m.
New Richmond High School and WITC
Deadline May 30th Limited to First 20!



SUMMER 4-H GATEWAY ACADEMY REGISTRATION FORM

Registrations must be returned to the St. Croix County UW-Extension Office. 1960 8th Ave, Baldwin, WI 54002
There is a \$15 fee for this program, and Space is Limited. Please complete one form per child

Student's Name Boy Girl Birth date / /

Ethnicity: Hispanic Not Hispanic Race: Caucasian Black Asian Native American Bi-Racial

Parent/Guardian Name Home Phone Work Phone

Mother's Cell phone: Father's Cell phone

School attended this past year: Gr. in School: 7th 8th (2008-09 school year) T-shirt Size S M L XL

YOUTH PLEASE READ: I accept the opportunity to participate in the 4-H Gateway Academy at New Richmond High School in New Richmond to develop my interests and skills in science, technology, engineering and math. During the Academy, I will conduct myself in a positive manner to represent myself, my school and my community. I will complete evaluations and activities as requested by the teachers and I understand that my participation in the 4-H Gateway Academy is dependent upon my ability to conduct myself in a responsible manner, to follow the camp and teacher rules and to behave in safe and appropriate ways. Failure to do so may result in dismissal from the Gateway Academy and will require that my parents provide for my transportation home from the 4-H Gateway Academy.

Student signature:

Name of Family Physician: Phone ()

Illnesses and injuries (check those that apply and give appropriate dates)

- Diabetes Hypertension Asthma Asthma medications/inhalers (please describe)
Ear Infection, Strep throat Bleeding/Clotting Disorders
Heart Defect/Disease Seizures

Allergies or medication:

This health history is correct as far as I know, and my son/daughter/ward has my permission to engage in all prescribed activities. In the event of a serious injury or illness, I will be notified. If I cannot be reached in an emergency, I hereby give my permission to the physician to hospitalize, secure proper treatment for and to order injection, anesthesia or surgery for my son/daughter/ward. I also agree not to hold Polk, or St. Croix UW-Extension, Polk, or St. Croix 4-H or the New Richmond School District, or WITC or agents responsible for any personal injury or accident while attending this session.

Media Release (please check one) I grant permission I do not grant permission

I grant the University of Wisconsin Board of Regents, University of Wisconsin Extension, WITC and New Richmond School District and agents unlimited permission to copyright and use, publish, and republish for purposes of advertising, public relations, trade or any other lawful use, information about my child's participation in this program and reproductions (photographic or otherwise) of my child's voice, likeness and any related creative works produced.

I have read all statements above and fully understand the contents. This release and contract shall be binding upon me and my legal representatives.

Signature of Parent/Guardian Print Name Parent/Guardian Date
City State Zip

***IF PARENTS ARE NOT AVAILABLE IN CASE OF EMERGENCY, PLEASE NOTIFY:

NAME: PHONE:

RELATIONSHIP TO CHILD

