

Name: \_\_\_\_\_

Age \_\_\_\_\_

Summer 2012



## Qualification for Camp His Way **Returning** Levites

Christians who are in the places of responsibility in the camp are required to be examples in faith, conduct, and business affairs. To maintain a high standard for workers is one of the best ways to present Christ to the visitors of our camp. Therefore, the following guidelines will be required of any person who works with Camp His Way.

1. Must be in agreement with the mission statement for Camp His Way.
2. Be a member of a church, or in the membership process and a faithful attendee.
3. Be able to commit to work at least 4 weeks in the summer (see page 5 calendar).
4. Return this Camp Worker Application to camp before April 30, 2012.
5. Be loyal to the camp director and the camp program.
6. Be faithful in your assigned positions.
7. Live a separated Christian life.
8. Attend all workers meetings and workshops.
9. Have a servant's heart.
10. Be at your designated post on or before starting time.
11. Be neat in your appearance.
12. Attend Levite Orientation and complete appropriate training.
13. Your home life must be in order. (ie – not running away)
14. Go through a personal interview.
15. Be at least 15 years old or have prior permission.

Please read and sign:

I have read the above qualifications and pledge to keep them to the very best of my ability.  
I clearly understand that failure to keep any above qualifications is grounds for dismissal.

Signed: \_\_\_\_\_ Date: \_\_\_\_\_

# **RETURNING LEVITE APPLICATION**

(CONFIDENTIAL)

This application is to be completed by all applicants for any position involving the supervision or custody of minors. It is being used to help the camp provide a safe and secure environment for those children and youth who participate in our program and the use of our facilities. You are to complete this application yourself without any influence of others.

\_\_\_\_/\_\_\_\_/\_\_\_\_  
DATE

Name \_\_\_\_\_ Goes By \_\_\_\_\_

Address (same ) \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Phone (\_\_\_\_) \_\_\_\_\_ Cell (\_\_\_\_) \_\_\_\_\_ E-mail \_\_\_\_\_

T-Shirt Size \_\_\_\_\_ Birthday (mm/dd/yyyy) \_\_\_\_/\_\_\_\_/\_\_\_\_ Marital Status \_\_\_\_\_ No. Children \_\_\_\_\_

**List Responsibilities Last Summer:**

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Other areas you are interested in: \_\_\_\_\_

**Certifications:**

**If No are you willing to be?**

CPR	Y	N	Expiration date _____	Y	N
First Aid	Y	N	Expiration date _____	Y	N
Lifeguard	Y	N	Expiration date _____	Y	N
Boater's Ed	Y	N	Expiration Date _____	Y	N

**Jobs Since Last Summer:**

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**Ministries Involved With Since Last Summer:**

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**Any Updates Since Your Last Application:**

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# APPLICANTS STATEMENT

The information contained in this application is correct to the best of my knowledge. I authorize any reference or church listed in this application to give Camp His Way any information they may have regarding my character and fitness for children's work. I release all such references from the liability for any damage that may result from the furnishing such evaluations to you and I waive any right that I have to inspect the references provided on my behalf. Should my application be accepted, I agree to be loyal to the camp director and camp policies of Camp His Way. I agree to refrain from unscriptural conduct in the performance of my services on behalf of the Camp.

Applicant's Signature \_\_\_\_\_ Date \_\_\_\_\_

As a Levite applicant for Camp His Way, I have been requested to furnish information for use in determining qualifications. In this connection, I do hereby authorize the release and full disclosure of any information that you may have concerning my volunteering with your organization.

I authorize you to release information about my background including, but not limited to, information as to my employment, education, military service, driving record, criminal record and/or public records history to those employees and agents of Camp His Way who require such information in order to make a decision with respect to any matter pertaining to my status as a Levite.

I hereby release Camp His Way, its employees and anyone acting on behalf of your organization from any and all claims, liability and/or damage of any nature with may result from furnishing the information requested, including, but not limited to, claims of negligence.

