



# **GROWING LEADERS FROM THE GROUND UP**

## **SOUTHEAST DISTRICT 8 COUNTY CAMP JULY 10-12, 2026**

### **LAKEVIEW METHODIST CONFERENCE CENTER PALESTINE, TEXAS**

**OPEN TO ALL 4-H MEMBERS  
3RD-12TH GRADE  
OPTION FOR 10TH-12TH GRADERS TO BE  
TEEN LEADERS**

**REGISTRATION DEADLINE  
MAY 15, 2026**



# *Southwest District 8*

## *4-H County Camp*

Bell, Bosque, Comanche, Coryell, Ellis, Erath, Falls, Freestone, Hill, Johnson, Leon, Limestone, McLennan, Milam, Navarro, Robertson, and Williamson Counties...

Open to ALL District 8 Counties

### COST

\$185 FOR CAMPERS & TEEN LEADERS

\$135 FOR ADULT CHAPERONES

(CHECK WITH YOUR COUNTY EXTENSION AGENT FOR YOUR LOCAL COST!)

INCLUDES: MEALS, LODGING, SNACKS, AND T-SHIRT

### CAMP SCHEDULE

- **FRIDAY, JULY 10th - Arrival time TBD!!**
- **SATURDAY, JULY 11TH - Camp activities, water relays, dance, and MORE!!!**
- **SUNDAY, JULY 12TH - Camp wrap-up & Departure at 10:00 am!**

SEE ATTACHED REGISTRATION FORMS. THERE ARE SEPERATE FORMS FOR CAMPERS, TEEN LEADERS, AND ADULT VOLUNTEERS

# REGISTRATION INFORMATION

## CAMPER FORMS

**NAME** \_\_\_\_\_

**CIRCLE: MALE OR FEMALE**

**COUNTY** \_\_\_\_\_

**GRADE** \_\_\_\_\_ **AGE** \_\_\_\_\_

**SHIRT SIZE (CIRCLE ONE):**

**YOUTH: SMALL MEDIUM LARGE**

**ADULT: SM M L XL 2XL 3XL**

**\*\*ALL FORMS MUST BE FILLED OUT - WAIVER, HEALTH AND SAFETY STATEMENT, OTC FORM, SAP FORM (IF YOUR CHILD IS UNDER THE AGE OF 15 PLEASE PUT N/A), ADM FORM**

**\*\*ANY MISSING FORMS WILL BE REQUIRED TO BE TURNED IN PRIOR TO CAMP!**

## 2025-2026 TEXAS 4-H YOUTH DEVELOPMENT PROGRAM

### 2026 SOUTHEAST DISTRICT 8 COUNTY CAMP

#### WAIVER, INDEMNIFICATION, AND MEDICAL TREATMENT AUTHORIZATION FORM

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**1. EXCULPATORY CLAUSE.** *In consideration for receiving permission to participate in any and all activities of Texas 4-H ("activity"), which is sponsored by Texas A&M AgriLife Extension Service and Texas 4-H Youth Development Program, ("sponsor"), a member of The Texas A&M University System, I hereby release, waive, covenant not to sue, and agree to hold harmless for any and all purposes sponsor, The Texas A&M University System, the Board of Regents for The Texas A&M University System, and their members, officers, agents, volunteers, or employees ("RELEASEES" or "INDEMNITEES") from any and all liabilities, claims, demands, injuries (including death), or damages, including court costs and attorney's fees and expenses, that may be sustained by me while participating in this activity, while traveling to and from the activity, or while on the premises owned, leased, or controlled by RELEASEES, including injuries sustained as a result of the sole, joint, or concurrent negligence, gross negligence, negligence per se, statutory fault, intentional torts, foreseeable criminal acts of third-parties, or strict liability of RELEASEES.*

