

Camp Hope[®] 2010

Counselor Application Packet

Camp Dates are July 10-16, 2010

**Please attach
a current
photo of
yourself here.
Thanks!**

DEADLINE: May 10, 2010 (Returning Counselors) and June 1, 2010 (New Counselors)

In 2010, Cell Phones WILL NOT BE ALLOWED AT CAMP

Counselor Fee: \$200
 Check Attached
 Paid On-Line

PERSONAL INFORMATION

Name _____ Name Used: _____
 Gender: Male Female (circle one) Date of Birth _____
 Address _____ Apt. # _____
 City, State, Zip _____ County: _____
 Home Phone: _____ Cell Phone: _____
 Work Phone: _____ E-mail Address _____

Please list children you plan to bring to camp and complete applications for each of them:
(Ages 3 years - 5th grade, use Children of Volunteer application/6th grade - Adult, use Counselor Application)

Name _____ Age _____
 Name _____ Age _____
 Name _____ Age _____

Are you a returning Camp Hope volunteer? Yes No If yes, how many years have you participated: _____

Shirt Size (circle one) Youth Sizes: S M L Adult Sizes: S M L XL XXL

Position for which you are applying (check one):

(Positions are available on a first-come, first-serve basis. Please know that what you select below is tentative and we ask that you be flexible to serve in other areas, if needed. The Application Packet must be completed and notarized to be considered for position.)

- Teen Counselor **CORNERSTONE** Adult Counselor **CORNERSTONE** Cabin Courier (Entering 8th grade)
- Student Counselor **LTA** (18-21 years old) Adult Counselor **LTA** Other _____

**If cabin leader, please complete additional application.*

ADDITIONAL INFORMATION

Church Home _____ Senior Pastor _____
 City, State _____ Church E-mail or Web page _____

Tell us about your involvement in your church: _____

Current School or Employer _____ Grade/Position _____
2009 - 2010 School Year

Professional Licenses/Certifications (attach photo copy) _____

Have you ever been convicted of a criminal offense? Yes No (circle one) If yes, please explain briefly: _____

If you will be using your own car to travel to and from the Rock Eagle 4-H Center, please provide the following:

Make of Vehicle _____ Manufacturer _____ Year _____

Automobile License Plate: Tag # _____ State _____

Automobile Insurance Company _____ Policy # _____

COUNSELOR APPLICATION

HEALTH HISTORY FORM

The information on this form is gathered to assist us in providing a safe and healthy camp experience for all participants. It may be shared with counselors or directors on an as-needed basis. Please also provide a copy of your Health Insurance Card. Health history forms must be filled out by parents/guardians of minors or by adults themselves .

Participant's Name: _____ Birth Date: _____
Last First Middle

Home Address: _____
Street Address Apt. # City State Zip

Custodial Parent/Guardian (if child is a minor): _____ Social Security # of Participant (optional): _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Camp Hope personnel MUST be able to reach a custodial parent during the entire week of camp in the event you/your child needs to come home due to illness, injury or disciplinary reasons.

EMERGENCY CONTACT #1

Name: _____

Home Phone: _____

Cell Phone: _____

Work Phone: _____

EMERGENCY CONTACT #2

Name: _____

Home Phone: _____

Cell Phone: _____

Work Phone: _____

INSURANCE INFORMATION

Is the participant covered by family medical/hospital insurance? Yes No *If Yes, please send a copy of your health insurance card.

Insurance Company: _____ Phone Number: _____

Name of Policy Holder: _____ Policy Number: _____

Social Security # of Policy Holder: _____

CONSENT FOR MEDICAL TREATMENT (MINOR) AND AUTHORIZATION REGARDING MEDICAL INFORMATION

I, _____ (Parent/Guardian's Name) hereby give permission to **kidz2leaders®**, inc., their representatives, agents and employees for any and all medical attention to be administered to my child, _____ (Child's Name), in the event of accident, injury, sickness, or the like. This care may be given under whatever conditions are necessary to preserve the life, limb or well-being of my dependent until such time as I may be contacted. I also assume the responsibility for the payment of any such treatment. This release is effective from Saturday, July 10, 2010 until Friday, July 16, 2010, inclusive. I hereby authorize that medical information contained in this Health History Form critical to the health and well-being of a camper may be shared with the camper's counselor/director. I hereby confirm that I have forwarded to my child's physician the enclosed HIPAA authorization form or have filled out a similar HIPAA authorization form provided by my child's physician and have provided such form to my child's physician.

