# CAMP HIGH HOPES 2017 – RETURNING STAFF APPLICATION

**Full Legal Name:** _______________________________________________

**Home address:** _______________________________________________

_______________________________________________

_______________________________________________

**E-Mail address:** _______________________________________________

**Home Phone:** ________________________ **Cell Phone:** ________________________

**Social Security Number:** ___________________ **Date of Birth:** ________________

**Driver's License - State:** ____ **License #:** ________________ **Class:** ____ **Expiration Date:** _________

**Employer:** _____________________________________ **Position:** ______________________________

**EMERGENCY CONTACTS** (while you're at camp):

Name: _______________________________ Phone: ______________________________

Name: _______________________________ Phone: ______________________________

**Camp High Hopes • P.O. Box 11038 • Syracuse, New York • 13218**
www.camphighhopes.org

*Our mission is to create a safe, fun experience for our campers, and by doing so give them a sense of community, and the opportunity to see what they can do. This in turn nurtures the strength of character they will need to deal with their bleeding disorder and the rest of their lives.*

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**CERTIFIED TRAINING** (First Aid, CPR, etc. - Please attach copies of each certification):

______________________________________________________________________________

______________________________________________________________________________

**Camp Assignment*:**

- 1st Choice: _________________________________________________

- 2nd Choice: _________________________________________________

** Every effort will be made to give you the assignment that you prefer, however you may be asked to take a different assignment.*

Will you be at camp all week? Yes: _____ No: _____

If not, what days can you attend? ____________________________________________________

Will you be **unavoidably late** to Orientation on Saturday? Yes: _____ No: _____

If "Yes" when will you arrive? __________________________________________

Are there any special accommodations (diet, mobility) you need?: _______________________________

______________________________________________________________________________

Shirt Size (check one):

Small: _____ Medium: _____ Large: _____ X-Large: _____ 2X: _____ Other: ________

# CAMP HIGH HOPES 2017 – RETURNING STAFF APPLICATION

**Mandatory Criminal Record & Sex Offender Check**

A.) Have you ever been **arrested** for any crime?

NO: ____ YES: ____ (*If "Yes" you must attach a letter explaining the details.*)

B.) Have you ever been **convicted** of any crime?

NO: ____ YES: ____ (*If "Yes" you must CALL immediately.*)

C.) Have you ever been investigated for any **sex offense** or sex related crime?

NO: ____ YES: ____ (*If "Yes" you must CALL immediately.*)

**(1)** I understand the information on this application is required to verify my eligibility for camp. This information won't be given to others except when required by law; in that event I will be notified. I certify this information is true, and I authorize Camp High Hopes to investigate me as necessary.

**(2)** I understand in asking to be part of camp I will be assigned specific responsibilities and given set rules to follow. I agree to fulfill my responsibilities as assigned, and adhere at all times to the rules set forth in the camp manual as well as the directives of the Camp Directors, the Infirmary Staff, and other supervisors.

**(3)** I give permission for pictures/audios made of myself to publicize camp. No identifying information other than a first name will be used unless I sign a separate release form.

**Signature:** ___________________________________________ **Date:** _________________

**Notes:**

1. *Read everything before you sign and complete the entire application form (in pen).*
2. *Please return your application by June 1st 2017.*
3. *Camp Date: July 30th –Aug 5th 201.*

## CAMP HIGH HOPES 2017 – RETURNING STAFF APPLICATION

**FOR CAMP DIRECTOR USE:**

Criminal Record Check: Date: ________ By: ____________ Via: ________________

Notes: ________________________________________________________________

Sex Offender Registry Check: Date: ________ By: ____________ Via: _______________

Notes: ________________________________________________________________

# CAMP HIGH HOPES 2017 – STAFF MEDICAL FORM

**Name: ________________________________________** **Age: ____________**

**Weight:** _____________ Pounds or Kilograms **Height:** ______ Feet ______ Inches

**Doctor/Health Care Provider: ________________________________________**

**Phone: ______________________________**

**Do you have Hemophilia? Yes: ____ No: ____**

- Hemophilia Type: Factor 8 ____ Factor 9 ____ Other ________
- Hemophilia Severity: Mild: ____ Moderate: ____ Severe: _____

**Do you have von Willebrands? Yes: ____ No: ____**

- von Willebrands Type: 1 _____ 2A _____ 2B _____ 2M _____ 2N _____ 3 _____

Inhibitor: _______ Prophylaxis: _______ Which brand of factor do you use?: ______________________________

Prophylaxis schedule: ____________________________________________________________

**PLEASE NOTE:** You MUST bring your own Factor and Medications to camp. You must bring any braces, supportive wraps, canes or other DME you will need.