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

Printed Name \_\_\_\_\_

Driver's License Number \_\_\_\_\_

Social Security Number \_\_\_\_\_

As youth workers, aware of contemporary culture, we know there is a high probability our campers and their parents will explore staff networking sites and personal blogs after camp. It is very important to us that you and your site(s) reflect Jesus; after all we want staff who imitate Jesus year-round not just in our summer camp setting. Therefore, as part of our Levite Application we ask for URL's for your personal blogs and accounts on social websites such as MySpace, Twitter, and Facebook. We hope you will see this as good accountability integral to mutual discipling. Please initial here to indicate that you have complied with this request and list such addresses below.

If you have no such site please initial here \_\_\_\_\_

Please print sites clearly \_\_\_\_\_

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

# SCHEDULING CALENDAR

Circle the sessions that you will be available to work.

This year staff will work for 4 sessions of 2-3 week periods.

Arrival times are on the Sunday evening or Monday morning @ CHW between 9-10am of the beginning session.

Departure times are the last Friday of the session @ 5pm.

Please try not to leave early so we can get the camp cleaned up. – You **must** make plans to go home (*your home*) in between sessions. The camp will be empty – you may **not** stay at camp. These are the already blacked out dates.

This does not mean you are scheduled for those weeks; we will schedule everyone during orientation weekend.

If you are coming with your church group as a counselor or helper – not as a Levite – it does not count as one of your committed weeks.

Also, **black out** any dates that might not be able to work with an explanation.

Remember **May 25-28** is mandatory Friday 5pm-Monday 2pm- Levite Orientation.

## May/June 2012

S	M	T	W	T	F	S
20	21	22	23	24	25	26
27	28	29	30	31	1	2
3	4	5	6	7	8	9
10	11	12	13	14	15	16
17	18	19	20	21	22	23
24	25	26	27	28	29	30

< Levite Orientation

← Session 1  
May 29-June 14  
Three weeks

## July 2012

S	M	T	W	T	F	S
1	2	3	4	5	6	7
8	9	10	11	12	13	14
15	16	17	18	19	20	21
22	23	24	25	26	27	28
29	30	31	1	2	3	4

← Session 2  
June 18 – July 6  
Three weeks

← Session 3  
July 9 – 20  
Two weeks

## August 2012

S	M	T	W	T	F	S
5	6	7	8	9	10	11
12	13	14	15	16	17	18

← Session 4  
July 23- August 10  
Three Weeks

Levite Rest Weekend  
August 10-12

# CAMPER HEALTH HISTORY FORM 1

Developed and reviewed by: American Camp Association, American Academy of Pediatrics Council on School Health, & Association of Camp Nurses

**If Child is to be administered Prescribed Medication FORM 2 must be completed and signed by a physician.**

Dates will attend camp: from \_\_\_\_\_ to \_\_\_\_\_  
Month/Day/Year Month/Day/Year

Camper Name: \_\_\_\_\_  
First Middle Last

Male  Female Birth Date \_\_\_\_\_ Age on arrival at camp: \_\_\_\_\_  
Month/Day/Year

**To Parent(s)/Guardian(s): Please follow the instructions below. Attach additional information if needed.**

- 1) Complete pages 1, 2 and 3 of this form (FORM 1) and make a copy.
- 2) Send the original, signed FORM 1 to camp with the camper.
- 3) Complete the top of FORM 2 (CAMPER HEALTH-CARE RECOMMENDATIONS) and provide the copy of FORM 1 with FORM 2 to your child's health-care provider for review and completion.
- 4) FORM 2 only needs to be completed by your child's health-care provider if you child is to be administered prescribed medication at camp.