CONSENT FOR MEDICAL TREATMENT (if adult of legal age) AND AUTHORIZATION REGARDING MEDICAL INFORMATION

I hereby give my consent for emergency medical care for myself as prescribed by a duly licensed Doctor of Medicine or Doctor of Dentistry. This care may be given under whatever conditions are necessary to preserve my life, limb or well-being. I also assume the responsibility for the payment of any such treatment. I hereby authorize that medical information contained in this Health History Form critical to my health and well-being may be shared with my counselor/director. I hereby confirm that I have forwarded to my physician the enclosed HIPAA authorization form or have filled out a similar HIPAA authorization form provided by my physician and have provided such form to my physician.

RELEASE OF LIABILITY

kidz2leaders®, inc. (k2l) d/b/a **Camp Hope®**, the **Leadership Training Academy (LTA)** and **CORNERSTONE** will not assume any liability for any accident of participants in their group while at the Rock Eagle 4-H Center. Utmost caution will be taken at all times to ensure participant's safety. The undersigned releases the Rock Eagle Center and **kidz2leaders®**, inc., their representatives, agents, and employees from liability resulting from the cause whatsoever occurring to a participant during the stay at the center, excepting only willful acts of such representatives, agents, servants and employees. I also certify that the **Health Information Form** is correct and complete to the best of my knowledge, and that the person herein described has permission to engage in all camp activities except as noted. I understand that from time to time, pictures and/or video footage of camp activities, which may or may not include me/my child, will be used by **kidz2leaders®**, inc. in various publications, for, but not limited to, camp advertisements. Further, it is my understanding that my/my child's identity will not be disclosed in said publications. I do hereby acknowledge that I have received and reviewed a copy of the rules and regulations and have shared its contents with my child. I also certify that I am the legal parent or guardian for the child that I am sending to **kidz2leaders®**, inc. .

Signature of Parent/Guardian or Adult Counselor/Staffer _____

Guardian Printed Name _____ Date _____

Notary: Sworn to and subscribed before me this _____ day of _____, 2010.

Name _____ **Notary Public**, State of _____ My commission expires _____

Health History/Allergies (Please check ALL that apply)

- | | | |
|---|--|--|
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Eating Disorders | Allergies:
<input type="checkbox"/> Animal dander
<input type="checkbox"/> Medications _____
<input type="checkbox"/> Bee Sting Allergy
<input type="checkbox"/> Dairy
<input type="checkbox"/> Hay Fever
<input type="checkbox"/> Seasonal allergies
<input type="checkbox"/> Peanuts/Nuts
<input type="checkbox"/> Grasses, hay, etc. _____
<input type="checkbox"/> Other allergies _____ |
| <input type="checkbox"/> Heart Problem(s) | <input type="checkbox"/> GI Digestive Problems | |
| <input type="checkbox"/> HIV/AIDS | <input type="checkbox"/> Headaches | |
| <input type="checkbox"/> Sexually Transmitted Disease | <input type="checkbox"/> Insect Bites | |
| <input type="checkbox"/> Pregnant | <input type="checkbox"/> Other _____ | |
| <input type="checkbox"/> Nose Bleeds | Recent Injuries: | |
| <input type="checkbox"/> Bedwetting | <input type="checkbox"/> _____ | |
| <input type="checkbox"/> Rash, Skin disorders | <input type="checkbox"/> No known illnesses or recent injuries | |
| <input type="checkbox"/> Convulsions/Seizure Disorder | Do you carry an inhaler with you? _____ | |
| <input type="checkbox"/> Sleepwalking | Do you carry an EpiPen® with you? _____ | |
| <input type="checkbox"/> Chicken Pox | | |

Please list any significant medical or surgical history, any hospitalization or doctor visits for an illness in the past year:

ACTIVITIES (Please explain any limitations to activities, reason for restriction and what adaptations or limitations are necessary)

All prescription medications must be turned into the camp nurse upon arrival and be in it's original, labeled container, which tells the camper's name, dose, frequency and duration to be administered at camp.

