KENTUCKY CAMPING MINISTRY

Summer Camp Staff Application 2012

APPLICANT: Complete this application and then give it to your Pastor for his/her endorsement. The Pastor will then mail the application to the appropriate Camp Director or to the Camp Coordinator. If you find that you will not be able to work in summer camp after submitting this application; please contact the appropriate Summer Camp Director and/or Camp Coordinator as soon as possible. All potential summer camp staff applicants will be subject to a criminal background check.

PASTOR: Please complete the endorsement/approval section of this form within five days of reception. All information on this form is to be kept confidential. Please return the form as soon as possible to the appropriate Summer Camp Director and/or Camp Coordinator.
Is this applicant: _____ Saved _____ Sanctified _____ Holy Ghost Baptism _____ Church Member
Does this applicant attend church regularly? ___ Yes ___ No. Does this applicant financially support the local church? ___ Yes ___ No. Does this applicant cooperate with the Pastor and other church leadership? ___ Yes ___ No. Does this applicant exhibit a general positive attitude? ___ Yes ___ No.

I personally recommend this person as a potential camp staff member? ____ Yes ____ No
If "No," please give a brief explanation: ____
____

Pastor's Signature: ______________________________________ Date: ____________________

Last Name: ________________________________ First Name: __________________ M.I. _____

Address: ___________________ City: ___________ State: ___ Zip ______Phone:____________

Age: _____ Sex: _____ Saved: _____ Sanctified: _____ Holy Ghost Baptism: _____ Church Member _____

I attend regularly (local church name): ___________________

In what capacity do you believe that you are best suited and/or qualified? ___ Teacher ___ Guide ___ Dean

___ Recreation ___ Kitchen (Cook) ___ Kitchen (Worker) ___ Program Director ___ Worship Director

___ Evangelist ___ Nurse ___ Lifeguard ___ Security ___ Concession Stand ___ Guide-In-Training

Do you have any previous camp/retreat staff experience? ___ Yes ___ No… If "Yes" what sort of experience (positions) do you have? ____

____

- Are you willing to abide by the rules and policies of Kentucky Camping Ministry? Yes – No
- Are you willing to assume any responsibility you may be placed in? Yes – No
- Are you willing to put the needs of the camper first for the entire week? Yes – No
- Are you physically capable (fit) to participation in all camp programming and activities? Yes – No
- Are you willing to arrive on time for camp and stay the entire week? Yes – No
- Are you willing to attend the Pre-Camp training session? Yes – No
- Are you willing to participate in camp training? Yes – No

I understand that my completion of this application in no way obligates the camp coordinator and/or any camp director to use me as a camp/retreat staff person. I understand that I will be subject to a criminal background check.
Signature: ____ Date: ______________

Which summer camp or camps are you interested in working in (circle one):

___ Jr High/Senior Camp (Ages 11 – 18) June 18 - 23 (Monday-Saturday) Directors - Mike & Dana Estep (michael.estep@powell.kyschools.us or 260 Walnut Lane, Stanton, KY 40380)

___ Junior Camp (Ages 7 – 11) June 24 – June 28 (Sunday – Thursday) Directors - Scott & Sherry Whaley (whaleysherry@yahoo.com or 583 Pamela Drive, Ashland, KY 41102)

Personal Information:

Social Security Number and/or Driver's License Number: ______________________________

Have you ever been convicted of a child related felony? ____ Yes ____ No. If "Yes" please explain:

____

Have you ever been convicted of a crime related to a minor? ____ Yes ____ No. If "Yes" please explain:

____

In case of a personal emergency call: ____________________ Home _______________Cell :__________________

Medical Release:

Health History (check all that applies to you)

___ Epilepsy	___ Asthma	___ Coma	___ Kidney Trouble	___ Other: ________
___ Convulsions	___ Heart Trouble	___ Tuberculosis	___ Rheumatic Fever	__________________
___ Diabetes	___ Sleep Walking	___ Fainting	___ HIV/Aids	__________________

Allergic Reactions:

___ Bee/Wasp Stings ___ Pollens ___ Poison Ivy/Oak/Sumac ___ Penicillin ___ Other drugs (names):

____

Allergies (names): ____

Last Tetanus Shot (date): _________________ Recent Surgery/Illness: ___________________________

Restrictions (Physical): ______________________________ History of Mental Illness: ___ Yes ___ No

Special Diet (Restrictions): ____

- **How would you rate your present physical condition: Poor – Fair – Average – Good – Excellent**
- **I give my permission to receive any over-the-counter medications by the camp nurse. ___ Yes ___ No**
- **In the case of an emergency where I am unable to authorize medical treatment for myself and the above emergency contact person is not available, I authorize the camp nurse to provide emergency first aid and to authorize emergency medical treatment for me.**
- **It is to be understood that all staff members will need to report to camp in "good" physical condition. The camp nurse is authorized to provide emergency medical treatment to camp staff only. It is not the responsibility of Camp Nikao and/or the camp nurse to provide medical treatment for pre-existing and/or chronic medical conditions. Staff members with pre-existing and/or chronic medical conditions which are manifested during camp will be immediately referred to an appropriate medical provider. Under no circumstances are camp nurses allowed to prescribe and/or write medical prescriptions without the direct authorization of a physician.**
- **It is understood by the camp administration that medical information provided is private according to Health Insurance Portability and Accountability Act (HIPPA). I hereby grant permission to camp administration to share pertinent health information with those only who must ensure the heath and safety of the applicant.**

My Doctor's name is: ___________________________________ Phone: ___________________________________

My Medical Insurance Company is: ____

My Medical Insurance I.D. number is: ____

My signature signifies that I have read, understand and agree to abide by the content of this application. I give emergency permission for needed medical treatment and verify that all information provided on this form is accurate and correct.

Signature: ____ Date: ______________

Signature: ____ Date: ______________

(NOTE: If under 18 years of age; a parent/guardian signature <u>is required</u>)