Summer Staff Registration Form (please print) Page A **Date:** _____
(Volunteers under 18 must fill out camper forms located on web site)

Name of Staff: _____ _____
Last First

Home Address: _____ _____ _____ _____
Street City State Zip

Home Phone _____ Cell Phone _____ Sex _____ DOB ____/____/____

Email Address _____

T-shirt size _____

Emergency Contact Information: (someone who is available 24/7)

Contact name_____Phone_____Relationship_____

Contact name_____Phone_____Relationship_____

Physician Name _____Phone_____

Physician Address _____

"A photocopy of the insurance card is required with this form."

Camps Staff is asked to be present from Saturday 1pm through Saturday 3pm
Camp volunteering for: (Please circle date and check areas willing to work)

Challenge Camp	July 2th -8th	Challenged Adults over 18
Chipmunks	July 9th - 12th / July16th - July 19th	Grades 1st -2nd
Science	July 9th-15th	Grades 3rd -8th
Music	July 16th-July 22th	Grades 3rd -8th
Night Owl Camp	July 23th - July 30th	Grades 8th – 12th
Impact 716	July 30th – Aug 5th	Grades 3rd – 12th

- ☐ Lifeguard
- ☐ Medical Staff
- ☐ Bible Study Leader
- ☐ Music Leader
- ☐ High Rope Cert.
- ☐ Camp Counselor
- ☐ Co-Cooks
- ☐ Activities Leader
- ☐ Craft Leader
- ☐ Archery Cert.
- ☐ Counselor in Training
- ☐ Kitchen Help
- ☐ CPR/AED, (dated within 1 year)
- ☐ Wilderness First Aid

_____ _____
Signature (if staff is under 18 must have parent signature) **Date**

Return this form to address below by May 1st .
Duffield Summer Camps, P.O. Box 55, Kenmore, NY, 14217

Summer Staff Registration Form (please print) Page B **Date: _____**

Name of Staff:_____ _____
Are you current in CPR or First Aid certification? _____
Please include current certification as soon as you can.
Have you traveled outside the country in the past 9 months? _____
When/Where _____

1.	Have you had a recent injury, illness or infectious disease?	☐ Yes ☐ No
2.	Do you have a chronic or recurring illness/condition?	☐ Yes ☐ No
3.	Ever been hospitalized or had surgery?	☐ Yes ☐ No
4.	Have frequent headaches?	☐ Yes ☐ No
5.	Ever had a head injury or been knocked unconscious?	☐ Yes ☐ No
6.	Ever pass out or been dizzy during or after exercise?	☐ Yes ☐ No
7.	Ever had seizures or convulsions?	☐ Yes ☐ No
8.	Ever been diagnosed with a heart murmur or heart condition?	☐ Yes ☐ No
9.	Ever had high blood pressure?	☐ Yes ☐ No
10.	Ever had chest pains during or after exercise?	☐ Yes ☐ No
11.	Ever had back or joint problems?	☐ Yes ☐ No
12.	Have diabetes?	☐ Yes ☐ No
13.	Have asthma?	☐ Yes ☐ No
14.	Have any skin problems?	☐ Yes ☐ No
15.	Bringing an orthopedic device to camp?	☐ Yes ☐ No
16.	Had problems with diarrhea/constipation?	☐ Yes ☐ No
17.	Bee sting reactions?	☐ Yes ☐ No
18.	Hay fever or other allergies?	☐ Yes ☐ No
19.	Ever had an eating disorder?	☐ Yes ☐ No
20.	Ever had a emotional problems for which professional help sought?	☐ Yes ☐ No
21.	Problems with sleepwalking?	☐ Yes ☐ No
22.	If female – abnormal menstrual history?	☐ Yes ☐ No
23.	Are you on a special diet, any restrictions?	☐ Yes ☐ No
24.	Any other medical facts we need to know:	☐ Yes ☐ No

Explain yes answers here:

_____

_____

_____

Authorizations: This health history is correct and complete to the best of my knowledge, and the person herein described has permission to engage in all camp activities except as noted on this form. I hereby give permission to the medical personnel selected by the Camp Director to secure proper treatment and transportation, for myself or my child named above if deemed necessary. I also give permission to share their medical information for this purpose.

_____ _____
Signature (if staff is under 18 must have parent signature) **Date**

Return this form to address below by May 1st .
Duffield Summer Camps, P.O. Box 55, Kenmore, NY, 14217

Summer Staff Registration Form (please print) Page C

Authorization of for medical treatment persons over 21

I, _____do hereby authorize Camp Duffield Staff to sign for any Medical treatment deemed necessary for myself. My date of birth is _____/____/_____. This authorization is valid from (date) _____ through and including _____.

Today's Date _____

Print Name _____

Signature _____

(if staff is under 18 / parent signature)

The person herein described has appeared before me and is known by me or has presented sufficient identification to prove that he or she is, indeed, the above individual.

