STAFF APPLICATION

July 27th - August 3rd, 2019

Please return by May 1st *Please print in pen.*

Full Legal Name: _____

Home address: _____

_____

_____

Social Security Number: _____ Date of Birth: _____

Home Phone: _____

Cell Phone: _____

E-Mail: _____

EMERGENCY CONTACTS (while you're at camp):

Name: _____ Phone: _____

Name: _____ Phone: _____

Driver's License –
State: ____ License #: _____ Class:____ Expiration Date: _____

Employer: _____Position:_____

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

_____

_____

*****Assignment - 1st Choice: _____

*****Assignment - 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?
_____

► Shirt Size (check one): Small: _____ Medium: _____ Large: _____ X-Large: _____
2X: _____ Other: _____

► Sweatshirt Size (check one): Small: _____ Medium: _____ Large: _____
X-Large: _____ 2X: _____ Other: _____

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:
_____

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:_____

1) Read everything before you sign.
2) Complete the entire medical form.
Please return your application by May 15th.

FOR CAMP DIRECTOR USE:

Criminal Record Check:

Date: _____ By: _____ Via: _____

Notes:_____

Sex Offender Registry Check:

Date: _____ By: _____ Via: _____

Notes:_____

CAMP HIGH HOPES 2019 – STAFF MEDICAL FORM

Name: _____ Age: _____

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

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

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

Inhibitor: _____ Prophylaxis: _____ What 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.

Doctor/Health Care Provider : _____ Phone: _____

Do you have any of the following:

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

If yes to any, please explain: _____

_____

Do you have any allergies to medicine, insect, food or environmental allergies? _____ If so please explain.

_____

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

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: _____

Have you had? CHICKEN POX: Yes ___ No ___ HEPATITIS: Yes ___ No ___ MEASELS: Yes ___ No ____

- Weight: _____ Pounds or Kilograms
- Height: _____ Feet _____ Inches

Do you have physical limitations/restrictions from any activities? Yes: ____ No: ____ If "Yes" Please explain:

_____

_____

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.**

♦ **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): _____ Date: _____

Printed name of Health Care Provider: _____

♦ **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.

Please return this form no later than May 1, 2019 in the enclosed envelope.