



KAY'S KAMP MEDICAL APPLICATION

Thank you so much for your interest in Kay's Kamp. Kamp will run from Saturday, August 7, 2010 through Saturday, August 14, 2010. Attached you will find an application that needs to be completed before we can consider you for employment. Please make sure that you sign all appropriate areas.

Once you have completed all required information and signatures, please forward the application to the following address:

Kaylyn Elaine Warren Foundation
560 Peoples Plaza #111
Newark, DE 19702
Or fax it to:
(302)-836-8534

Please be sure to include the following with your application:

- Copy of your Driver's License
- Copy of Medical Insurance Card, front & back
- Copy of your Medical License
- Copy of your CPR card

Once we have received your completed application, it will be reviewed and your references will be checked. Once your references have been checked, we will contact you to set up an interview. Please make sure to regularly check the Kamp website at www.kayskamp.org for updates on information.

Application deadline is June 1, 2010. Any applications received after this date will automatically be put on a waiting list will be accepted on an as needed basis. Please do not delay in returning your application!

Please do not hesitate to contact me at lisa@kayskamp.org. My staff and I look forward to meeting you and your future camper! Go Kamp!!

Lisa Schmalbach
Executive Director
Kamp Director

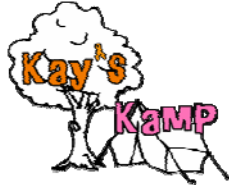
****FOR USE BY KAMP STAFF ONLY****
Enter the date for the following information

Application received: _____ Complete Original application given to Volunteer Coordinator _____
Complete copy given to Kamp Director _____ Medical Director _____



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Personal Information					
Are you a returning staff member? Yes <input type="checkbox"/> No <input type="checkbox"/> If yes, what was your previous role at Kamp?					
Last Name	First	M.I.	Date		
Street Address				Apt. #	
City		State		Zip	
Phone		Email address			
DOB	Age	Male	Female	SSN	
Do you have a valid Driver's License? Yes <input type="checkbox"/> No <input type="checkbox"/>		State	DL #		
Occupation		Employer/School			
Employer/School Address					
Work Phone		Alternate email			
Cell Phone		Pager			
Please list Nursing/Physician licensure information. Also, please include any additional states in which you hold privileges.					
License #	State	expiration			
License #	State	expiration			
License #	State	expiration			
** Please include a copy of all licenses with you application **					
Position applying for <input type="checkbox"/> Staff Nurse <input type="checkbox"/> Physician <input type="checkbox"/> Nurse Practitioner					
CPR certification yes <input type="checkbox"/> no <input type="checkbox"/> expiration					
Additional Certifications with expiration date					
What hospitals/clinics are you affiliated with?					
What is your specialized field of Medicine?					
Do you have your own private practice? Yes <input type="checkbox"/> No <input type="checkbox"/>					
I would like to volunteer for: the whole week 24 hour shifts 8 hour shifts					
T-Shirt Size <input type="checkbox"/> S <input type="checkbox"/> M <input type="checkbox"/> L <input type="checkbox"/> XL <input type="checkbox"/> XXL					



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May we publish your address, phone number and email address in the Counselor Directory? yes no

May we publish your address, phone number and email address in the Camper Directory? yes no

Why are you interested in being apart of Kay's Kamp Medical Team?

Have you had any specialty camp or related experience? Please explain

What is your educational experience? (Colleges and degrees)

Describe your professional experience in the medical field?

What valuable experience do you hope to gain from Kay's Kamp?

Please list any staff or campers that you know that are involved with Kay's Kamp.

How did you hear about Kay's Kamp?

Do you carry your own individual malpractice insurance as a supplement to your employers insurance? Yes No

If no, please verify that you are covered on Kay's Kamp site.



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REFERENCES

Please list three (3) people who are not your relatives to serve as references. Please include one (1) former employer (if you have previous work experience) and two (2) people that can attest to your character and ability to work in different situations. **If you are a returning staff member you DO NOT have to fill out this section.**

Reference #1			
Name of Reference		Relationship	
Phone	Email address		
Street Address			
City	State	Zip	
Reference #2			
Name of Reference		Relationship	
Phone	Email address		
Street Address			
City	State	Zip	
Reference #3			
Name of Reference		Relationship	
Phone	Email address		
Street Address			
City	State	Zip	

Have you ever been convicted of a felony or misdemeanor other than minor traffic offenses?
yes **no** If yes, please attach an explanation.

Kay's Kamp policy is to prohibit all forms of harassment by our volunteers. This includes sexual, racial, religious, and other forms of harassment. Have you ever been accused of harassment of any person including, but not limited to, workplace harassment? **yes** **no** If yes, please attach an explanation.

Note: A prior conviction or accusation is not an automatic bar from volunteering. The type of conviction or accusation will be evaluated by Kay's Kamp before any decision is made.



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AUTHORIZATION TO PERFORM CRIMINAL BACKGROUND CHECK

I, _____, hereby authorize Kay's Kamp to obtain information pertaining to any charges I may have for federal and state criminal law violations. This information will include convictions committed upon minors and adults and will be gathered from any law enforcement agency of this state or any other state or federal government to the full extent permitted by law.