Notary Public Signature/Stamp/Date "MUST BE COMPLETED"

Health Insurance Company_____

Name of Insured _____Relationship_____

Identification Number _____Group No._____

Place of Employment_____

A photocopy of insurance card is required with this form.

Camper Physician _____ Phone _____

Camper Dentist/Orthodontist _____ Phone _____

Return this form to address below by May 1st .
Duffield Summer Camps, P.O. Box 55, Kenmore, NY, 14217

Background Check Consent Form for Volunteers or Employees

This information will be used by Duffield Camp And Retreat Center, Inc. to determine suitability for hiring or volunteering at Duffield Summer Camps. Duffield, Inc. will contact Intellicorp Records, Inc in compliance with our Insurance Company requirements for a criminal background check and NYS, for background check that will include a search of sex offender databases.

Last Name _____

First Name _____

Middle Name _____

Former Last Name _____

Date of Birth _____ MM _____DD _____ YEAR

SSN _____ - ____ - _____

Gender _____

Signed _____ Date _____

All information in this form will be maintained in full confidence and will NOT be shared with any other organization or individual than those necessary for employment or volunteer approval at Duffield, Inc. Summer Camp(s). Before taking adverse employment action based on this report, applicant will be provided a copy of report and a copy of consumer rights per the FTC.

Return this form to address below by May 1st .
Duffield Summer Camps, P.O. Box 55, Kenmore, NY, 14217

Physician's Report Page 1 of 3
Staff Health History (can be from the past 2 year period)

Name of Staff:_____DOB: ___/___/
Date of physical: _____/_____/_____
Has this person been hospitalized within the past 3 years? _____
If yes explain details and dates: _____
Patient's HT _____ WT _____ P _____ BP _____/_____ RR _____

PHYSICAL EXAMINATION

SYSTEM	WITHIN NORMAL	ABNORMAL	REASON
HEAD, NECK			
EARS,NOSE,THROAT			
LUNGS			
HEART			
ABDOMEN			
GENITALIA			
SPINE			
EXTREMITIES			
NEURO			
SKIN			
EYES			

MEDICATIONS

Please list all medications (including over the counter or non prescription drugs) being taken. Bring enough medication to last the entire time at camp. Keep in original packaging/bottle that identifies the medication, the prescribing doctor, the dosage and frequency of administration. Attach additional sheet if needed.

MEDICATION	DOSAGE	TIMES GIVEN	REASON	SPECIAL INSTRUCTIONS

Return this form to address below by May 1st .
Duffield Summer Camps, P.O. Box 55, Kenmore, NY, 14217

Physician's Report Page 2 of 3
Staff Health History

Name of Staff: _____DOB____/____/_____
Date of physical: _____/_____/_____

Immunization History: Provide the **month and year for each immunization.** Immunizations must be current. Copies of immunization records from health-care providers are preferred.

Immunization (List or attach doctors records)

DTaP or TdaP _____
MMR _____
IVP _____
HIB _____
RV _____
Hepatitis A _____
Hepatitis B _____
Varicella _____
Meningococcal _____
Pertussis _____
Covid _____

Allergy Information: _____ Does not apply (no allergies, please check)

Allergy to:	Reaction:	Treatment:
Dust/Mold		
Insect Bites:		
Animals:		
Latex		
Sunscreen		
Food:		
Food:		
Medications:		
Medication:		

If you are required to carry an epi pen, you must bring the epi pen and your physicians' Rx with you to camp .

Signature of Physician_____**Date**_____

Print Name or stamp _____

Return this form to address below by May 1st .
Duffield Summer Camps, P.O. Box 55, Kenmore, NY, 14217

Duffield
Camp & Retreat Center

Physician's Report Page 3 of 3
Staff Health History

Name of Staff: _____DOB____/____/_____
Date of physical: _____/_____/_____

OVER THE COUNTER MEDICATION FORM
Your medical doctor must complete this form

I hereby authorize that the following medications may be given to the above named person at Camp Duffield after nursing assessment.

Bactine (topical) for minor wound care, first aid as needed

Triple Antibiotic Ointment (topical) for wound healing

Tylenol (oral) as directed on bottle

Ibuprophen (oral) as directed on bottle

Cough Drops for coughing, minor throat irritation as needed

Antacid Tablet (oral) for stomach discomfort

Benydryl (oral or topical) for swelling, hives, allergic reaction as directed on bottle

Calamine Lotion or Cortaid (topical) for insect bites/bee stings

Visine/ Murine Plus Eye Drops (topical in eye) for minor eye irritation

Other (please describe)

_____

_____

_____

PHYSICIAN CONSENT
Physician Signature _____ Date _____
Printed Name _____ License Number _____
Address _____Phone _____
City _____ State _____ Zip _____ Fax _____

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Duffield Summer Camps, P.O. Box 55, Kenmore, NY, 14217