Camper Home Address: \_\_\_\_\_  
Street Address City State Zip Code

Parent/guardian with legal custody to be contacted in case of illness or injury:

Name: \_\_\_\_\_ Relationship to Camper: \_\_\_\_\_ Preferred Phones: (\_\_\_\_\_) \_\_\_\_\_ (\_\_\_\_\_) \_\_\_\_\_  
Relationship to Camper  
 Email: \_\_\_\_\_

Home Address: \_\_\_\_\_  
(If different from above) Street Address City State Zip Code

Second parent/guardian or other emergency contact:

Name: \_\_\_\_\_ Relationship to Camper: \_\_\_\_\_ Preferred Phones: (\_\_\_\_\_) \_\_\_\_\_ (\_\_\_\_\_) \_\_\_\_\_  
Relationship to Camper  
 Email: \_\_\_\_\_

Additional contact in event parent(s)/guardian(s) can not be reached:

Name(s): \_\_\_\_\_ Relationship to Camper: \_\_\_\_\_ Preferred Phones: (\_\_\_\_\_) \_\_\_\_\_ (\_\_\_\_\_) \_\_\_\_\_  
Relationship to Camper

**Allergies:**  No known allergies.  This camper is allergic to:  Food  Medicine  The environment (insect stings, hay fever, etc.)  Other  
*(Please describe below what the camper is allergic to and the reaction seen.)*

**Diet, Nutrition:**  This camper eats a regular diet.  This camper eats a regular vegetarian diet.  
 This camper has special food needs. *(Please describe below.)*

**Restrictions:**  I have reviewed the program and activities of the camp and feel the camper can participate without restrictions.  
 I have reviewed the program and activities of the camp and feel the camper can participate with the following restrictions or adaptations. *(Please describe below.)*

**Medical Insurance Information:**

This camper is covered by family medical/hospital insurance  Yes  No

**Include a copy of your insurance card if appropriate; copy both sides of the card so information is readable.**

Insurance Company \_\_\_\_\_ Policy Number \_\_\_\_\_

Subscriber \_\_\_\_\_ Insurance Company Phone Number (\_\_\_\_\_) \_\_\_\_\_

**Parent/Guardian Authorization for Health Care:**

This health history is correct and accurately reflects the health status of the camper to whom it pertains. The person described has permission to participate in all camp activities except as noted by me and/or an examining physician. I give permission to the physician selected by the camp to order x-rays, routine tests, and treatment related to the health of my child for both routine health care and in emergency situations. If I cannot be reached in an emergency, I give my permission to the physician to hospitalize, secure proper treatment for, and order injection, anesthesia, or surgery for this child. I understand the information on this form will be shared on a "need to know" basis with camp staff. I give permission to photocopy this form. In addition, the camp has permission to obtain a copy of my child's health record from providers who treat my child and these providers may talk with the program's staff about my child's health status.

Signature of Custodial Parent/Guardian \_\_\_\_\_ Date: \_\_\_\_\_ Relationship to Camper: \_\_\_\_\_

**If for religious or other reasons you cannot sign this, contact the camp for a legal waiver which must be signed for attendance.**

Camper Name

First

Middle

Last

(For Camp Use) Cabin or Group

(For Camp Use) Session Code(s):

# CAMPER HEALTH HISTORY FORM 1

Developed and reviewed by: American Camp Association, American Academy of Pediatrics Council on School Health, & Association of Camp Nurses

Camper Name: \_\_\_\_\_  
 First Middle Last

Birth Date: \_\_\_\_\_  
 Month/Day/Year

**Immunization History:** Provide the month and year for each immunization. Starred (★) immunizations must be current. Copies of immunization forms from health-care providers or state or local government are acceptable; please attach to this form.

Immunization	Dose 1 Month/Year	Dose 2 Month/Year	Dose 3 Month/Year	Dose 4 Month/Year	Dose 5 Month/Year	Most Recent Dose Month/Year
Diphtheria, tetanus, pertussis ★ (DTaP) or (TdaP)						
Tetanus booster ★ (dT) or (TdaP)						
Mumps, measles, rubella ★ (MMR)						
Polio ★ (IPV)						
Haemophilus influenzae type B (HIB)						
Pneumococcal (PCV)						
Hepatitis B						
Hepatitis A						
Varicella (chicken pox)	<input type="checkbox"/> Had chicken pox Date: _____					
Meningococcal meningitis (MCV4)						

Tuberculosis (TB) test      Date: \_\_\_\_\_       Negative       Positive

**If your camper has not been fully immunized, please sign the following statement:** I understand and accept the risks to my child from not being fully immunized.

