COUNSELOR APPLICATION 2010

DATE OF APPLICATION: _______________

PLEASE CHECK THE WEEKS YOU WILL BE AVAILABLE AND THE CPR CLASS & DIRECTORS MEETING YOU WILL ATTEND

WE MUST HAVE A RECENT PICTURE OF EACH COUNSELOR

For Office Use
Date Recd: ________________
Date Conf: ________________
Weeks: ________________
Ref. Check: ________________
CPR: ________________
Permission: ________________

_____ *** Counselor Training…… June 24-26 2010**

_____ Camp SMILE I ………….. June 28-July 3, 2010
_____ Camp SMILE II ……..……... ... July 5-10, 2010
_____ Camp SMILE III……..……..… July 12-17, 2010
_____ Camp SMILE IV………….. ... July 19-24, 2010
_____ Meet the Directors…………….. April 29, 2010
_____ Meet the Directors…..…..……… May 13, 2010
_____ CPR 1………… 9:00-3:00………May 15, 2010
_____ CPR 2…………9:00-3:00………May 22, 2010

**** Attendance at Counselor Training is Required!***

Please circle T-shirt Size:

S M L XL 2X 3X

All shirts are adult sizes

NAME	AGE	SEX	Date of Birth	Email address

MAILING ADDRESS	CITY	STATE	ZIP CODE	HOME PHONE CELL PHONE

EDUCATION-GRADE in HS/YEAR in COLLEGE	NAME OF SCHOOL	HEIGHT	WEIGHT

NAME OF PARENT OR GAURDIAN	HOME PHONE	CELL PHONE WORK PHONE

Experience with people with disabilities:____
____

Certifications/Special skills (circle all that apply): RN Life Guard CPR First Aid Horses Arts & Crafts

Photography Sign Language Play musical instrument: type ____________ willing to bring & play? _________

Please attach a copy of any certifications and their expiration date.

********PLEASE ATTACH WORK EXPERIENCE********

List two adults (not relatives) who have knowledge of your qualifications/character. Have the individuals named below fill out the attached reference forms. These forms must be received by April 1st in order for your application to be complete.

Name	Phone Number	Address	Email and / or Fax number

APPLICANTS MUST BE AT LEAST 15 YRS. OLD BY June 1st, CURRENT PHOTO FOR NEW APPLICANTS IS NECESSARY!

WORK AND VOLUNTEER EXPERIENCE: Indicate all permanent, part-time, cooperative, summer and volunteer work, including any previous camping experience. List most recent experience first.

Name and address of employer (Include street, city, state and zip code)	Nature of Work	Dates (Mo. & Yr.) From	To	Reason for Leaving

NARRATIVE

1. State briefly the reason you desire to work at Camp SMILE

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2. State briefly what you feel your strengths are and how you feel they will assist you at Camp SMILE.

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3. State briefly what you perceive to be your weaknesses and how (if at all) they will affect your performance at Camp SMILE.

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4. How do you feel the Camp SMILE work experience will assist you in meeting your future goals? Please define your goals. ____

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MEDICAL HISTORY

Please check all that apply:

____Asthma ____Back Injury ____Cardiac ____Diabetes ____Hypertension ____ Seizures ____*Other

*Please explain: ____

Immunizations up to date? ____Yes _____No Date of last Tetanus shot: ________________

Can volunteer take Tylenol: ____Yes ____No Can volunteer take Aspirin? ____Yes ____No

List all allergies to food or medicines, indicating reaction & action to be taken: ________________________________

____

List all medications and times to be taken (including over the counter): ________________________________

____

Do you have any special dietary requirements? ____

Should any specific activities be restricted? ____

****This portion, including parent signature, MUST BE COMPLETED or your application will not be processed.****

IN CASE OF EMERGENCY PLEASE CONTACT:

