



# 2010 Camp Fire USA Day Camp Staff Application & Service Agreement

RECEIVED:

(For staff over the age of 18 as of the first day of the first session of camp.)

Directions: Complete all sections on both sides of this application.  
Mail completed form to: Day Camp Registrar, 4241 21st Ave W, Suite 200, Seattle, WA 98199

Name \_\_\_\_\_  
Last First Mid. In.

Gender:  Female  Male

Address \_\_\_\_\_

Are you or will you be 18 or older when camp starts?  
 Yes  No

City \_\_\_\_\_ State \_\_\_\_\_ ZIP \_\_\_\_\_

Driver's License # \_\_\_\_\_

Home Phone (\_\_\_\_\_) \_\_\_\_\_

State \_\_\_\_\_ Expiration Date \_\_\_\_\_

Cell/Pgr (\_\_\_\_\_) \_\_\_\_\_ Work Phone (\_\_\_\_\_) \_\_\_\_\_

Best E-mail Address \_\_\_\_\_

Employer \_\_\_\_\_ Occupation \_\_\_\_\_

## LOCAL EMERGENCY CONTACT

Name: \_\_\_\_\_ Home Phone: \_\_\_\_\_ Other Phone: \_\_\_\_\_ Relationship: \_\_\_\_\_

## BASIC HEALTH INFORMATION

Date of last Tetanus: Year \_\_\_\_\_ Current Immunizations (measles, polio, DPT)?  Yes  No

Family Physician \_\_\_\_\_ Phone (\_\_\_\_\_) \_\_\_\_\_

Medical Specialist \_\_\_\_\_ Phone (\_\_\_\_\_) \_\_\_\_\_  
*(for applicable preexisting conditions)*

Medical Insurance Company \_\_\_\_\_ Policy # \_\_\_\_\_

Policy Holder \_\_\_\_\_ Group # \_\_\_\_\_

Have you ever been diagnosed or treated for any of the following?  No

- |                               |  |                                |   |   |   |
|-------------------------------|--|--------------------------------|---|---|---|
| <input type="checkbox"/> ADD  | <input type="checkbox"/> Asthma-Mild   | <input type="checkbox"/> Blind | <input type="checkbox"/> Diabetes             | <input type="checkbox"/> Hearing Impairment | <input type="checkbox"/> Physical impairments or mobility limitations |
| <input type="checkbox"/> ADHD | <input type="checkbox"/> Asthma-Severe | <input type="checkbox"/> Deaf  | <input type="checkbox"/> Epilepsy or Seizures | <input type="checkbox"/> Hyperactive        | <input type="checkbox"/> Speech/Language Impairments                  |

Allergies (list all allergies plus **reaction and treatment**, include over-the-counter medications):

Please list all medications, prescription and over-the-counter, that you currently take regularly

| Name of Medication | Dosage | Purpose | Effect |
|--------------------|--------|---------|--------|
|                    |        |         |        |
|                    |        |         |        |
|                    |        |         |        |

Describe any special needs, chronic illness, recent operations or injuries, health or emotional issues which might affect participation in regular camp activities:

Describe past medical treatment, if any. \_\_\_\_\_

## DEMOGRAPHICS (optional) Completing this information below correctly helps Camp Fire USA seek & receive funding from the community. Camp Fire USA activities are open to all without regard to race, gender, creed, national origin, sexual orientation, economic status, or mental or physical disabilities.

|  |   |  |
|--|---|--|
| Number in Family _____   | Status of Head of Household:                  | Household Income:                            |
| Ethnicity _____  | <input type="checkbox"/> Married (two parent) | <input type="checkbox"/> Under 15,000        |
| Latino/Latina/Hispanic? <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Single Parent        | <input type="checkbox"/> \$15,001-\$25,000   |
|  | <input type="checkbox"/> Partnership          | <input type="checkbox"/> \$25,001-\$35,000   |
|  | <input type="checkbox"/> Guardianship         | <input type="checkbox"/> \$35,001-\$45,000   |
|  | <input type="checkbox"/> Foster Parent        | <input type="checkbox"/> \$45,001-\$55,000   |
|  |   | <input type="checkbox"/> \$55,001-\$75,000   |
|  |   | <input type="checkbox"/> \$75,001-\$100,000  |
|  |   | <input type="checkbox"/> \$100,001-\$150,000 |
|  |   | <input type="checkbox"/> \$150,001-\$200,000 |
|  |   | <input type="checkbox"/> Over \$200,000      |

Immigrant or Refugee from \_\_\_\_\_  
*(country)*

**OVER -- Both sides of form must be completed**



**ENROLLMENT**

Day Camp(s) for which you are applying: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 Grades/Ages with whom you *have* worked: PreK K 1-2 3-5 6-8 Specialist \_\_\_\_\_  
 Grades/Ages with whom you *would like* to work: PreK K 1-2 3-5 6-8 Specialist \_\_\_\_\_  
 I have no **Grade/Age** preference.  
 If an overnight stay is part of the program, I *will* stay overnight with my group. Yes No

*Registrar's Use Only*

ID # \_\_\_\_\_

Reg Date \_\_\_\_\_

Notes \_\_\_\_\_

\_\_\_\_\_

**EXPERIENCE**

Have you worked at Day Camp before? No Yes at \_\_\_\_\_ Day Camp for \_\_\_\_\_ summers.