Signature of Custodial Parent/Guardian: \_\_\_\_\_ Date: \_\_\_\_\_ Relationship to Camper: \_\_\_\_\_

**Medication:**     This camper will not take any daily medications while attending camp.  
 This camper will take the following daily medication(s) while at camp:

"Medication" is any substance a person takes to maintain and/or improve their health. This includes vitamins & natural remedies. ***Please review camp instructions about required packaging/containers. Many states require original pharmacy containers with labels which show the camper's name and how the medication should be given. Provide enough of each medication to last the entire time the camper will be at camp.***

Name of medication	Date started	Reason for taking it	When it is given	Amount or dose given	How it is given
			<input type="checkbox"/> Breakfast <input type="checkbox"/> Lunch <input type="checkbox"/> Dinner <input type="checkbox"/> Bedtime <input type="checkbox"/> Other time: _____		
			<input type="checkbox"/> Breakfast <input type="checkbox"/> Lunch <input type="checkbox"/> Dinner <input type="checkbox"/> Bedtime <input type="checkbox"/> Other time: _____		
			<input type="checkbox"/> Breakfast <input type="checkbox"/> Lunch <input type="checkbox"/> Dinner <input type="checkbox"/> Bedtime <input type="checkbox"/> Other time: _____		

The following non-prescription medications may be stocked in the camp Health Center and are used on an as needed basis to manage illness and injury. ***Cross out those the camper should not be given.***

- |   |   |
|---|---|
| Acetaminophen (Tylenol)                                   | Ibuprofen (Advil, Motrin)                                     |
| Phenylephrine decongestant (Sudafed PE)                   | Pseudoephedrine decongestant (Sudafed)                        |
| Antihistamine/allergy medicine                            | Guaifenesin cough syrup (Robitussin)                          |
| Diphenhydramine antihistamine/allergy medicine (Benadryl) | Dextromethorphan cough syrup (Robitussin DM)                  |
| Sore throat spray   | Generic cough drops   |
| Lice shampoo or cream (Nix or Elimite)                    | Antibiotic cream  |
| Calamine lotion   | Aloe  |
| Laxatives for constipation (Ex-Lax)                       | Bismuth subsalicylate for diarrhea (Kaopectate, Pepto-Bismol) |

# CAMPER HEALTH HISTORY FORM 1

Developed and reviewed by: American Camp Association, American Academy of Pediatrics Council on School Health, & Association of Camp Nurses

Camper Name: \_\_\_\_\_  
First Middle Last

Birth Date: \_\_\_\_\_  
Month/Day/Year

**General Health History: Check "Yes" or "No" for each statement. Explain "Yes" answers below.**

Has/does the camper:

- |   |   |
|---|---|
| 1. Ever been hospitalized? ..... <input type="checkbox"/> Yes <input type="checkbox"/> No                   | 11. Had fainting or dizziness? ..... <input type="checkbox"/> Yes <input type="checkbox"/> No                         |
| 2. Ever had surgery? ..... <input type="checkbox"/> Yes <input type="checkbox"/> No                         | 12. Passed out/had chest pain during exercise? ..... <input type="checkbox"/> Yes <input type="checkbox"/> No         |
| 3. Have recurrent/chronic illnesses? ..... <input type="checkbox"/> Yes <input type="checkbox"/> No         | 13. Had mononucleosis ("mono") during the past 12 months?... <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 4. Had a recent infectious disease? ..... <input type="checkbox"/> Yes <input type="checkbox"/> No          | 14. If female, have problems with periods/menstruation?..... <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 5. Had a recent injury? ..... <input type="checkbox"/> Yes <input type="checkbox"/> No                      | 15. Have problems with falling asleep/sleepwalking? ..... <input type="checkbox"/> Yes <input type="checkbox"/> No    |
| 6. Had asthma/wheezing/shortness of breath?..... <input type="checkbox"/> Yes <input type="checkbox"/> No   | 16. Ever had back/joint problems?..... <input type="checkbox"/> Yes <input type="checkbox"/> No                       |
| 7. Have diabetes? ..... <input type="checkbox"/> Yes <input type="checkbox"/> No                            | 17. Have a history of bedwetting?..... <input type="checkbox"/> Yes <input type="checkbox"/> No                       |
| 8. Had seizures? ..... <input type="checkbox"/> Yes <input type="checkbox"/> No                             | 18. Have problems with diarrhea/constipation?..... <input type="checkbox"/> Yes <input type="checkbox"/> No           |
| 9. Had headaches? ..... <input type="checkbox"/> Yes <input type="checkbox"/> No                            | 19. Have any skin problems?..... <input type="checkbox"/> Yes <input type="checkbox"/> No                             |
| 10. Wear glasses, contacts, or protective eyewear? <input type="checkbox"/> Yes <input type="checkbox"/> No | 20. Traveled outside the country in the past 9 months?..... <input type="checkbox"/> Yes <input type="checkbox"/> No  |