**2. INDEMNITY CLAUSE.** I am fully aware that there are inherent risks to myself and others involved with this activity, including but not limited to illness, injury (including death), and damage to personal property, and I choose to voluntarily participate in this activity with full knowledge that the activity may be hazardous to me and my property, and to the person and property of others. I acknowledge there may be physically strenuous activities. I know of no medical reason why I should not participate. **I agree to indemnify and hold harmless INDEMNITEES** from any and all liabilities, claims, demands, injuries (including death), or damages, including court costs and attorney's fees and expenses, which may occur to myself, other participants, and third-persons as a result of my participation and conduct in this activity, **including injuries sustained as a result of the sole, joint, or concurrent negligence, gross negligence, negligence per se, statutory fault, intentional torts, foreseeable criminal acts of third-parties, or strict liability of INDEMNITEES.**

**3. WARNING NOTICE.** Under Texas Law (Chapter 87, Civil Practice and Remedies Code), a farm animal professional or farm owner or lessee is not liable for an injury to or the death of a participant in farm animal activities, including an employee or independent contractor, resulting from the inherent risks of farm animal activities.

**4. NO INSURANCE.** I understand that RELEASEES do not maintain any insurance policy covering any circumstance arising from my participation in this activity or any event related to that participation. As such, I am aware that I should review my personal insurance coverage. Sponsor does not carry general liability insurance to cover claims arising from this activity so it seeks a waiver of claims as additional consideration for the right to participate so sponsor, a governmental unit of the State of Texas, can (a) provide the activity at the lowest possible cost to participants; and (b) provide access to a greater number of participants by expending limited resources on program materials rather than on liability insurance.

**5. BINDS HEIRS.** It is my express intent that this agreement shall bind the members of my family and spouse, if I am alive, and my heirs, assigns and personal representatives, if I am deceased, and shall be governed by the laws of the State of Texas.

**6. MEDICAL AUTHORIZATION, INDEMNITY FOR MEDICAL EXPENSES, and WAIVER.** I understand RELEASEES cannot be expected to control all of the risks associated with this activity and RELEASEES may need to respond to accidents and potential emergency situations. Therefore, I hereby give my consent for any medical treatment that may be required, as determined by a medical professional at the medical facility, during my participation in this activity with the understanding that the cost of any such treatment will be my responsibility. I agree to indemnify and hold harmless INDEMNITEES for any costs incurred to treat me, even if an INDEMNITEE has signed hospital documentation promising to pay for the treatment due to my inability to sign the documentation. I further agree to release, waive, covenant not to sue, and agree to hold harmless for any and all purposes, RELEASEES from any and all liabilities, claims, demands, injuries (including death), or damages, including court costs and attorney's fees and expenses, that may be sustained by me while receiving medical care or in deciding to seek medical care, including while traveling to and from a medical care facility, **including injuries sustained as a result of the sole, joint, or concurrent negligence, negligence per se, gross negligence, statutory fault, intentional torts, foreseeable criminal acts of third-parties, or strict liability of RELEASEES.**

7. NO STRICT RULES OF CONSTRUCTION. In the event of a dispute over the meaning or application of this agreement, it shall be construed fairly and reasonably and neither more strongly for nor against either party.

8. VOLUNTARY SIGNATURE. In signing this agreement I acknowledge and represent that I have read it, understand it, and sign it voluntarily as my own free act and deed; sponsor has not made and I have not relied on any oral representations, statements, or inducements apart from the terms contained in this agreement. I execute this document for full, adequate and complete consideration fully intending to be bound by the same, now and in the future. **For students engaging in extracurricular activities:** I understand I can choose not to sign this document and free myself from its terms and the associated risks of the activity by simply not participating in the activity and choosing some other activity available to me that has a lower level of risk to me. I further understand this is a voluntary, extracurricular activity; therefore it is not required for me to obtain college credits and not participating in this activity will in no way hinder my ability to obtain a degree from the university. **For students going on fieldtrips or other class-related activities:** I understand participation in this class/fieldtrip/activity is not mandatory and I will not be penalized for failing to participate in this activity because an alternative activity exists for which I can receive like credit. While I understand alternative activities are available to me that do not have the risks associated with this activity I still desire to voluntarily engage in this activity.