Camping Experience: Circle years attended at Day Camp 94 95 96 97 98 99 00 01 02 03 04 05 06 07 08 09 **First Aid Training** (Check those completed)

Day Camper \_\_\_\_\_ Name of camp(s) \_\_\_\_\_ First Aid Expiration Date \_\_\_\_\_

Camp Sealth \_\_\_\_\_ Other resident camp \_\_\_\_\_ CPR Expiration Date \_\_\_\_\_

Group Camping \_\_\_\_\_ Other (explain) \_\_\_\_\_

**Camp Fire USA Training** (Check those completed)

Field Trip Training/Outdoor 101 Baby Sitter Training Horizon Other (explain) \_\_\_\_\_

Cooking & Cabins/Outdoor 201 Special Sitters Training Adventure

Backpack Training Starflight Discovery

**Medical Credentials** (Check all that apply) LPN RN EMT MD DO Other \_\_\_\_\_

**Education** (Circle last year completed.) middle 6 7 8 high 9 10 11 12 college 13 14 15 16 graduate 17 18 19 20 voc. tech.

**Camp Fire USA Member?** No Yes: Leader Association \_\_\_\_\_ Group Leader \_\_\_\_\_

**Relevant Training** (List trainings you have completed through school, work, etc. in the 12 months prior to camp.)

\_\_\_\_\_

**I can Teach or Lead** (Check all that apply)

Active Games Dramatics Folk Dancing Nature Lore Outdoor Cooking Knots Other \_\_\_\_\_

Quiet Games Crafts Songs Story Telling Fire Building & Safety Orienteering/Compasses Other \_\_\_\_\_

**SERVICE AGREEMENT FOR ALL STAFF-** In order to participate in Day Camp projects and activities, staff volunteers must provide written permission to the terms and conditions as follows. **Read carefully and sign below:**

**I agree** to carry out the responsibilities of my position, as described in my job description, to the very best of my abilities.

**I agree** to participate in all day camp activities, as assigned by the camp director, to the very best of my abilities.

**I agree** to model for youth and adults the Camp Fire USA philosophy of good citizenship and abide by the policies and standards of Camp Fire USA.

**I agree** to attend all training sessions, to be on time and to be present during the entire training session.

**I agree** to the **5-DAY COMMITMENT** of Day Camp, to be on time and be present for the entire day.

**I agree** to notify the Camp Director immediately if, for any reason, I find that I am unable to carry out my responsibilities at Day Camp.

**APPLICANT AUTHORIZATION**

**Confirmation** – All statements contained in this application are subject to confirmation by the Central Puget Sound Council of Camp Fire USA.

**Disclosure** – I understand that Day Camp activities involve a normal level of risk. I assure that I am willing and able to participate in all Day Camp activities, am willing and able to participate in program activities, and am willing to abide by program policies and follow directions of supervisors. In the event that I am filmed, recorded, or photographed while participating in Day Camp programs, Camp Fire may use the film, recording, or photo for publicity, promotional, or instructional purposes.

**Medical Care Authorization** – I understand that reasonable measures will be taken to safeguard the health and safety of all participants.

**Over-the-counter medications**, if deemed necessary by the camp medical personnel, will be dispensed according to directions on the packaging unless a physician directs otherwise: *antibiotic ointment, Benadryl, Calamine lotion, 1% hydrocortisone, Ibuprofen, low-level DEET insect repellent, PABA-free sunscreen (SPF 15/35), saline eye solution, Tylenol, skin moisturizer, throat lozenges, Tums, 7-up.*

**Please list any over-the counter treatment exceptions under allergies.**

**In case of medical or surgical emergency**, after every effort has been made to contact the family physician (or medical specialist where applicable), or the emergency contacts named above, I hereby give my permission to the physician secured by the camp director to administer treatment, including transportation, hospitalization, injections, anesthesia or surgery. In the event any such treatment is not covered by insurance applicable to the activities, I agree to be responsible for the expenses incurred in these measures.

APPLICANT'S SIGNATURE \_\_\_\_\_ DATE \_\_\_\_\_