



Atlantic INTERMEDIATE Member Conference—Application Form
March 23-25, 2018—Debert, NS

General Information. Please print clearly...

Member Name:		Male <input type="checkbox"/> Female <input type="checkbox"/>								
Club:	Province:									
Parent/Guardian Name:										
Primary Ph:	Secondary Ph:									
Mailing Address:										
Email Address:										
<p>Members ages 12-15 (as of January 1, 2018) are eligible to attend this year's Conference.</p> <p>I will be _____ years of age, as of January 1, 2018.</p>										
<p>I am currently filling, have filled or would be interested in learning more about the following Executive Roles:</p> <table style="width:100%; border:none;"> <tr> <td align="center">_____</td> <td align="center">President/Vice-President</td> <td align="center">_____</td> <td align="center">Secretary</td> </tr> <tr> <td align="center">_____</td> <td align="center">Treasurer</td> <td align="center">_____</td> <td align="center">Reporter</td> </tr> </table>			_____	President/Vice-President	_____	Secretary	_____	Treasurer	_____	Reporter
_____	President/Vice-President	_____	Secretary							
_____	Treasurer	_____	Reporter							

Make sure the following items are included with your Application and sent to your Provincial Office:
 ___ Application Form ___ Health Form ___ Conduct Form ___ Registration Fee (Nova Scotia \$125)

Deadline for Receipt: 4:30 pm, Friday, February 9, 2018
Absolutely no late applications will be accepted. A maximum of 80 Atlantic 4-H members will be accepted.
Confirmation of acceptance will be communicated on or before February 16, 2018.

4-H Nova Scotia
 60 Research Drive
 Bible Hill, NS
 B6L 2R2

4-H New Brunswick
 267 Connell Street,
 Unit 5
 Woodstock, NB
 E7M 1L2

4-H PEI
 PO Box 2000
 Charlottetown, PEI
 C1A 7N8

4-H Newfoundland & Labrador
 Box 50
 Calvert, NL
 A0A 1N0

The Canadian 4-H Councils and your Provincial 4-H Council protects your personal information by adhering to all legislative requirements with respect to privacy. We use your information to provide services, to keep you informed about 4-H activities, for statistical and research purposes, to satisfy government and regulatory

***ATLANTIC 4-H PROGRAM
PARTICIPANT CONDUCT FORM***

Attention Intermediate Member Applicants:

Please ensure you share the information on this page your parent(s) or guardian(s). We require your signature as well the signature of your parent or guardian on the bottom of this form.

The Atlantic 4-H Program requires 100% cooperation and participation from all participants. There are few rules for the programs but the ones that we have are necessary to ensure that everyone can achieve the maximum benefits of the program and be safe.

Rules

1. 4-H programs require 100% cooperation and participation from all participants.
2. Possession or use of alcoholic beverages and/or non-prescription drugs is not permitted: If found, authorities will be contacted, parents/guardians will be informed and participants will be sent home at their own expense.
3. Participants are asked not to smoke during the 4-H program.
4. No intermediate member participant may leave the program site without the permission of a staff member. This will be strictly adhered to.
5. Vandalism of any form will not be tolerated. Any damage costs will be charged to the member and his/her parents.
6. Indecent language of any form will not be tolerated.
7. All participants must complete and submit a Health Information form and this Conduct form.

NOTE: Those who do not adhere to the rules may forfeit the privileges of the program. Should this happen, your parent(s) or guardian(s) will be asked escort you home, at their own expense.

I _____ (*participant's name*) of the _____
4-H Club understand and will adhere to the rules outlined for this 4-H program.

(*participant signature*)

(*parent/guardian signature*)

(*date*)

(*date*)

ATLANTIC 4-H PROGRAM

HEALTH INFORMATION FORM

This form is to be signed and completed and returned with the Participant's Conduct Form and registration fee. Accurate and complete information is essential. These forms are confidential and will be available only to 4-H staff and a physician, if necessary. For members under the age of 18, the parent or guardian is assuming full responsibility for the participant's health being such that the program activities will in no way aggravate any condition present. This program may be of a strenuous nature both physically and mentally.

