UW-MADISON EXTENSION

Winnebago County 4-H Camp

Camp Lakotah – Wautoma - June 14-17, 2026

Get your application in early to reserve a spot at camp!

Date: _____ Camper Name: _____

Address: _____ City, State & Zip: _____

Primary Phone: _____ Additional Phone: _____

Age: _____ Date of Birth: _____/_____/_____ M or F (Circle one) Grade: _____

2025-2026 school year

E-Mail Address: _____

4-H Club Name:_____ **OR** School Name:_____

I give permission for my child(ren) photo to be taken at camp and use in social media and/or publications ___ Yes ___ No

_____ I will drop off and pick up my child at Camp Lakotah N1875 21st Ave, Wautoma

_____ I would like my child to ride the bus to and from Camp Lakotah

Residence (check one):

1. ❑ Farm **2.** ❑ Rural/10,000 **3.** ❑ Town/10,000-50,000 **4.** ❑ Suburbs/50,000> **5.** ❑ City/50,000>

Ethnicity (check one): **1.** ❑ Hispanic **2.** ❑ Not Hispanic

Race (check all that apply): **1.** ❑ White **2.** ❑ Black **3.** ❑ Alaskan/American Indian **4.** ❑ Asian

5. ❑ Hawaiian/Pacific Islander **6.** ❑ Two or more

T-Shirt – ADULT Sizes Only: Small _____ Medium _____ Large _____ X-Large _____ XX-Large _____

Do you have any roommate requests? _____

COST: $100 per camper

Actual cost of camp is $285 per person. The 4-H Leaders' Association provides monies to help reduce costs.

I require an accommodation for a disability to participate in this program. ☐ Yes ☐ No

I would like to discuss financial arrangements with a 4-H Program Educator. ☐ Yes ☐ No

**Archery: I understand that if participating in archery, it may be necessary for the leader to position my child for proper stance and aiming for a safe shooting position. A leader may also need to adjust safety equipment to prevent injury to the archer.*

My child has my permission to attend 2026 4-H Summer Camp at
Camp Lakotah in Wautoma, Sunday, June 14th – Wednesday, June 17th

Parent/Guardian Print: _____ Parent/Guardian Signature: _____

NO REFUNDS after application is received!
Registration Deadline April 1st at 4:30pm
Camp Waitlist begins when we reach 80 campers

Make check payable to: ***UW Extension*** **Winnebago County**
Send payment with completed 4-H Camp Application to:
UW-Extension 4-H Camp, 625 E County Rd Y Suite 600, Oshkosh, WI 54901

For Office Use

Payment Received

Check Number

Youth Expectations Agreement

Dear Parent and Youth:

The **Winnebago County 4-H Summer Camp Program** provides a positive learning experience for youth. Their health, welfare and positive development is our most important consideration. Because youth represent a large number of families from a wide variety of backgrounds and family customs, we want to be sure that we have common expectations.

Parent or guardian and youth are to read and discuss the following expectations:

1. Youth should be responsible and sufficiently mature to conduct themselves at all times in an appropriate manner. Youth are expected to respect the rights of others to hear speakers and others during the programs.
2. Youth are to participate in the scheduled activities related to their staff positions while at the camp experience.
3. Youth will abide by the safety and behavior guidelines of the Winnebago County 4-H Summer Camp program and their school or group.
4. Youth will accept that responsible behavior includes no possession or use of alcohol, tobacco and nonprescription drugs and weapons before, during or after this camp experience.
5. Youth will not leave **Camp Lakotah** without consulting the teacher or leader in charge.
6. Youth will abide by the camp policy that no food/candy, cell phones and radios/music players be brought to camp.
7. Youth will refrain from participating in initiation ceremonies, hazing, harassment, and other behaviors that involve humiliation or embarrassing another person. Such activities will not be tolerated.

I agree to meet these expectations.

_____ _____

Youth Signature Date

I understand and agree with the camp guidelines that my son/daughter/ward has agreed to. If the agreements are broken, I understand that it is my responsibility as a parent to provide transportation home for my son/daughter/ward.

_____ _____

Signature of Parent/Legal Guardian Date

Wisconsin 4-H Camp Health Form

UW–MADISON EXTENSION

Event Name: Winnebago County Summer Camp

Dates: June 14-17,2026

PARTICIPANT'S PERSONAL INFORMATION *(please print)*

FIRST NAME:	MIDDLE INIT.:	LAST NAME:	BIRTHDATE (Mo/Day/Yr.):	SEX:	PRIMARY PHONE NUMBER:

MAILING ADDRESS STREET:	CITY:	STATE:	ZIP:

NAME OF PRIMARY PARENT/LEGAL CUSTODIAN IN CASE OF ILLNESS OR INJURY:	WORK TELEPHONE NUMBER:	CELL PHONE NUMBER:

NAME OF SECOND PARENT/LEGAL CUSTODIAN IN CASE OF ILLNESS OR INJURY:	WORK TELEPHONE NUMBER:	CELL PHONE NUMBER:

PARTICIPANT'S HEALTH CARE PROVIDER INFORMATION

HEALTH CARE PROVIDER NAME:

MEDICAL FACILITY NAME:	TELEPHONE NUMBER:

☐ This participant has no known allergies.

☐ This participant is allergic to this food(s):	■ Does this allergy cause anaphylaxis? ☐ Yes ☐ No
☐ This participant is lactose intolerant.	☐ This participant is gluten intolerant.

☐ Other *(please explain):*

☐ This participant is allergic to medication(s):	☐ Environment (insect stings, hay fever, etc)	☐ Other:

Please describe below what this participant is allergic to and the reaction seen:

MEDICATION

☐ This participant will NOT take any prescription medications while attending camp.

