

2015 SGBA SUMMER CAMP – VOLUNTEER APPLICATION

Sunday, July 19th – Friday, July 24th 2015

PERSONAL INFORMATION

Name of Volunteer: _____ Gender: M / F Birth Date: ___/___/___
Please PRINT Last Name First

Address: _____
Street City State Zip

Phone(s): (____) ____--____ (____) ____--____ Email: _____
Home Cell

Have you ever been convicted of anything other than a minor traffic violation? No __ Yes __ (if yes, please explain) _____

CHURCH INFORMATION

Name of Church: _____ Pastor: _____ Phone: (____) ____--____

Address: _____
Street City State Zip

SGBA Affiliated? Yes __ No __ (if no, please include a reference from an SGBA pastor or official in the reference section below)

Are you a member in good standing? Yes __ No __ (if no, please explain) _____

POSITION & EXPERIENCE

Desired Position (please check one):

- Counselor (must be age 21 or older) Activities Director
- Assistant Counselor (must be age 18 or older) Assistant Activities Director
- Assistant Craft Director

Please list previous youth camp or Winter Blast experience:

Year(s)	Camp	Position	Responsibilities

REFERENCES - Under Michigan state law, no reference will be accepted from a family member of the applying individual. Please have your references read and sign their agreement below.

I recommend the above individual identified above to serve as a volunteer at the Sovereign Grace Baptist Association of Churches Youth Camp. In addition, I hereby state that I trust the capabilities and character of this individual with the care of my own child.

Pastoral Recommendation Name: _____ Phone: (____) ____-____

Signature: _____ Date: ___/___/___

Second Recommendation Name: _____ Phone: (____) ____-____

Signature: _____ Date: ___/___/___

Third Recommendation Name: _____ Phone: (____) ____-____

Signature: _____ Date: ___/___/___

Contact Information:

Jared Leuck - Camp Director (810) 309-9043, camp@sgba.net
 Laura Clayton - Registrar (810) 441-4606, llclayton61@gmail.com

2015 SGBA SUMMER CAMP – VOLUNTEER MEDICAL FORM

Sunday, July 19th – Friday, July 24th 2015

Name: _____ Age: _____ M / F Birth Date: ____ / ____ / ____
Please PRINT Last Name *First Name*

Address: _____ Church Affiliation: _____
Street City State Zip Code

In case of emergency, notify: _____ Phone: (____) ____ - ____
Please PRINT

Relationship: _____

Family Doctor(s): _____ Phone: (____) ____ - ____

Medical Insurance Provider: _____ Policy #: _____ Policy Holder: _____

HEALTH HISTORY – CONFIDENTIAL

Last Tetanus Shot ____/____
 Heart Condition Allergies: Drugs/Insect Stings/Food (list below) Epilepsy/Seizure Disorder
 Diabetes: Insulin Dependent? Y / N Asthma Inhaler? Y / N (if yes, does the inhaler need to be carried at all times? Y / N) Physical Handicap
 Nervous/Mental Disorder

Other Issues or Restrictions (please specify) _____

Please describe any condition listed above in the space provided: _____

MEDICATIONS

Name of Medications	Dosage	Times

MEDICAL RELEASE MUST BE SIGNED FOR PARTICIPATION

1. In the event I incapacitated in an emergency, I hereby give my permission to the physician selected by SGBA staff/agent to hospitalize, to secure proper treatment for and/or order an injection, anesthesia, or surgery for myself as deemed necessary.
2. By this Agreement, I authorize the SGBA staff/agent to administer First Aid (including over-the-counter medicines) as required for illness and injury. The signature of named individual below is intended to serve as a medical release.
3. I have carefully read this agreement and fully understand its contents. I am aware that this is a release of liability and medical release. I am signing it of my own free will.

Signature Date: ____ / ____ / 2015