



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 7 th -14 th	Challenge Adults over 18
Foxes	July 14 th -21 st	Grades 3 th -5 th
Raccoons	July 14 th -21 st	Grades 6 th -8 th
Night Owl Camp	July 21 st -28 th	Grades 9 th -12 th

- | | | |
|---------------------------------------------|--------------------------------------------|---------------------------------------------------------|
| <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 |

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? | <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:

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

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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.

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 _____

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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.

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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

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**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 _____

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 _____

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**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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