WESTERN HOLINESS YOUTH CAMP

ADULT WORKER REGISTRATION

NAME_____M___F____

AGE_____ PHONE NO._____

ADDRESS_____

HOME CHURCH_____

PASTOR_____

If Counsler Postion Desired: Age Group_____ Co-Counselor_____
(Will try to match, no guarantee!!!)

CHILDREN UNDER 10 YEARS OF AGE:

Name_____Age_____
Name_____Age_____
Name_____Age_____
Name_____Age_____
Name_____Age_____
Name_____Age_____

Did you work at W.H. Y. last year?_____ if so,what position?_____

I authorize my pastor to provide an evaluation of myself; I waive my right to inspect this evaluation; and I release my pastor from any liability for information furnished pursuant to this authorization.

I further understand that the dress code found on the Camp WHY Rules has been set by the Camp administration. As a staff member, I will be expected to, and agree to follow the dress code and rules for myself and enforce these rules to those I supervise.

_____ _____

Signature Date

WHY CAMP T-SHIRT ORDER FORM

This form is for you to order your Camp T-shirts. We will be pre-ordering, so this form must be received by June 1. Please submit this form before this date or your t-shirt will not be ordered. Select both the size and the amount needed to be ordered.

Youth	Amount	Adult	Amount
		S	
S		M	
M		L	
L		XL	
XL		2X-L	
		3X-L	

JACKASS ROCK CAMP

Primary Screening for work with Children or Youth

CONFIDENTIAL

This application is to be completed by all applicants for any position (volunteer or compensated) involving the supervision or custody of minors. This is not an employment application form. This form is being used to help *[name of camp]* provide a safe and secure environment for those children and youth who participate in our programs and use our facilities.

PERSONAL

Date _____

Note: ***Upon request, identity must be confirmed with state driver's license or other photographic identification.***

Name _____
Last First Middle

Address _____

City _____ State _____ Zip Code _____

Home Phone (_____) _____ Driver License No. _____

Have you ever been convicted of or pleaded guilty to a felony? □ Yes □ No

If yes, please explain. (Attach a separate page, if necessary) _____

_____

*Were you a victim of abuse or molestation while a minor? □ Yes □ No

**Note:* *If you prefer, you may refuse to answer this question, or you may discuss your answer in confidence with the camp director rather than answering it on this form. Answering yes, or leaving the question unanswered, will not automatically disqualify an applicant for children or youth work.*

Are you a registered sex offender? □ Yes □ No

REQUEST FOR
CRIMINAL RECORDS CHECK AND AUTHORIZATION

I hereby authorize and request that any law enforcement agency, or other persons having personal knowledge about me, furnish to *[name of camp]*, or its authorized agent, information in their possession about me regarding criminal convictions. This information is sought in connection with my work with children and young people at *[name of camp].* I agree that a photocopy, facsimile or other electronic form of this Authorization will have the same authority and authenticity as the original.

Date: _____ Signature _____

Print Name _____

Print any and all names you have used in the past:

_____

_____

Date of Birth _____ Place of Birth _____

Social Security Number _____

PERSONAL REFERENCES

(not former employers or relatives)

Name _____ Name _____

Address _____ Address _____

Telephone (____)_____ Telephone (____)_____

List, by name and address, any organizations for which you have done youth work during the past five years:

Name _____ Name _____

Address _____ Address _____

The information contained in this application is correct to the best of my knowledge. I authorize any references or organizations listed in this application to provide any information, including opinions, they may have regarding my character for work with children or youth. In consideration of this receipt and evaluation of this application by *[name of camp]* I hereby release any individual, organization, charity, employer, reference, or any other person or organization, including record custodians, both collectively and individually, form any and all damages of whatever kind or nature which may at any time result to me, my heirs, or family on account of compliance, or any attempts to comply, with this authorization. I waive any right I may have to inspect any information provided about me by any person or organization identified by me in this application.

I HAVE CAREFULLY READ THE FOREGOING RELEASE AND KNOW THE CONTENTS THEREOF AND I SIGN THIS RELEASE AS MY OWN FREE ACT. THIS IS A LEGALLY BINDING AGREEMENT WHICH I HAVE READ AND UNDERSTAND.

Date: _____ Applicant's Signature _____

Date: _____ Witness _____

Emergency contact no. _____ Allergies: _____ DOB: _____ Full name: _____

GENERAL INFORMATION

Name _____ Date of birth _____ Age _____ Male ☐ Female ☐

Address _____

City _____ State _____ Zip _____ Phone No. _____

Health/accident insurance company _____ Policy No. _____

IF FAMILY HAS NO MEDICAL INSURANCE, STATE "NONE."

IN CASE OF EMERGENCY NOTIFY:

Name _____ Relationship _____

Address _____

Home phone _____ Business phone _____ Cell phone _____

Alternate contact _____ Phone _____

HEALTH HISTORY

Are you now, or have you ever, been treated for any of the following:

Yes	No	Condition	Explain
		Asthma Date of last attack:	
		Diabetes Date of last HbA1c:	
		Hypertension (high blood pressure)	
		Heart disease (e.g. CHF, CAD, MI)	
		Stroke/TIA	
		Lung/respiratory disease	
		Ear/sinus problems	
		Muscular/skeletal condition	
		Psychiatric/psychological and emotional difficulties	
		Behavioral disorders (e.g. ADD, ADHD, Asperger syndrome, autism)	
		Bleeding disorders	
		Fainting spells	
		Seizures Date of last seizure:	
		Sleep disorders (e.g. sleep apnea)	
		Abdominal/digestive problems	
		Surgery	
		Serious injury	
		Other	

Allergies or Reaction to:

Medication _____

Food, plants, or insect bites _____

_____

Immunizations:

The following are recommended by JAR and the Co of Madera. If had disease, put "D" and the year immunized, check box and put the year received.

Yes	No		Date
[ ]	[ ]	Tetanus	
[ ]	[ ]	Pertussis	
[ ]	[ ]	Diphtheria	
[ ]	[ ]	Measles	
[ ]	[ ]	Mumps	
[ ]	[ ]	Rubella	
[ ]	[ ]	Polio	
[ ]	[ ]	Chicken pox	
[ ]	[ ]	Hepatitis A	
[ ]	[ ]	Hepatitis B	
[ ]	[ ]	Influenza	
[ ]	[ ]	Other (i.e. HIB)	

MEDICATIONS

List all medications currently used. (If additional space is needed, please photocopy this part of the health form). Inhalers and EpiPen information must be included, even if they are for occasional or emergency use only.

Medication _____ Strength _____ Frequency _____ Approx. date started _____ Reason for medication _____	Medication _____ Strength _____ Frequency _____ Approx. date started _____ Reason for medication _____	Medication _____ Strength _____ Frequency _____ Approx. date started _____ Reason for medication _____
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Be sure to bring medications in sufficient quantities and in the original containers. Make sure they are NOT expired, including inhalers and EpiPens. You SHOULD NOT STOP taking any maintenance medication.

I, the undersigned, am the legal guardian of the above-named child. I consent to the camp staff giving such health care to my child would normally give in my home and any further medical care that is deemed necessary in the judgment of camp staff. I hereby consent for that medical care to be administered by a physician selected by the camp administrator(s).

_____

PARENT OR GUARDIAN'S SIGNATURE DATE