List any medications routinely taken (especially those taken during school year): _____

Reason for medication (be specific): _____

Other medical information you should know about: _____

Do you experience difficulty managing anger? Yes No Explain: _____

Are your immunizations up to date? Yes No Date of last physical: _____

Name of Physician: _____ Phone: _____

Name of Dentist/Orthodontist: _____ Phone: _____

MEDICATIONS THAT MAY BE ADMINISTERED AT CAMP: The Camp Hope® Clinic stocks the following medications in the event that you/your child should require them. These medications are administered by a health professional under the direction of our Camp Physician. *Please do not bring the following medications to camp with you:*

- | | | | |
|-----------------------|-----------------------------|-------------------------|-------------------------|
| Acetaminophen/Tylenol | Calamine lotion | Hydrocortisone 1% cream | Phenylephrine |
| Aleve | Chlorpheniramine | Ibuprofen | Providine Ointment |
| Anbesol | Chlortrimeton | Immodium | Rid Shampoo |
| Aspirin | Claritin | Kaopectate | Robitussin syrup |
| Aveeno cream/lotion | Cortisporin otic suspension | Lomotil | Rolaids |
| Bacitracin | Debrox/Ear Drops | Maalox | Sudafed |
| Bactroban | Dextromethorphan | Milk of Magnesia | Throat lozenges |
| Benadryl | Dimetapp elixir | Mylanta | Tinactin |
| Benedryl lotion | Dramamine | Nix Shampoo | Triple Antibiotic cream |
| Betadine | Ducolax | Pepto Bismol | Tums |
| Caladryl | Eyewash/Saline | Pepcid | Visine/Visine AC |

Medication Authorization—please check which one you agree to:

- I hereby give permission to Camp Hope® medical personnel to administer any of the above medications per the label instructions by age/weight PRN.
- I hereby give permission to Camp Hope® medical personnel to administer any of the above medications per the label instructions by age/weight PRN with the following exceptions: _____

For office use only (Health Check-In Questions) Screened by _____

Date Screened _____ Time _____ am pm Updates/additions to health history noted Yes No None Required

Meds received _____

List any current health needs identified _____

Observational Notes _____

CONFIDENTIAL INFORMATION

REFERENCES

List at least two persons who know you. **One reference should be your pastor or youth minister.** Other references may include your employer, co-worker, teacher, faculty advisor, etc (**please, NO family members**). Either provide a letter of reference or let the person know that we will be contacting him or her by phone.

Name _____
Phone Number _____
Address _____
City/State/Zip _____

Name _____
Phone Number _____
Address _____
City/State/Zip _____

Please read the following information carefully and acknowledge your agreement by initialing AND signing below:

By making this application, I agree to the terms of this application and the following:

- If I am a first time counselor, I agree to attend one of the required training sessions prior to camp. _____ (INITIAL)
- I agree to have **kidz2leaders® , inc. (k2l)** perform a background check on me (if 18 years of age or over). _____ (INITIAL)
- I agree to conform to all the rules and regulations established by both **k2l, inc.** and the Rock Eagle 4-H Center. _____ (INITIAL)
- **I AGREE TO LEAVE MY CELL PHONE LOCKED IN MY CAR OR LEAVE IT AT HOME AND NOT BRING TO CAMP. IF I USE IT WHILE CAMP IS IN SESSION, I KNOW THAT IT WILL BE GROUNDS FOR DISMISSAL.** _____ (INITIAL)
- I will commit to pray for the children of the camp. _____ (INITIAL)
- I will, at all times, maintain self-control and self-discipline while at camp setting a good example for the campers. _____ (INITIAL)
- I will come with a servant's heart, servant's hands, servant's feet and most importantly, the love of Christ Jesus for these children. _____ (INITIAL)
- I will serve where needed, understanding that the camp's needs take precedent to my personal desires. _____ (INITIAL)

Signature of Counselor: _____

Signature of Parent (*if counselor under 18*): _____

This application packet must be completed on all sides and notarized for it be considered complete

You may pay **ON-LINE** at www.kidz2leaders.org, or

attach a check payable to "Camp Hope" for your counselor fees of \$200.

Please return EVERYTHING to the Camp Hope® office no later than

May 10, 2010 (if returning counselor) or **June 1, 2010** (if new counselor).