Name of Participant _____
(surname) (first)

Mailing Address _____ Postal Code _____

Primary Phone _____ Alternate Phone: _____

Date of Birth: _____

In Emergency Notify _____ Relationship _____

Address _____

Primary Phone _____ Alternate Phone _____

Doctor's Name _____ Phone _____

Health Card Number (Not S.I.N.) _____ Expiry Date _____

Other Hospital Insurance _____

PERSONAL HEALTH RECORD

Please check any of the following conditions which the participant is subject to:

- | | | | |
|--|---|--|--|
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Skin Condition | <input type="checkbox"/> Frequent Colds | <input type="checkbox"/> Rheumatism |
| <input type="checkbox"/> Tonsillitis | (contagious or not, specify) | <input type="checkbox"/> Ear Trouble | <input type="checkbox"/> Hysteria |
| <input type="checkbox"/> Sinis Trouble | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Kidney Trouble | <input type="checkbox"/> Nightmares |
| <input type="checkbox"/> Bronchitis | <input type="checkbox"/> Eye Trouble | <input type="checkbox"/> Motion Sickness | <input type="checkbox"/> Sleep Walking |
| <input type="checkbox"/> Convulsions | <input type="checkbox"/> Boils | <input type="checkbox"/> Fainting | |

Please give details of usual treatment should said condition occur:

Other medical concerns (e.g. Diabetes) of which the program staff should be made aware?
(Specify - give details of medication necessary.)

- | | | | |
|--|----------------------------------|---------------------------------|----------------------------------|
| <input type="checkbox"/> Foods | <input type="checkbox"/> dusts | <input type="checkbox"/> Plants | <input type="checkbox"/> Pollens |
| <input type="checkbox"/> Insect stings | <input type="checkbox"/> Animals | <input type="checkbox"/> Drugs | <input type="checkbox"/> Other |

Specify: _____
Signs/Symptoms: _____
Treatment: _____

Check any of the following illnesses which the participant has had:

Any illness or disability not included on this list: _____

<input type="checkbox"/> Appendicitis	<input type="checkbox"/> Jaundice	<input type="checkbox"/> Pleurisy	<input type="checkbox"/> Scarlet Fever
<input type="checkbox"/> Chicken Pox	<input type="checkbox"/> Measles	<input type="checkbox"/> Pneumonia	<input type="checkbox"/> Tuberculosis
<input type="checkbox"/> German Measles	<input type="checkbox"/> Mumps	<input type="checkbox"/> Pneumatic Fever	<input type="checkbox"/> Whooping Cough

Recent operations and injuries (give dates and nature): _____

Precautions that have been advised: _____

Date of last tetanus immunization: _____

The program may include rigorous activities. Does the applicant suffer from any physical or emotional disorders that would prevent full participation in this program? Yes No
(if yes, state particulars) _____

Is the participant currently taking medication? Yes No

Name of Drug: _____ Dosage: _____

Condition for which drug was prescribed: _____

As the parent/guardian of the participant, under circumstances as stated below, I hereby authorize the leader in charge of the program to secure such medical advice and treatment as may be deemed necessary for the health and safety of my child or ward, _____, and I agree to accept financial responsibility in excess of the benefits allowed by the Provincial Health Plan:

1. Where the health and well-being of the participant is involved.
2. Where medical advice has been such that further services are required - services which require the consent of parent/guardian.
3. Where all attempts to contact the parent/guardian have failed, or where due to the nature of the emergency there is insufficient time to contact such parent/guardian, it will be at the discretion of the leader in charge of the program to decide what steps must be taken for the welfare and safety of the delegate.

(Date)

(Signature of Parent/Guardian)

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