**SIGNING THIS DOCUMENT INVOLVES THE WAIVER OF VALUABLE LEGAL RIGHTS.  
CONSULT YOUR ATTORNEY BEFORE SIGNING THIS DOCUMENT.**

<b>EMERGENCY CONTACT INFORMATION</b>		
<b>Emergency Contact Name:</b>	_____	
<b>Emergency Contact Number:</b>	_____	
<b>PARTICIPANT INFORMATION - ADULT OR YOUTH</b>		
<b>SIGNED</b> this _____ day of _____, 20 _____	Date	Month Year
<b>Participant Signature:</b>	_____	
<b>Participant Printed Name:</b>	_____	
<b>Participant Date of Birth:</b>	_____	
<b>PARENT OR GUARDIAN INFORMATION</b>		
If the participant above is under age 18, there should be consent by a parent or guardian, as follows:		
<b>Parent or Legal Guardian Signature:</b> (If Participant is under 18 years old)	_____	
<b>Parent or Legal Guardian Printed Name:</b> (If Participant is under 18 years old)	_____	

INSTRUCTIONS: (1) The document should be printed in a font size no smaller than 10-point type. This is 10-point type. This is 12-point type. (2) The formatting/font style (***bolded, underlined, and italicized***) in paragraph nos. 1, 2, & 5 should not be altered by a system member.

# TEXAS 4-H YOUTH DEVELOPMENT FORM HSS - HEALTH AND SAFETY STATEMENT 2025-2026



Revised: 6/2025

Check One:  Youth  Adult  
 County: \_\_\_\_\_ District: \_\_\_\_\_  
 Event: \_\_\_\_\_ Event Dates: \_\_\_\_\_

## Section I. Participant Information

First Name: \_\_\_\_\_ Gender:  Female  Male  
 Last Name: \_\_\_\_\_ Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_ Age: \_\_\_\_  
 Address: \_\_\_\_\_ Name of Physician: \_\_\_\_\_  
 City, State, Zip: \_\_\_\_\_ Physician's Number: \_\_\_\_\_  
 Phone Number: ( ) - Date of last physical exam: \_\_\_\_\_

## Section II. Emergency Contact Information

Contact Name #1: \_\_\_\_\_ Relationship: \_\_\_\_\_ Contact Name #1: \_\_\_\_\_ Relationship: \_\_\_\_\_  
 Phone Numbers: ( ) - ( ) - Phone Numbers: ( ) - ( ) -  
 Address: \_\_\_\_\_ Address: \_\_\_\_\_

## Section III. Health History (Check the appropriate answer; if YES, use space to the right to provide additional information)

Have you had any operations or injuries that impede participation?	<input type="checkbox"/> No	<input type="checkbox"/> Yes	_____
Are there any activities to be limited/discouraged by a physician's advice?	<input type="checkbox"/> No	<input type="checkbox"/> Yes	_____
Have you had or do you currently have any heart problems?	<input type="checkbox"/> No	<input type="checkbox"/> Yes	_____
Do you require any accommodation to participate in scheduled activities?	<input type="checkbox"/> No	<input type="checkbox"/> Yes	_____
Do you have any chronic recurring illness or communicable diseases?	<input type="checkbox"/> No	<input type="checkbox"/> Yes	_____
Are you allergic to any medications, food or food ingredients, insects, or pollens?	<input type="checkbox"/> No	<input type="checkbox"/> Yes	_____
Do you require an inhaler, epinephrine injector, or other item that you keep at all times?	<input type="checkbox"/> No	<input type="checkbox"/> Yes	_____
Do you have a medically prescribed meal plan or dietary restrictions?	<input type="checkbox"/> No	<input type="checkbox"/> Yes	_____
Do you have Epilepsy?	<input type="checkbox"/> No	<input type="checkbox"/> Yes	_____
Do you have Diabetes?	<input type="checkbox"/> No	<input type="checkbox"/> Yes	_____
List any other health related information:	<input type="checkbox"/> No	<input type="checkbox"/> Yes	_____

