



## KAY'S KAMP STAFF 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 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](http://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!

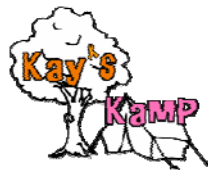
Please do not hesitate to contact me at [lisa@kayskamp.org](mailto:lisa@kayskamp.org). My staff and I look forward to meeting you and your future camper! Go Kamp!!

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 \_\_\_\_\_



## KAY'S KAMP STAFF APPLICATION

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		
Do you meet the minimum age requirement of 21 years of age? yes <input type="checkbox"/> no <input type="checkbox"/>					
May we publish your address, phone number and email address in the <u>Counselor</u> Directory? yes <input type="checkbox"/> no <input type="checkbox"/>					
May we publish your address, phone number and email address in the <u>Camper</u> Directory? yes <input type="checkbox"/> no <input type="checkbox"/>					
T-Shirt Size      S <input type="checkbox"/> M <input type="checkbox"/> L <input type="checkbox"/> XL <input type="checkbox"/> XXL <input type="checkbox"/>					
Position desired: Counselor <input type="checkbox"/> Activity Director <input type="checkbox"/> Food Services <input type="checkbox"/> Other					
If applying for counselor position, please rank order of preference (1-4) for ages of children					
6-8	9-11	12-14	15+		
If applying for activity director, which activity?					

1. Are you interested in a lead counselor position?

2. Are you CPR certified? Yes  No

**A current copy of CPR certification must accompany this application.** *If you are not currently CPR certified, will you be attending the certification course offered in the spring by The KEWF/Kay's Kamp or will you seek your own certification course?    KEWF / private certification course (circle one)*

**\*\* Please send a copy of you current CPR card with your application \*\***

3. Have you had any camp counseling or related experience? Please explain.

4. How did you hear about Kay's Kamp?

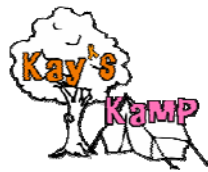


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5. Why are you interested in being a volunteer for Kay's Kamp?
  
6. Describe your experience in working with children.
  
7. Please list any staff or campers that you know that are involved with Kay's Kamp.
  
8. What contributions do you think you can make to Kay's Kamp to fulfill the special needs of children with cancer?
  
9. What valuable experience do you hope to gain from Kay's Kamp?

For all first-time applicants, 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.**

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



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Have you ever been convicted of a felony or misdemeanor other than minor traffic offenses?  
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.

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.

### 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: \_\_\_\_\_  
(Signature of applicant)

Date: \_\_\_\_\_

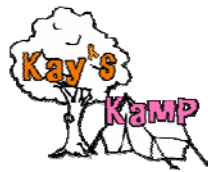
### PHOTOGRAPHIC AND VIDEO CONSENT

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: \_\_\_\_\_  
(Signature of applicant)

Date: \_\_\_\_\_



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**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: \_\_\_\_\_  
(Signature of applicant)

**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			
<b>Primary Medical Insurance Information</b>						
Insurance Company Name						
Street Address			City	State	Zip	
Policy Holder's Name			Policy or group #			
Phone Number						
<b>Emergency Contact Information</b>						
Name			Relationship			
Street Address			City	State	Zip	
Phone (H)		Phone (W)		Phone (C)		
<input type="checkbox"/> Please check here if you currently do not carry medical insurance coverage.						
<b>** PLEASE PHOTOCOPY FRONT AND BACK OF HEALTH INSURANCE CARD AND ATTACH TO THIS FORM **</b>						



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**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

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



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- 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)

Please list dates of most recent immunizations

VACCINE	DATE	VACCINE	DATE
Tetanus (DTaP, DT, Td, Tdap)		Polio	
Hepatitis B		Hib	
MMR (Measles, Mumps, Rubella)		2009/2010 Influenza Vaccine	
Varicella		Shingles Vaccine	
H1N1 Vaccine, if eligible		Last Tuberculin Test	pos <input type="checkbox"/> neg <input type="checkbox"/> If pos, _____ mm

FAMILY PHYSICIAN	
Name	Phone
Address	
DENTIST / ORTHODONTIST	
Name	Phone
Address	

**NOTE: If you have been exposed to any communicable disease, particularly chicken pox (which is especially dangerous to children on chemotherapy), during the month prior to Kamp, please contact us as soon as possible.**

