



## Staff Form 31 July - 5 August 2011

NAME: \_\_\_\_\_ DATE OF BIRTH: \_\_\_\_\_  
LAST NAME FIRST NAME

ADDRESS: \_\_\_\_\_  
STREET ADDRESS CITY STATE ZIP

HOME PHONE: \_\_\_\_\_ CELL PHONE: \_\_\_\_\_

CHURCH INFO: \_\_\_\_\_  
NAME AND CITY OF CHURCH YOU REGULARLY ATTEND

**\*CHURCH RECOMMENDATION:** \_\_\_\_\_

SIGNATURE OF DESIGNATED DEPT. PASTOR, DEACON, OR TRUSTEE TITLE

YES NO \*RECOMMENDATION BY CHURCH OFFICIAL **MUST** BE COMPLETED BY YOUR HOME CHURCH TO BE ACCEPTED AS CAMP STAFF \_\_\_\_\_

INITIAL OF CHURCH OFFICIAL

PLEASE LIST THE NAMES OF YOUR IMMEDIATE FAMILY MEMBERS ATTENDING CAMP:

FAMILY MEMBER #1 \_\_\_\_\_  
NAME AGE GRADE  
FAMILY MEMBER #2 \_\_\_\_\_  
NAME AGE GRADE  
FAMILY MEMBER #3 \_\_\_\_\_  
NAME AGE GRADE  
FAMILY MEMBER #4 \_\_\_\_\_  
NAME AGE GRADE

PLEASE NOTE WHAT AREAS OR ROLES YOU WOULD LIKE TO WORK AT CAMP. PLEASE LIST ANY ACTIVITY LIMITATIONS THAT SHOULD BE MADE KNOWN TO THE CAMP DIRECTOR

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**NOTE:** Plan to report at Camp JIM for orientation/preparation/set-up on Sunday, 31 Jul at 3:00 P.M.

I certify the above information is correct and I understand a criminal background check will be completed as required by the Northwoods Baptist Association to be able to work with children.

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

**MEDICAL INFORMATION:**

NAME: \_\_\_\_\_ DOB: \_\_\_\_\_  
LAST NAME FIRST NAME DATE OF BIRTH

ADDRESS: \_\_\_\_\_  
STREET ADDRESS CITY STATE ZIP

EMERGENCY CONTACT NAME: \_\_\_\_\_ PHONE: \_\_\_\_\_

OTHER CONTACT NUMBERS IN THE EVENT OF EMERGENCY:

\_\_\_\_\_  
NAME PHONE NUMBER WORK/CELL/OTHER NAME PHONE NUMBER WORK/CELL/OTHER

**Personal Health History**

Check all that apply:

- |                         |                        |
|-------------------------|------------------------|
| Convulsions or Seizures | Fainting spells        |
| Bleeding problems       | Heart Murmur           |
| Headaches               | Diabetes               |
| Asthma                  | Ear trouble            |
| Cancer                  | Head injury/Concussion |
| Allergy to Bee stings   | Food Allergies         |

**Insurance Information:**

\_\_\_\_\_  
Insurance Company

\_\_\_\_\_  
Policy Number

\_\_\_\_\_  
ID or Subscriber Number

**Medications:**

Please list meds routinely taken:

\_\_\_\_\_  
Drug Name Reason or Purpose

\_\_\_\_\_  
Drug Name Reason or Purpose

\_\_\_\_\_  
Drug Name Reason or Purpose

**Allergies:**

Please list allergies and note reaction type.

\_\_\_\_\_

**Over the Counter Medications:** I give permission for the administration of over the counter medications, such as Ibuprofen, Tylenol, Benadryl, antacids, etc. to my child in the event of minor illness or injury as directed by the Camp Nurse.

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

**Medical Consent :** I give my consent to undergo medical treatment for any injury or illness I may sustain or acquire as deemed appropriate by the Camp Nurse. In the event that serious medical procedures are required, such as surgery or other invasive procedure, I authorize any duly licensed medical practitioner to perform any medically necessary procedures and administer medication.

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

\*For privacy purposes, this form will be kept in the possession of the camp nurse.

Please mail forms by 15 July 2011 to:

NWBA Camp  
C/O Northwoods Baptist Association  
P.O. Box 479  
Grand Rapids, MN 55744