



# Episcopal Diocese of Kansas **YOUTH MINISTRY**

## Camp Wood Nurse Application 2009

Name \_\_\_\_\_

Birth Date (month/day/year) \_\_\_\_\_

Address / City / State / Zip \_\_\_\_\_

Phone # (include home and cell if available) \_\_\_\_\_

Email \_\_\_\_\_

Home Parish \_\_\_\_\_

For which session are you applying? (Check)

**High School:** May 31 – June 6, Orientation May 30th \_\_\_\_\_

**Junior High:** June 7-13, Orientation June 6th \_\_\_\_\_

**Intermediate:** June 14-20, Orientation June 13<sup>th</sup> \_\_\_\_\_

*Orientations will begin at 5 pm on the scheduled day. Please plan accordingly. We will also be gathering the entire 2009 camp staff on Sat. May 2nd for a meeting in Emporia. The meeting will begin at 10 am. This meeting is required, so please plan to attend.*

Please answer the following questions briefly, if this is your first time applying as a staff member.

1. Why do you wish to be a camp nurse in the Episcopal Diocese of Kansas Summer Camp Program?
2. Describe your relationship with God and what you think it means to be a Christian.
3. What are some of your strengths and weaknesses?

**\* Please list three references and provide addresses and phone #'s. These people should not be relatives.**

- 1.
- 2.
- 3.

**\*\*Please include a photocopy of your state nursing license.**

Signature \_\_\_\_\_ Date \_\_\_\_\_

**Please return applications BY March 16<sup>TH</sup> to:** 7236 Robinson St. Overland Park, KS 66204



# Episcopal Diocese of Kansas **YOUTH MINISTRY**

## Community Expectations & Covenant

The **mission** of the Episcopal Diocese of Kansas Youth Program is to *gather, equip, and send* young disciples of Jesus Christ to witness to God's reconciling love. In order to live out our mission statement, all participants agree to actively participate in all parts of the event and to abide by the standards of the community, which are as follows:

1. I will respect and follow the rules of Camp Wood YMCA and the Episcopal Diocese of Kansas Youth Program.
2. I will respect the property of others, and the property of Camp Wood YMCA.
3. I will be an active participant in scheduled activities.
4. I will wear appropriate clothing.
5. I will hand in all prescription medication to the event nurse.
6. I will not enter the sleeping areas of the opposite sex.
7. I will not engage in sexual activity.
8. I will not use alcohol, illegal drugs, or tobacco.
9. I will not bring anything that could be considered a weapon.
10. I will seek to set a Christian example for the campers in my behavior, attitude, and in prayer as I seek to love God and my neighbor.

### **These Standards apply to all Adult and Youth participants.**

By signing below I agree that these are reasonable expectations and I will do everything I can to live up to them. If I choose to violate the rules set for the event I am planning to attend, I understand that there will be consequences, which may include my being sent home.

**Participant Signature** \_\_\_\_\_

**Date:** \_\_\_\_\_

As parent and/or legal guardian of this child I have read the above and believe that he/she is capable of aspiring to and following these community expectations and rules.

**Parent Signature:** \_\_\_\_\_

**Date:** \_\_\_\_\_

### **Photo / Video Publicity Release Statement**

The undersigned participant does agree to grant the Episcopal Diocese of Kansas permission to record on film, videotape, or audiotape, his or her participation in Camp in June of 2008. He or she further agrees that any or all of the material recorded may be used, in any form, as part of any future production(s) made by the Diocese of Kansas Youth Program, and further that such use shall be without payment of fees, royalties, special credit, or other compensation.

**Participant Signature** \_\_\_\_\_

**Date:** \_\_\_\_\_

**Parent Signature (if under 18)** \_\_\_\_\_

**Date:** \_\_\_\_\_

**EPISCOPAL DIOCESE OF KANSAS  
Summer Camp Staff Health Form 2009**

Counselor's Name \_\_\_\_\_

Session Attending \_\_\_\_\_

Address \_\_\_\_\_

City, State, ZIP \_\_\_\_\_ Phone \_\_\_\_\_

Parent/Legal Guardian \_\_\_\_\_

Day Phone \_\_\_\_\_ Evening Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_

Parent/Legal Guardian \_\_\_\_\_

Day Phone \_\_\_\_\_ Evening Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_

Alternative (other than Parent/Legal Guardian) \_\_\_\_\_

Day Phone \_\_\_\_\_ Evening Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_

Family Physician \_\_\_\_\_

Office Phone \_\_\_\_\_ After Hours Phone \_\_\_\_\_

Parish Priest \_\_\_\_\_

Day Phone \_\_\_\_\_ Evening Phone \_\_\_\_\_

Insurance Company \_\_\_\_\_ Policy No. \_\_\_\_\_

Name of Person on Policy \_\_\_\_\_ Employer \_\_\_\_\_

Is pre-approval for treatment required before treatment? \_\_\_\_\_ NO \_\_\_\_\_ YES

Do you know how to swim? \_\_\_\_\_ NO \_\_\_\_\_ YES Level of ability \_\_\_\_\_

Are you able to participate in all phases of the program? \_\_\_\_\_ NO \_\_\_\_\_ YES

If NO, please specify \_\_\_\_\_

**Permission for Care Statement:** In the case of accident or illness, I give permission for emergency treatment to be provided by the physician and/or health care facility determined by the persons responsible for the safety and welfare of the campers at the above program as well as those designated by Camp Wood.

Signature \_\_\_\_\_ Date \_\_\_\_\_

Witness \_\_\_\_\_

**(Over, please)**

**HEALTH HISTORY** (check and/or give approximate dates)

**Chronic or Recurrent Illness**

Ear Infections \_\_\_\_\_

Rheumatic Fever \_\_\_\_\_

Convulsions/Seizures \_\_\_\_\_

Diabetes \_\_\_\_\_

Asthma \_\_\_\_\_

Nosebleeds \_\_\_\_\_

Bed Wetting \_\_\_\_\_

Epilepsy \_\_\_\_\_

**Allergies**

Hay Fever \_\_\_\_\_

Poison Ivy \_\_\_\_\_

Insect Stings \_\_\_\_\_

\_\_\_\_\_

Penicillin \_\_\_\_\_

Other Medication \_\_\_\_\_

Food \_\_\_\_\_

**Immunizations (MO/Year)**

Tetanus

Last Booster \_\_\_\_\_

Measles, Mumps, Rubella

Last Booster \_\_\_\_\_

Comments/explanations on any of the above: \_\_\_\_\_

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Operations or serious injuries (include date): \_\_\_\_\_

Medications to be administered at camp (specify dosages): \_\_\_\_\_

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Information about any physical limitations: \_\_\_\_\_

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**Food allergies/dietary restrictions/vegetarian?** \_\_\_\_\_

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Additional comments/information (use separate sheet if necessary): \_\_\_\_\_

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OPTIONAL:

**PHYSICIAN/HEALTH CARE PROVIDER STATEMENT:** I have reviewed the above information and believe the patient is in good health.

**Signature** \_\_\_\_\_ **Date** \_\_\_\_\_