**IMMUNIZATIONS:** Please attach a copy of your immunization record if you have one.

Date of last tetanus immunization (*must be within the last 10 years*). Month: __________ Year: __________

***If you have not been fully immunized, you must sign the following statement:**

***I understand and accept the risks of not being fully immunized.***

Signature: ___________________________ Date: ______________

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# CAMP HIGH HOPES 2017 – STAFF MEDICAL FORM

**Have you had?**

CHICKEN POX: Yes ___ No ___ HEPATITIS: Yes ___ No ___ MEASELS: Yes ___ No ____

Do you have any allergies to medicine, insect, food or environmental allergies? __________________

If so please explain: ___________________________________________________________________

Do you receive allergy shots? Yes: _____ No: _____ For: ___________________________________

Do you have any of the following? **(Check all that apply):**

| | | | |
|---|---|---|---|
| Artificial joint: ☐ | Appetite loss: ☐ | Asthma: ☐ | Constipation: ☐ |
| Diabetes: ☐ | Diarrhea: ☐ | Fainting: ☐ | False Teeth: ☐ |
| Fevers: ☐ | Frequent colds: ☐ | Frequent sore throat: ☐ | Glasses/Contacts: ☐ |
| Hay fever: ☐ | Heart Disease: ☐ | Hypertension: ☐ | Kidney disease: ☐ |
| Seizures: ☐ | Sleepwalking: ☐ | Sinus infections: ☐ | Stomach problems: ☐ |
| Sun Sensitivity: ☐ | Swimmer's Ear: ☐ | Tubes in ears: ☐ | Other: ☐ |

Please explain all checked items:

_____________________________________________________________________________________

_____________________________________________________________________________________

_____________________________________________________________________________________

Are you on any medications at present? Yes ____ No ____ If "Yes" please list all medications:

_____________________________________________________________________________________

_____________________________________________________________________________________

_____________________________________________________________________________________

*** You MUST bring at least a 9 day supply of these medications to camp. ALL medication must come with written instructions from your Physician. NY State Health Dept. regulations require all medications to be kept in the Infirmary and to be taken under the supervision of the Camp Infirmary Staff.**

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♦ **OPTIONAL:** If you feel you have a medical condition that may need monitoring at camp, providing the following information will greatly aid the Infirmary Staff in providing for your care needs.

Physical Exam: (Care provider to complete) P: __________ BP: __________

Exam Date: ________________

Skin: ______________________________________________________________________

HEENT: ____________________________________________________________________

Lymph Nodes: _______________________________________________________________

Chest: _____________________________________________________________________

Heart: _____________________________________________________________________

Abdomen: __________________________________________________________________

Neurro: ____________________________________________________________________

Musculoskeletal: _____________________________________________________________

G.U.: ______________________________________________________________________

Other pertinent medical information: ________________________________________________

______________________________________________________________________________

MD Signature (if exam completed): ______________________________________________

Printed name of Health Care Provider: ___________________________________________

Date: ___________________

# CAMP HIGH HOPES 2017 – STAFF MEDICAL FORM

**Agreement/Release:** I will immediately report any injury or illness I have at camp to the Infirmary Staff. I will follow the health and care directions of the Infirmary Staff at all times. If I incur any expense for medical care given me during camp I accept sole responsibility for paying said cost. I expressly agree to waive all claims against Camp High Hopes Inc., Camp Aldersgate and Camp Oswegatchie for any injury or illness arising at or from my time at camp.

*** Bring any insurance cards/proof of coverage you have with you to camp just in case.**

Staff member signature: ______________________________________________ Date: ________________

**This form is confidential and used solely by the Infirmary Staff to meet your medical needs while at camp.**

**If you have questions please call our Health Director, Hope Woodcock-Ross at (607) 222-8412.**

**Notes:**

1. *Read everything before you sign and complete the entire application form (in pen)*
2. *Please return your application no later than June 1, 2017 in the enclosed envelope.*
3. *Camp Date: July 30th –Aug 5th 2017*