## Section IV: Medications (ALL medications must be in ORIGINAL container with ORIGINAL LABEL.)

Are there prescribed or over-the-counter medications currently being taken?  No  Yes  
 If yes, please describe: \_\_\_\_\_

## Section V. Insurance Information – Please provide a copy of your insurance card.

Do you carry family medical/hospital insurance?  No  Yes  
 Carrier: \_\_\_\_\_ Policy: \_\_\_\_\_

## Section VI. Release of Participant (If minor) at conclusion of activity/camp/event/program

I/We do hereby authorize release of said minor child to the following person/people: (please list all persons, including parents)  
 \_\_\_\_\_  
 Further, I/We require that said minor child NOT be released to the following person/people:  
 \_\_\_\_\_

## Section VII. Health and Safety Statement Certification

By signing below, I certify that my answers and statements are true and complete to the best of my knowledge and belief. I understand this information is confidential and is to be used only by AgriLife Extension Staff or designated Volunteers for health and safety reasons. I hereby consent to the use of this information for such purposes.

Participant Certification
Printed Name: _____
Signature: _____
Date: _____

Parent/Guardian Certification (only if participant is under the age of 18)
Printed Name: _____
Signature: _____
Date: _____

Programs with multiple dates/sessions. I certify this information is correct.

Date: \_\_\_\_\_ Initial: \_\_\_\_\_ Date: \_\_\_\_\_ Initial: \_\_\_\_\_



## Parent Guardian Authorization, Waiver, & Consent for Over-the-Counter Medication

Over-the-Counter (OTC) Medication may at times need to be administered, if approval is indicated by the youth's parent or guardian. Please complete the following section to save time if your child needs any of these OTC medications during her/his stay. Note: Unless we have parental authorization, we cannot administer ANY medications.

Participant name \_\_\_\_\_ Date of birth \_\_\_\_\_ Age \_\_\_\_\_

County \_\_\_\_\_ District \_\_\_\_\_ Name of Event Attending \_\_\_\_\_

- |  |  |
|--|--|
| <input type="checkbox"/> Ointments for minor wound care, first aid (Antiseptic, anti-itch, anti-sting, antibiotic, sunburn) as directed. | <input type="checkbox"/> Milk of Magnesia, Pepto Bismol, or Mylanta for upset stomach or nausea as directed.     |
| <input type="checkbox"/> Tylenol/Acetaminophen as directed   | <input type="checkbox"/> Calamine lotion for bug bites and poison ivy  |
| <input type="checkbox"/> Ibuprofen as directed   | <input type="checkbox"/> Micatin or anti-fungus treatment as directed for athlete's foot                         |
| <input type="checkbox"/> Kaopectate or Imodium for diarrhea as directed  | <input type="checkbox"/> Visine or other eye drops for minor eye irritation                                      |
| <input type="checkbox"/> Rolaids or Tums for acid reflux, heartburn, or indigestion as directed  | <input type="checkbox"/> Actifed or Sudafed as directed for nasal congestion or allergy relief as directed       |
| <input type="checkbox"/> Benadryl for swelling, hives, allergic reaction, as directed  | <input type="checkbox"/> Throat lozenges and/or spray as directed for sore throat                                |
| <input type="checkbox"/> Medicated powder for skin irritation as directed  | <input type="checkbox"/> Swimmer's ear drops as directed   |
| <input type="checkbox"/> Hydrocortisone ointment as directed for mild skin irritations, poison ivy, and insect bites                     | <input type="checkbox"/> Medicated lip ointment for dry, chapped lips, lip blisters, or canker sores as directed |
| <input type="checkbox"/> Robitussin or other cough syrup as directed   | <input type="checkbox"/> Bug repellent   |
| <input type="checkbox"/> Sunscreen   |  |

Other (list any other approved OTC drugs): \_\_\_\_\_

Program staff reserve the right to use generic equivalents when available for the name brand over-the-counter medications listed above. I understand that such administration will not be done under the supervision of medical personnel. I also agree that any first aid treatment may be given as needed. I understand that these over-the-counter medications are not necessarily kept on hand and available to be administered immediately.

