

2011-12 Camp Brosend Staff Application (Short Form)

(Summer 2011-Spring 2012) **This short form is for returning applicants.** First time applicants need to fill out the long form.
Please type or print clearly. Illegible applications will not be processed.

Personal Data

Date _____

Full Legal Name—Last _____ First _____ Middle _____

Home Address _____

Home Phone Number _____ Personal Email _____

Cell Number _____ Texting: Yes No Carrier: (circle one) AT&T Verizon T-Mobile Sprint

Sex (for housing purposes): Male Female (circle one) MySpace id: _____ Facebook: _____

Necessary for criminal history check: Date of Birth ___/___/_____ Social Security # _____

Driver's License # _____ State _____ Accidents _____

T-shirt Size: S M L XL XXL (circle one)

Church _____ Pastor _____

Church Address _____ Phone _____

Adults: Spouse's Name _____ Cellular _____ Work Phone _____

Students: School Name _____

School Address _____

School Office Phone Number _____ Year in school _____ Expected graduation year _____

College Major/Degree Area _____ Minor Area _____

Mother's Name _____ Cellular _____ Work Phone _____

Father's Name _____ Cellular _____ Work Phone _____

Parents' Address _____ Home Phone _____

City _____ State _____ ZIP Code _____

If hired, can you document that you may legally work in the United States? Yes No

Certifications: (list expiration dates) CPR First Aid Lifeguard WSI Other _____

Position I am interested in the following position(s) at Camp Brosend (please indicate preference by numbering choices).

Paid Staff (attend both training retreats) Volunteer Staff (attend only one training retreat)

Program Staff: Counselor Counselor-in-training (age 13-20)

Areas of interest: Teaching Lifeguard Recreation Crafts Vocalist

Musician (instrument(s) _____)

Operational Staff: Nurse Food Service (Cook Kitchen Assistance) Grounds Maintenance

Janitorial Maintenance Secretarial/Office Open to any position

Dates you are available:

Fall/Winter Retreats After School Camp Day Camp—May 21-Aug 5

Staff Training I May 21 Staff Training II May 28

Senior High Camp—July 3-8 Junior High Camp—July 10-15

First Adventure Camp—June 21-23 Junior Camp—June 26-July 1

Dates of any/all interruptions to your volunteering/employment (i.e. appointments, family reunions, weddings, etc.)

Have you ever been formally or informally accused of improper conduct regarding children? If yes, please describe.

Fully describe any and all: current pending charges and past arrests _____

Convictions of any felony or other crimes _____

Convictions of any sexual misconduct or child abuse _____

Please attach completed "Camper Health-Care Recommendations by Licensed Medical Personnel Form 2".
Admission to camp will be denied without this current health record.

The Emergency Contact should be someone other than a parent/spouse in case they cannot be reached.

Emergency Contact Name _____ Relationship _____ Phone _____

Family Doctor _____ Phone _____

Medical Insurance Carrier _____ ID No. _____

Known Drug Allergies _____

Other Allergies _____

Current physical, mental, or psychological conditions requiring medication, treatment, or special restrictions or considerations while at camp (e.g. asthma, diabetes) _____

Immunization Record: Date of Last Tetanus Shot/Booster _____ Polio _____ MMR _____ Hep B _____

Hospital Preferred (circle one) Deaconess St Mary's

Any camp activities which staff should be exempted for health reasons _____

Recent major medical treatment (past 6 months) _____

Current Medications _____



ALL medications (including over the counter drugs such as Aspirin/Tylenol) are to be given to the camp nurse in their original container upon arrival at camp.

I (parent/guardian), hereby give permission for Camp Brosend to administer the following over-the-counter medications if the nurse deems it necessary. Dosages will be administered according to directions on the bottle unless a physician directs otherwise (check all that apply).

Acetaminophen or ibuprofen (1 or 2 as needed for headache, fever, cramps, or muscle aches & pains)

Cough syrup as directed for cough Emetrol for upset stomach

Calamine lotion or similar topical preparation for poison oak or ivy

Anti-diarrheal for diarrhea as directed Antihistamine or decongestant as needed for itching/allergy relief

Parent/Guardian Signature _____ Date _____

Please read carefully. A check indicates your agreement.

I certify that I voluntarily agree with the Doctrinal Statement of Brosend Ministries without reservation or coercion and agree to exemplify and teach the principles contained therein, in word and action, in my duties for Brosend Ministries and in my private life.

