Eagle River UM Camp Staff/CIT Registration & Application Form

Fill out and email to: bunti.reed@gmail.com

If you have questions please contact Bunti Reed at 907-321-3348

Name: ______________________________ Email: ________________________ Gender: Male / Female

Address: ____ City / State / Zip: ___________________________

Home Phone: __________________ Work Phone: __________________ Cell Phone: ___________________

Emergency Contact: ______________________________ Cell Phone: _______________________________

Church Name: ____ Date of Birth__________________

Position (circle one): CIT / Counselor / Day Helper or Kitchen Staff

Can you perform the essential functions of the job? Y / N

Shirt Size: Adult S M L XL XXL

Present Employer: ____ Since: ______/_____/______

Present Employer's Address:__________________________________ Phone: _________________

References: Three persons not related to you who have knowledge of your character & experience with children. Name, Phone Number, Address, and/or Email Address

1. ____

2. ____

3. ____

List experience or training you have had in working with this age level: __________________________

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Identify expectations you have for this camping experience: ______________________________________

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For Discovery camp only: Please share a little of your faith story: _________________________________

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I am willing and eager to be nurturing staff at the Eagle River United Methodist Summer Camp

Staff Signature: ____

Eagle River United Methodist Camp Southeast Health Record

Name: ____________________________________ **Age:** _________ **Camp & Year:** ____________________

Insurance Information Is the participant covered by family medical insurance? Yes or No

If yes, indicate Carrier ______________________________ Group # ________________

Insured Name ____________________________________ Policy # ________________

Allergies (Please list known allergy and reaction)

Food Allergy ____

Medication Allergy ____

Other (include insect stings, asthma, etc.) ______________________________________

Medications Will the participant be bringing medications to camp? Yes ☐ No ☐

If yes, list medications (prescription and over the counter) and instructions for taking medication use additional sheets if needed ____

____

Medications must be in original bottle and turned in to Health Care Manager upon arrival.

Contact Information

Camper's Doctor__________________________________ Doctor's Phone___________

History of Illnesses (Please check any that apply and explain below)

☐Diabetes ☐Seizures ☐Bed wetting ☐Sleep walking ☐Constipation ☐Fainting ☐Diarrhea ☐Heart problems ☐Recent illness ☐Recent exposure to contagious disease ☐Behavioral or emotional (e.g. ADHD)

☐Other: ____

Activities which should not be participated in for medical reasons_____________________________________

Parent/Guardian Authorization: *I understand that camp staff needs to know pertinent information about the camper's mental and physical health. Therefore, I have disclosed all information that could jeopardize the camper's health and safety or the safety of others. Failure to disclose information could require my child to be sent home from camp. I give permission to the camp to provide routine health care, administer prescribed and over-the-counter medications and seek emergency medical treatment including ordering x-rays and routine tests. I give permission to the camp to arrange necessary related transportation. I agree to the release of any records necessary for insurance purposes. In the event I cannot be reached (or cannot respond if an adult camper) in case of an emergency, I give permission to the physician(s) selected by the camp staff to secure and administer proper treatment, including hospitalization, for the above named person and to release information regarding said medical treatment to camp staff.*

Signature: ____**Date:** __________________

(Parent, legal guardian or adult camper)