Any condition which is associated with fever, significant inflammation, and/or does not respond to the above outlined treatment will be followed-up by a consultation with the student's parents. Parent/guardian will be contacted if any conditions develop requiring treatment with any of the above over-the-counter medications that are not checked.

I authorize the administration of over-the-counter medications to my child as indicated above. I shall indemnify and hold harmless for any all purposes program staff, The Texas A&M University System, the Board of Regents for the Texas A&M University System, Texas A&M University, Texas A&M AgriLife Extension, the Texas 4-H Youth Development Program and their members, officers, servants, agents, volunteers, or employees (RELEASEES) against any claims that may arise relating to my child being administered the above indicated over-the-counter medications **including injuries sustained as a result of the sole, joint, or concurrent negligence, negligence per se, statutory fault, intentional torts, or strict liability of RELEASEES.**

I/We have legal authority to consent to medical treatment for the participant named above, including the administration of medication at the program hosted by/at Texas A&M AgriLife Extension.

Participant Name: \_\_\_\_\_ Parent/Guardian Name: \_\_\_\_\_

Parent/Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_

## Parent Guardian Authorization, Waiver, & Consent for Self-Administration of Prescription Medication - Participants 14 years of age or older

This portion of the form must be completed fully in order for participants to self-administer required medication. This form must be completed for each camp/program attended by the youth, for all medications, and each time there is a change in dosage or time of administration of a medication. Program Managers reserve the discretion to use this form.

Participant name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_ County: \_\_\_\_\_ District: \_\_\_\_\_

Name of Event Attending: \_\_\_\_\_ Event Date(s): \_\_\_\_\_

- No, my child does not need to take any prescription medication while at the program.  
 Yes, my child will need to take prescription medication while at the program.

All prescription medications, including medications for conditions such as food, drug or insect allergies, diabetes; asthma; or epilepsy may be brought to the program under the condition that the participant can self-manage care and delivery of medication with written authorization to do so at program by a parent/legal guardian. Prescription medication must be in its original container labeled by the pharmacist or prescriber. Label must include the name, address and phone number for pharmacist or prescriber. Containers must hold only the amount required for the time the youth will be attending the program.

Medication Name: \_\_\_\_\_ Dose: \_\_\_\_\_

Specific Directions (i.e. on empty stomach, with water, etc.) \_\_\_\_\_

Time/Frequency of administration: \_\_\_\_\_

Relevant side effects: \_\_\_\_\_

Special Storage Requirements (if any): \_\_\_\_\_

Is the participant capable of self-managed care?  Yes  No

Prescribing Physician: \_\_\_\_\_

Telephone of Physician: \_\_\_\_\_

I authorize and recommend self-medication by my child for the above medication. I also affirm thats/he has been instructed in the proper self-administration of the prescribed medication(s) by her/his attending physician. I agree to indemnify and hold harmless for any and all purposes sponsor, The Texas A&M University System, the Board of Regents for the Texas A&M University System, Texas A&M University, Texas A&M Agrilife Extension, the Texas 4-H Youth Development Program and their members, officers, servants, agents, volunteers, or employees against any claims that may arise relating to my child's self-administration of prescribed medication(s) **including injuries sustained as a result of the sole, joint, or concurrent negligence, negligence per se, statutory fault, intentional torts, or strict liability of RELEASEES.**

Parent/Guardian Name: \_\_\_\_\_

Parent/Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_