I agree to abide by all the rules and regulations set by Brosend Ministries.

I understand that by accepting a position at Brosend Ministries I will be committing myself to serving others, and my behavior and attitude will be examined in terms of my modeling and ministry to others.

Describe your current daily quiet time and relationship with God. _____

Describe your current church attendance and opinion of the importance of church attendance. _____

I certify that statements provided in this application are true and complete, and that any misrepresentation or omission may be grounds for rejection of my application or for dismissal if I am accepted as a paid or volunteer employee. I also understand that statements provided in this application may be viewed by any member of the administration or Board of Directors of Brosend Ministries Inc. I give my permission to provide routine health care, dispense medications, and seek emergency medical treatment for the applicant. I understand that I am financially responsible for any expenses incurred through emergency medical treatment given to this applicant. I give my permission for the applicant to be photographed for publicity purposes and optional photo purchasing. I give my permission to request a criminal history check on the applicant.

Signature of Applicant _____ Date _____

Signature of Parent/Guardian (if under 18) _____ Date _____

**CAMPER HEALTH-CARE RECOMMENDATIONS
by LICENSED MEDICAL PERSONNEL FORM 2**

Developed and reviewed by: American Camp Association,
American Academy of Pediatrics Council on School Health, &
Association of Camp Nurses

Mail this form to the address below by _____ (date)

To Parent(s)/Guardian(s): Complete this section and give **this form (FORM 2)** and a copy of your **completed CAMPER HEALTH HISTORY FORM (FORM 1)** to your child's health-care provider for review.

Dates will attend camp: from _____ to _____
Month/Day/Year Month/Day/Year

Camper Name: _____
First Middle Last

Male Female Birth Date _____ Age on arrival at camp _____
Month/Day/Year

Camper home address: _____

City _____ State _____ Zip Code _____

Custodial parent(s)/guardian(s) phone: (_____) _____ (_____) _____

Parent(s)/guardian(s) stop here. Rest of form to be completed by medical personnel.

The following non-prescription medications are commonly stocked in camp Health Centers and are used on an as needed basis to manage illness and injury. **Medical personnel: Cross out those items the camper should not be given.**

- Acetaminophen (Tylenol)
- Ibuprofen (Advil, Motrin)
- Phenylephrine (Sudafed PE)
- Pseudoephedrine (Sudafed)
- Chlorpheniramine maleate
- Guaifenesin
- Dextromethorphan
- Diphenhydramine (Benadryl)
- Generic cough drops
- Chloraseptic (Sore throat spray)
- Lice shampoo or scabies cream (Nix or Elimate)
- Calamine lotion
- Bismuth subsalicylate (Pepto-Bismol)
- Laxatives for constipation (Ex-Lax)
- Hydrocortisone 1% cream
- Topical antibiotic cream
- Calamine lotion
- Aloe

Medical Personnel: Please review the CAMPER HEALTH HISTORY FORM (FORM 1) and complete all remaining sections of this form (FORM 2). Attach additional information if needed.

Physical exam done today: Yes No (If "No," date of last physical: _____)
Month/Day/Year

ACA accreditation standards specify physical exam within last 24 months.

Weight: _____ lbs Height: _____ ft _____ in Blood Pressure _____ / _____

Allergies: No Known Allergies

To foods (**list**):

To medications: (**list**):

To the environment (**insect stings, hay fever, etc.—list**):

Other allergies: (**list**):

Describe previous reactions:

Diet, Nutrition: Eats a regular diet. Has a medically prescribed meal plan or dietary restrictions: (**describe below**)

The camper is undergoing treatment at this time for the following conditions: (describe below) None.

Medication: No daily medications. Will take the following prescribed medication(s) while at camp: (**name, dose, frequency—describe below**)

Other treatments/therapies to be continued at camp: (describe below) None needed.

Do you feel that the camper will require limitations or restrictions to activity while at camp? No Yes

If you answered "Yes" to the question above, what do you recommend? (describe below—attach additional information if needed)

"I have reviewed the CAMPER HEALTH HISTORY FORM (FORM 1), and have discussed the camp program with the camper's parent(s)/guardian(s). It is my opinion that the camper is physically and emotionally fit to participate in an active camp program (except as noted above.)"

Name of licensed provider (please print): _____ Signature: _____ Title: _____

Office Address _____
Street City State Zip Code

Telephone: (_____) _____ Date: _____