**Please explain "Yes" answers in the space below,** noting the number of the questions. For travel outside the country, please name countries visited and dates of travel.

**Mental, Emotional, and Social Health: Check "Yes" or "No" for each statement.**

Has the camper:

1. Ever been treated for attention deficit disorder (ADD) or attention deficit/hyperactivity disorder (AD/HD)? .....  Yes  No
2. Ever been treated for emotional or behavioral difficulties or an eating disorder?.....  Yes  No
3. During the past 12 months, seen a professional to address mental/emotional health concerns?.....  Yes  No
4. Had a significant life event that continues to affect the camper's life?.....  Yes  No  
(History of abuse, death of a loved one, family change, adoption, foster care, new sibling, survived a disaster, others)

**Please explain "Yes" answers in the space below,** noting the number of the questions. The camp may contact you for additional information.

**Health-Care Providers:**

Name of camper's primary doctor(s): \_\_\_\_\_ Phone: (\_\_\_\_\_) \_\_\_\_\_  
Name of dentist(s): \_\_\_\_\_ Phone: (\_\_\_\_\_) \_\_\_\_\_  
Name of orthodontist(s): \_\_\_\_\_ Phone: (\_\_\_\_\_) \_\_\_\_\_

**What Have We Forgotten to Ask? Please provide in the space below** any additional information about the camper's health that you think important or that may affect the camper's ability to fully participate in the camp program. **Attach additional information if needed.**

**Parents/Guardians: STOP here. The rest of this is form is completed when the camper arrives at camp. Keep a copy for your records.**

**CAMPER HEALTH-CARE RECOMMENDATIONS  
by LICENSED MEDICAL PERSONNEL FORM 2**

Developed and reviewed by: American Camp Association,  
American Academy of Pediatrics Council on School Health, &  
Association of Camp Nurses

**This FORM 2 must be signed by a physician if the camper is to be administered prescribed medication while he/she is attending camp.**

**To Parent(s)/Guardian(s): Complete this section and give this form (FORM 2) and a copy of your completed CAMPER HEALTH HISTORY FORM (FORM 1) to your child's health-care provider for review.**

Dates will attend camp: from \_\_\_\_\_ to \_\_\_\_\_  
Month/Day/Year Month/Day/Year

Camper Name: \_\_\_\_\_  
First Middle Last

Male  Female Birth Date \_\_\_\_\_ Age on arrival at camp \_\_\_\_\_  
Month/Day/Year

Camper home address: \_\_\_\_\_  
City State Zip Code

Custodial parent(s)/guardian(s) phone: (\_\_\_\_\_) (\_\_\_\_\_) \_\_\_\_\_  
**Parent(s)/guardian(s) stop here. Rest of form to be completed by medical personnel.**

The following non-prescription medications are commonly stocked in camp Health Centers and are used on an as needed basis to manage illness and injury. **Medical personnel: Cross out those items the camper should not be given.**

