

**Simon Kenton Council/Tri-Creek District Day Camp 2008
Adult Staff Application and Health Form**

What **PACK** are you associated with? _____

What **District** are you associated with? _____

Circle dates you will volunteer at day camp: 6/24 6/25 6/26 6/27

Day Camp Staff receive a free t-shirt. Circle size (AS, AM, AL, XL, XXL, XXXL)

YOUR Name: _____

List your Scout's Name here: _____ Rank: _____

Mailing Address: _____

City: _____ **State** _____ **Zip:** _____

Home Phone: _____ **Cell Phone:** _____ **E-mail:** _____

Are you volunteering for an Activity Station? (Yes/No) Which One? _____

Have you volunteered at camp before? (Yes/No) How Many Years? _____

Will you have children in **Tot Lot** while you are at camp (**Yes / No**) ?

Name: _____ Age: _____

Name: _____ Age: _____

EMERGENCY PHONE CONTACTS

_____ Phone: _____ **And/Or**

_____ Phone: _____

-----**SPECIAL INSTRUCTIONS**-----

Family Doctor _____ Phone: _____

Family Dentist _____ Phone: _____

Preferred Hospital _____

HEALTH HISTORY Do you have any Health Problems (write Yes/No) ----->

Asthma?____ Anaphylaxis?____ Convulsions?____ Diabetes?____

Environmental Allergies?____ Fainting?____ Food Allergies?____ Heart Disease?____

Other?_____

Difficulty with: Eyes?__ Nose?__ Throat?__ Lungs?__ Digestion?__

Will you be bringing Medication to Camp (write Yes/No)? ----->

Describe Medication / Dosage: _____

I/we give permission to the camp health director to give medication as listed above and understand that all medication must be secured at the camp office: yes / no (circle one) -

-----**SELF AUTHORIZATION**-----

This health history is correct and complete to my/our knowledge, and the person described on this application is able to participate in all activities except as noted by me/us and the physician. In the event of an emergency in which the above-named becomes ill or injured and I/we cannot be reached, I/we give permission to the physician selected by the adult leader in charge, to transport, hospitalize, secure proper anesthesia, or to order injection or surgery for the above applicant.

Your Signature(s): _____ **Date:** _____

Mail Forms to: Simon Kenton Council
1901 E. Dublin-Granville Rd.
P.O. Box 29207
Columbus, Ohio 43229

Adults: Please complete all information on this form and sign above.