I understand that such access is for the purpose of considering my application as a volunteer and that I expressly DO NOT authorize the Kamp, its' directors, officers, employees or other volunteers to disseminate this information in any way to any other individual, group, agency, organization, or corporation.

Signed: _____ Date: _____
(Signature of applicant)

PHOTOGRAPHIC AND VIDEO CONSENT

I, _____, consent that photographic and/or video pictures may be taken for the purpose of obtaining publicity for Kay's Kamp or for providing documented materials to be shared with campers and staff. Such use may include, but shall not be limited to any advertisements, documentation of camp activities, or promotion on television, radio, newspaper, magazine, promotional film, webpage, flier, etc.

I understand there will be no compensation for the use of such materials and that materials, so used, shall remain the property of the Kaylyn Elaine Warren Foundation. I agree to hold harmless the Kaylyn Elaine Warren Foundation, its employees, legal representatives or assigns and all persons acting under their authority from any liability that may arise from publication of such photographic and/or video material.

Signed: _____ Date: _____

AUTHORIZATION FOR MEDICAL TREATMENT

As a volunteer of Kay's Kamp, I, _____, agree that any medical/surgical emergency is my financial responsibility.

In case of a medical and/or surgical emergency I authorize the Kay's Kamp medical team to render care or arrange for any x-rays, anesthetic, medical, dental, or surgical diagnosis, surgery or treatment and hospital care which is deemed advisable to and is under the supervision of any duly licensed physician, dentist or surgeon.

I acknowledge that certain activities at Kay's Kamp may have an increased risk of injury. I assume full responsibility of my safety. I agree to release and indemnify Kay's Kamp, the Kaylyn Elaine Warren Foundation, and all of its' agents, representatives, employees (paid or voluntary) from any claims, costs, expenses, and/or damages which I may sustain or incur by joining in such activities, unless restrictions for such activities are noted by myself or my physicians.

Signed: _____ Date: _____



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STAFF HEALTH HISTORY FORM

The information on this form is gathered to assist us in identifying appropriate care. Any changes to information contained on this form should be provided to the Kamp health personnel upon your arrival at Kamp. Please provide complete information so that Kay's Kamp can be aware of your medical information.

Last Name		First		M.I.	Today's Date
Home Address				Apt. #	
City			State		Zip
SSN	Gender male <input type="checkbox"/> female <input type="checkbox"/>		DOB		
Emergency Contact			Relationship		
Phone (H)		Phone (W)		Phone (C)	
If emergency contact is not available, notify:					
Phone (H)		Phone (W)		Phone (C)	
Insurance Information					
Name of Carrier					
Address					
Phone #			Policy or group #		
** PLEASE PHOTOCOPY FRONT AND BACK OF HEALTH INSURANCE CARD AND ATTACH TO THIS FORM **					

Allergies: Please list all known medication and food allergies (include insect stings, hay fever, asthma, etc.)

Allergy	Describe reaction and management of the reaction

Medications: Please list all medication (including over-the-counter or non-prescription drugs) taken routinely. Bring enough medication to last the entire time at Kamp. If you are bringing prescription drugs, keep it in the original packaging that identifies the prescribing physician, the name of the medication, the dosage, and the frequency of administration.

DRUG	DOSE and ROUTE	TIME	DAYS OF WEEK



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Please explain any restrictions to activity (ex: what cannot be done, what adaptations or limitations are necessary).

Dietary restrictions (please be specific).

General Questions (please check yes or no)

Have you / Do you:

1. Had any recent injury, illness or infectious disease? Yes No
2. Have a chronic or recurring illness/injury? Yes No
3. Been hospitalized in the past 18 months? Yes No
4. Had surgery in the last 18 months? Yes No
5. Have frequent headaches? Yes No
6. Had a head injury? Yes No
7. Been knocked unconscious? Yes No
8. Wear glasses, contacts or protective eyewear? Yes No
9. Passed out during or after exercise? Yes No
10. Been dizzy during or after exercise? Yes No
11. Had seizures? Yes No
12. Had chest pain during or after exercise? Yes No
13. Had high blood pressure? Yes No
14. Been diagnosed with a heart murmur? Yes No
15. Had back problems? Yes No
16. Had problems with joints (knees, ankles, etc.)? Yes No
17. Have any skin problems (itching, rash, acne)? Yes No
18. Have diabetes? Yes No
19. Have asthma? Yes No
20. Had mononucleosis in the past 12 months? Yes No
21. Had problems with diarrhea/constipation? Yes No
22. Have problems sleepwalking? Yes No
23. If female, have abnormal menstrual history? Yes No
24. Had an eating disorder? Yes No
25. Have ADD/ADHD? Yes No

Please explain and "Yes" answers, noting the number of the question.

MEDICAL HISTORY: Please provide a brief description of any medical problems not addressed above.

Medical Diagnosis	Date of Diagnosis and Brief Description

Which of the following have you had? Please check all that apply.

- Measles Chicken Pox/Shingles German Measles (Rubella)
 Mumps Pertussis (Whooping Cough)