- Acetaminophen (Tylenol)
- Ibuprofen (Advil, Motrin)
- Phenylephrine (Sudafed PE)
- Pseudoephedrine (Sudafed)
- Chlorpheniramine maleate
- Guaifenesin
- Dextromethorphan
- Diphenhydramine (Benadryl)
- Generic cough drops
- Chloraseptic (Sore throat spray)
- Lice shampoo or scabies cream (Nix or Elimate)
- Calamine lotion
- Bismuth subsalicylate (Pepto-Bismol)
- Laxatives for constipation (Ex-Lax)
- Hydrocortisone 1% cream
- Topical antibiotic cream
- Calamine lotion
- Aloe

**Medical Personnel: Please review the CAMPER HEALTH HISTORY FORM (FORM 1) and complete all remaining sections of this form (FORM 2). Attach additional information if needed.**

**Physical exam done today:**  Yes  No (If "No," date of last physical: \_\_\_\_\_)  
Month/Day/Year

ACA accreditation standards specify physical exam within last 24 months.

Weight: \_\_\_\_\_ lbs Height: \_\_\_\_\_ ft \_\_\_\_\_ in Blood Pressure \_\_\_\_\_ / \_\_\_\_\_

**Allergies:**  No Known Allergies

To foods (**list**):

To medications: (**list**):

To the environment (**insect stings, hay fever, etc.—list**):

Other allergies: (**list**):

**Describe previous reactions:**

**Diet, Nutrition:**  Eats a regular diet.  Has a medically prescribed meal plan or dietary restrictions: (**describe below**)

**The camper is undergoing treatment at this time for the following conditions: (describe below)**  None.

**Medication:**  No daily medications.  Will take the following prescribed medication(s) while at camp: (**name, dose, frequency—describe below**)

**Other treatments/therapies to be continued at camp: (describe below)**  None needed.

**Do you feel that the camper will require limitations or restrictions to activity while at camp?**  No  Yes

**If you answered "Yes" to the question above, what do you recommend? (describe below—attach additional information if needed)**

**"I have reviewed the CAMPER HEALTH HISTORY FORM (FORM 1), and have discussed the camp program with the camper's parent(s)/guardian(s). It is my opinion that the camper is physically and emotionally fit to participate in an active camp program (except as noted above.)"**

Name of licensed provider (please print): \_\_\_\_\_ Signature: \_\_\_\_\_ Title: \_\_\_\_\_

Office Address \_\_\_\_\_  
Street City State Zip Code

Telephone: (\_\_\_\_\_) \_\_\_\_\_ Date: \_\_\_\_\_

## What to bring

Bedding—(beds are twin size) sleeping bags work as well.

Durable shoes

Swimming suits—One piece only for girls (or wear shirt over), must have modest shorts

2 Towels, toiletries, dirty clothes bag

**Old shoes or water shoes for lake activities (not flip-flops)**

Flashlight

Lifejacket—Optional, but you might like to have your own

Bible

1-2 Workshirts, Modest shorts, Blue jeans (sharp looking for chapel dress)

Underclothes and socks—(duh)

Write your name on everything—lost items will be thrown away.

## What not to bring

No radios, MP3 or CD players, video games televisions or cell phones.

(All should be turned in on arrival to be locked in office)

No fireworks, lighters, matches, or guns of any type are allowed.

No food allowed in the dorm.

## Important Dates

May 25-28—Levite Orientation

May 29—First Day of Camp

May 29-June 14—Session 1      June 16-17—Rest Weekend

June 18-July 6—Session 2      July 7-8—Rest Weekend

July 9-20—Session 3      July 21-22—Rest Weekend

July 23-August 10—Session 4      August 11-12—Rest Weekend

## Contact

Camp His Way—561 McGilberry Rd, Zavalla, TX 75980—mailing address

936-897-9974—business line; 936-897-3274 fax line

[www.camphisway.com](http://www.camphisway.com)

[www.camphisway.com/campermail](http://www.camphisway.com/campermail)—how family can get email you

[info@camphisway.com](mailto:info@camphisway.com)—camp email

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