SGBA SUMMER CAMP – VOLUNTEER APPLICATION

Sunday, July 17th – Friday, July 22nd 2016

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)
- ☐ Assistant Counselor (must be age 18 or older)
- ☐ Assistant Craft Director
- ☐ Activities Director
- ☐ Assistant Activities 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) 3099043, camp@sgba.net Laura Clayton Registrar (810) 4414606, llclayton61@gmail.com

SGBA SUMMER CAMP – VOLUNTEER MEDICAL FORM

Sunday, July 17th – Friday, July 22nd 2016

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
☐ Diabetes: Insulin Dependent? Y / N
☐ Other Issues or Restrictions (please specify) _____
☐ Allergies: Drugs/Insect Stings/Food (list below)
☐ Asthma Inhaler? Y / N (if yes, does the inhaler need to be carried at all times? Y / N)
☐ Epilepsy/Seizure Disorder
☐ Physical Handicap
☐ Nervous/Mental Disorder

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 am 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.

_____ Date: _____/_____/ 2016
Signature