Staff Application

T-Shirt Size (circle one)

S M L XL 2XL

- Senior High Week ☐
- Middle School Week ☐
- Primary Week ☐
- Junior Week ☐

First Name | MI | Last Name

Male ☐ Female ☐

Street Addr | City | STATE | ZIP

NC

E-mail | Home Ph

Birth City ST | Work Ph

Cell Ph

DL# | DL Expiration | Date of Birth | Age | SSN

Status ☐ Single ☐ Married ☐ Widowed ☐ Separated ☐ Divorced

Position Applying For

Please number your top three choices from 1 to 3 (1 being most desired). Positions marked with an asterick (*) require certification or previous experience.

_____ Canteen Coordinator	_____ Counselor	_____ Media Assistant/Video*
_____ Canteen Worker	_____ Dining Room Cleaner	_____ Medic/Nurse (Circle One)*
_____ Challenge Course Belay*	_____ Dishwasher	_____ Recreation Assistant
_____ Challenge Course Operator*	_____ Kitchen Server	_____ Sound Technician*
_____ Cook	_____ Lifeguard*	

Emergency Contacts

Name | Name

Phone | Phone

Insurance Information

☐ Please check here if not covered by health insurance

Name of Company: _____ Policy/Group#: _____

City, State: _____ Insurance Co. Phone _____

Medical Information

Camper has had the following (include the year occurring):

☐ Anemia	☐ Asthma	☐ Bronchitis	☐ Chronic Intestinal Problems
☐ Chicken Pox	☐ Chorea	☐ Sinusitis	☐ Venereal Disease
☐ HIV Positive	☐ Diphtheria	☐ Eczema	☐ Speech Defect
☐ Scarlet Fever	☐ Epilepsy	☐ Frequent Colds	☐ Whooping Cough
☐ Hay Fever	☐ Hives	☐ Diabetes (Insulin)	☐ Diabetes (Non-Insulin)
☐ Kidney Disease	☐ Rubella	☐ Rheumatic Fever	☐ Frequent Sore Throats
☐ Hearing Problems	☐ Malaria	☐ Measles	☐ Inflammatory Bowel
☐ Jaundice/Hepatitis	☐ Mumps	☐ Mononucleosis	☐ Orthopedic Problems
☐ Operations	☐ Pneumonia	☐ Otitis Media	☐ Rheumatoid Arthritis
☐ Malignancy	☐ Polio	☐ Tuberculosis	☐ Other: _____

Date of last Tetanus shot (Must be within the last 10 years): _____/_____/_____

Name of Physician: _____ Phone Number: _____

Special medical problems, conditions or restrictions:

_____

_____

Please list all medications:

_____

_____

(State law requires that all medications be given to the camp nurse. All prescriptions must be in the original container and prescribed to the person taking them.)

Please check all that camper is allergic to: ☐ Penicillin ☐ Sulfa ☐ Aspirin ☐ Other: _____

Any food allergies/Special diet needs? ☐ Yes ☐ No

If yes, please explain: _____

Is camper troubles with bed-wetting? ☐ Yes ☐ No

Able to pursue all normal athletic activities? ☐ Yes ☐ No

If no, please explain: _____

Staff Members Under 18 Years of Age

All staff members are required to be at least 16 years of age to qualify to volunteer at any camp session. If you are at least 16 years of age and have not yet completed the 12th Grade, you must attend the Senior High Camp Session (for Grades 9-12). Failure to attend this camp session as a camper will render this application void.

I understand that by being under 18 years of age, I must attend Camp DaySpring as a camper and agree to attend the Senior High Camp Session. I vouch that I will submit Camper Application as soon as possible and understand that my Staff Application will not be considered until I have done so.

Staff Signature: _____ Date: _____

Under 18 Parent Agreement

I am giving my child permission to attend Camp DaySpring as a staff member for the camp sessions specified. My child has permission, without restriction, to participate in all programming unless I notify the camp otherwise in writing. I understand and realize that Camp DaySpring will follow safety procedures and precautions and that all activities include a certain risk. Camp DaySpring will assume no liability for injury, damage or loss of property that result from my child's participation in any activity. I have assumed all possible risks and intend to hereby be legally bound to not hold Camp DaySpring and its agents liable from any injury, damage or loss which may arise in connection to camp activities. The terms hereof shall serve as a Release and Assumption of Risk for any minors. In the event that I cannot be reached in an emergency, I hereby give permission to the physician or dentist selected by Camp DaySpring to secure proper treatment for my child as a Camp DaySpring staff member. I understand that Camp DaySpring provides secondary insurance that will only take effect after the staff member's personal insurance has paid. I also give Camp DaySpring permission to use my child's name, voice, testimonial and/or picture in any type of promotional material, press releases and news stories about Camp DaySpring and Cornerstone Conference IPHC. I will notify the camp office in writing of any other specifications.

All camp policies must be obeyed by every staff member. Major disobedience or defiance of authority will result in the staff member being sent home after parental notification. By signing below, you are agreeing to adhere and support all Camp DaySpring policies and guidelines including the statements in the above paragraphs.

Parent Signature: _____ Date: _____

Application Priority Deadline April 15, 2020

Application review will begin no later than the priority deadline. Applications received after this date will be accepted but will be considered only if positions are unfilled and the application is complete.