



**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 check areas willing to work)**

Challenge Camp - Challenged Adults over 18

Chipmunks - Grades 1st -2nd, First Timers

Science - Grades 3rd -8th

Music - Grades 3rd -8th

Night Owl - Grades 8th – 12th

Camp Impact 716 - Grades 1st - 8th

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

Signature (if staff is under 18 must have parent signature) \_\_\_\_\_

Date \_\_\_\_\_

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

**Explain yes answers here:**

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**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 1<sup>st</sup>**.  
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**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.

<b>Notary Public Signature/Stamp/Date</b> <b>"MUST BE COMPLETED"</b>
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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 1<sup>st</sup>**.  
**Duffield Summer Camps, P.O. Box 55, Kenmore, NY, 14217**



**Summer Staff Registration Form (please print) Page D**

**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 1<sup>st</sup>**.**  
**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 1<sup>st</sup>**.  
**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** \_\_\_\_\_



**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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