Name: ______________________________ Phone: ______________________

Address: ____________________ City: __________ State: _____ Zip Code: __________

Family Doctor: ____________________________Phone:____________________________

Name of your Health Insurance Company: ______________________________________

Policy or Medicaid Number: ____

Hospital Choice: ____

RELEASE, WAIVER & INDEMNITY

The undersigned has volunteered to be a counselor at Camp SMILE, provided by United Cerebral Palsy of Mobile, Inc. The undersigned acknowledges that as a Counselor, he/she will engage in, and assist others in engaging in, sport, recreational and other activities which are, or may be, potentially dangerous. The undersigned hereby acknowledges that he/she understands that he/she will be engaging in, and assisting others to engage in such activities, and the undersigned hereby releases United Cerebral Palsy of Mobile, Inc., the owners of the property upon which Camp SMILE is conducted, and their respective agents, employees, successors and assigns, from, and hereby waives, any and all liability, claims, demands, actions, causes of action, expenses and damages in any way resulting from personal injuries, conscious suffering, death or property damage sustained by the undersigned arising out of the undersigned's participation in such camp activities. This Release, Waiver & Indemnity shall be binding upon the undersigned and his/her heirs, successors and assigns.

I hereby grant to the Camp Physician or his authorized representatives permission to furnish or arrange for the furnishing of such hospital and medical care as (Name of Counselor) __________________________ MIGHT REQUIRE DURING SUCH TIME AS HE/SHE IS A VOLUNTEER AT CAMP SMILE. This medical care shall include, but not be limited to, examinations, treatment, immunizations, injections, anesthesia, surgery and other procedures, etc. I understand that I shall be notified as soon as possible. Failure in such efforts shall not prevent the provision of emergency treatment necessary for the best interest of the life and health of said Counselor.

For and in consideration of Camp SMILE receiving the herein named counselor in the camp, and in consideration of the same, and any services which might be performed for the counselor, the undersigned, as natural guardian of said counselor, for and on behalf of the camp or the undersigned individually, hereby releases, acquits, covenants to hold harmless and indemnify the camp physician, Camp SMILE, and all other persons, firms and corporations associated with them, from all claims, damages, actions and causes of action of whatever nature may accrue to the said counselor or the undersigned, their heirs, executors, administrators, and legal representatives and assigns, arising out of any of the above procedures.

The undersigned further grants permission for said counselor to be photographed, with such pictures and names to be used in public relations and fund raising efforts to promote programs of Camp SMILE.

If the undersigned counselor is under the age of nineteen years, his/her parent and/or legal guardian will also be required to execute this Release, Waiver and Indemnity. By doing so, the undersigned parent and/or legal guardian hereby releases United Cerebral Palsy of mobile, Inc., the owners of the property upon which Camp SMILE is conducted, and their agents, employees, successors and assigns, from, and hereby waive, all of the aforementioned liabilities, claims, demands, action, causes of action, expenses and damages in any way resulting from personal injury, conscious suffering, death or property damage sustained by the undersigned counselor and hereby agree to hold harmless, United Cerebral Palsy of Mobile, Inc., the owners of the property upon which Camp SMILE is conducted, and their agents, employees, successor and assigns, from and against all losses, claims, demands, actions or proceedings of any kind which may be initiated against any of the foregoing by any person and arising out of any action or inaction on the part of United Cerebral Palsy of Mobile, Inc. or such owner, agents, employees,

__________ Date   ______________________ Counselor Name (Printed)   ______________________ Counselor Signature

______________________________ Parent/Guardian Printed Name   ______________________ **Parent/Guardian Signature**
(If under 19 years old)

DO YOU SMOKE? _____Yes _____No **CAMP SMILE IS A SMOKE FREE FACILITY!**

Please complete and return to: **United Cerebral Palsy of Mobile, Inc.**
Attn: Camp SMILE
3058 Dauphin Square Connector
Mobile AL 36607

DEADLINE FOR APPLICATION IS: APRIL 1, 2010