☐ This participant will take the following prescription medication(s) while attending camp. I am bringing enough medication to last the entire session and it is in the original container labeled by the pharmacy. (If more space for medications is needed, staple another page with additional medications to the end of the form.)

Name of Medication	Amount or Dose Given	Reason for Taking It	When It Is Given	How It Is Given	Emergency Medication Only Legal Guardian to initial below if camper is **able to carry and self-administer** (i.e inhaler, epi-pen)
			☐ Breakfast ☐ Lunch ☐ Dinner ☐ Bedtime ☐ Other time: _____		
			☐ Breakfast ☐ Lunch ☐ Dinner ☐ Bedtime ☐ Other time: _____		
			☐ Breakfast ☐ Lunch ☐ Dinner ☐ Bedtime ☐ Other time: _____		
			☐ Breakfast ☐ Lunch ☐ Dinner ☐ Bedtime ☐ Other time: _____		

			☐ Breakfast ☐ Lunch ☐ Dinner ☐ Bedtime ☐ Other time: _____		

MEDICAL INSURANCE INFORMATION:

The participant is covered by family medical/hospital insurance. ☐ Yes ☐ No	
Insurance Company:	Policy Number:
Subscriber:	Insurance Company Phone Number:

ASTHMA

☐ This participant **does NOT** have asthma.	☐ This participant **does** have asthma.

Asthma Triggers (check all that apply)		Signs/Symptoms of asthma episode	Frequency of episodes	How episode is managed
☐ Exercise	☐ Colds			
☐ Infections	☐ Emotions			
☐ Allergies (to what?)				
☐ Weather (what type?)				
☐ Other (list)				

IMMUNIZATIONS

List the MONTH, DAY, AND YEAR your child received each of the following immunizations. DO NOT USE (√) OR (X) except to answer the question about chickenpox, Tdap or Td. If you do not have an immunization record for this child at home, contact your doctor or public health department to obtain it. A copy of the child's complete immunization record from the WIR may be attached to this form http://www.dhfswir.org or from healthcare providers, state, or local government are also acceptable.

TYPE OF VACCINE*	FIRST DOSE Mo/Day/Yr	SECOND DOSE Mo/Day/Yr	THIRD DOSE Mo/Day/Yr	FOURTH DOSE Mo/Day/Yr	FIFTH DOSE Mo/Day/Yr
DTaP/DTP/DT/Td (Diphtheria, Tetanus, Pertussis)					
Adolescent booster (Check appropriate box) ☐ Tdap ☐ Td					
Polio (IPV)					
Hepatitis B					
MMR (Measles, Mumps, Rubella)					
Varicella (Chickenpox) Vaccine Vaccine is needed only if your child has not had Chickenpox disease.			Has your child had Varicella (chickenpox) disease? ☐ Yes, year: ☐ No or Unsure (vaccine needed)		

☐ For health reasons, this child is not fully immunized.
☐ For personal conviction or religious reasons, this child is not fully immunized. **Include any immunizations received above.*

RESTRICTIONS:

☐ I have reviewed the program and activities of the event and feel the participant can participate without restrictions.

☐ I have reviewed the program activities of the event and feel the participant can participate with the following restrictions or adaptations *(Please describe below):*

OTHER CAMPER CONSIDERATIONS

PLEASE INDICATE ANY OTHER IMPORTANT MEDICAL CONDITIONS
(eg. Diabetes; seizures; physical conditions; non-prescription medications not to be given; mental, emotional, or social health)

SIGNATURE

This health history is correct and accurately reflects the health status of the participant. The person described has permission to participate in all event activities except as noted by me or an examining physician. I give permission to the event to provide routine healthcare services, administer medications, and seek emergency services.

SIGNATURE – Parent/Guardian/Legal Custodian _____ DATE _____

CONSENT FOR MEDICATION ADMINISTRATION AND MEDICAL TREATMENT

TO THE PARENT(S) OR LEGAL GUARDIAN:

If your son, daughter, or ward will be under the age of 18 while participating in a University of Wisconsin – Madison Division of Extension event/camp/program, it is event/camp/program policy to secure your consent for medication distribution and for the use of medical devices. The medication or medical device must be administered by designated event/camp/program health staff with the exception that a limited amount of medication for life-threatening conditions may be carried and administered by my son/daughter/ward (i.e. bee sting kit, inhaler, insulin syringe).

It is event/camp policy to secure your consent for medication distribution and for the use of medical devices by signing below.
Please check all that apply:

Yes	No		
☐	☐	Over-the-counter medication(s) has been brought to event/camp.	
☐	☐	Prescription medication(s) has been brought to event/camp. All prescription medication must be in the original medicine bottle and labeled with the youth participant's name, doctor's name, medication name, dosage, prescription number, date prescribed, and instructions. Also, information about any prescription medications must be provided in writing to event/camp health staff with the information requested in the later section of this form.	
☐	☐	Over-the-counter medications may be administered by event/camp health staff as needed. The following over-the-counter medications may NOT be administered by event/camp health staff:	

If your son, daughter, or ward will be under the age of 18 years while at the event/camp, it is our policy to secure your consent for **all of the following**. By signing below,

- I am giving my consent in advance for medical treatment at an appropriate medical facility in case of illness or injury.
- I am stating that I am aware of and accept the risk inherent in the program activity.
- I attest that all information on this form is correct and up-to-date, and that I will provide any and all significant material, and important changes to any information in this form to event/camp staff no later than check-in.

Participant Name (Please Print)

SIGNATURE OF PARENT OR LEGAL GUARDIAN **Date**

This is the approved health form for 4-H events and camps.