THE ORIGINAL CAMP ReCREATION OF CATHOLIC CHARITIES OF ORANGE COUNTY SINCE 1978

Volunteer Information 2019

PLEASE CHECK WHICH CAMP YOU ARE ABLE TO BE A PART OF:

_____ CAMP RECREATION JR. (June 27-30, 2019; Training June 26th)

_____ CAMP RECREATION (July 7-10, 2019; Training July 6th)

PLEASE NOTE: ALL DATES ARE MANDATORY TO BE AT CAMP

Name _____ Age_____ Birth Date _____

T-Shirt Size: S M L XL XXL

Please circle your choice above – these are Adult Sized T-Shirts.

PERMANENT Address:

_____Apt. # _____

City _____ State _____ Zip _____

Cell phone ( )_____

E-Mail Address _____

Sex___ Height ____ Weight _____

(This information is used to best pair you with a camper.)

School (If Still Enrolled) _____ Graduating Year _____

Employer _____

Does Your Employer, or Your Parent's Place of Employment, have a foundation or gift matching program that we can reach out to for a donation to Camp? YES NO

Parent(s)/Guardian(s) Name(s) _____

Mother's cell phone ( )_____ Father's cell phone ( )_____

Parent's Email Address _____

Please list an additional person to contact in the event of an emergency if your parents/guardians listed on the previous page can't be reached:

Name _____ Relationship _____

Phone ( ) _____

This year at Camp ReCreation will be my _____ year at Camp.

***If it's your 5th, 10th, 15th or 20th year, please highlight or change font color** CONGRATS!!*

This year at Camp ReCreation Jr. will be my _____ year at Camp.

Please list previous Camp ReCreation experience (include year, position, camper). If you have been a Team Leader, please list your past co-team leaders.

_____

_____

_____

Do you have ***current*** certification for any of the following:

_____ CPR _____ First Aid _____ Lifeguard

Expires _____ _____ _____

Photography/Video Consent:
I hereby give my consent to Camp ReCreation **to photograph or film me** and to use such footage and/or stories in connection with any kind of work of the nonprofit without consideration of compensation of any kind, and I do hereby release said Camp ReCreation from any claims whatsoever which may arise in said regards.

_____ _____
Signature Date

_____ _____
Signature of parent/guardian required if volunteer is under 18 Date

DEADLINE FOR RETURNING COUNSELOR & STAFF APPLICATIONS IS APRIL 15, 2019

Your application must be postmarked by April 15, 2019 and sent to:
Catholic Charities of Orange County
Attn: Camp ReCreation
1820 E 16th Street
Santa Ana, CA 92701

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Volunteer Agreement

Participation in **Camp ReCreation and Camp ReCreation Jr.** is voluntary. For the welfare of the campers as well as the entire camp community, it is essential that you read, understand and agree to abide by the provisions of this agreement.

- To show respect for all campers and maturity in all conversations while at Camp
- To take a personal interest in your Campers' health, happiness and mental well-being
- To abstain from alcoholic beverages and un-prescribed drugs. *Please note: If you are using drugs or alcohol while on campus, along with other repercussions, you will be asked to leave immediately*
- To refrain from smoking except in designated areas and always out of site of the Campers and only when approved by staff or director
- To refrain from profanity or indecent language or discussion topics
- To refrain from the use of cell phones, computers, iPods, etc. except for free time and in emergencies
- To respect the personal property of campers, camp facilities, other counselors and staff members
- **To respect the safety and privacy of the Campers and refrain from posting pictures, letters, gifts, or other forms of correspondence, etc. on any/all social media sites, taking particular care to exclude all identifying information of any campers included in your photos (I.E. do not add their names, locations, etc.)**
- To cooperate with the Camp Director, Nurses, Team Leaders and other staff members
- To maintain discretion concerning all confidential/health matters you are made aware of
- To keep program issues, concerns, and observations within the program
- To only share information regarding your camper files or files of other volunteers with appropriate staff as it relates to their health and well-being while at Camp
- **To NEVER share your personal contact information (including address, emails, social media accounts, etc) with campers and their families or receive and use personal contact information of campers for any reason**

I, _____, agree to abide by the provisions of the Volunteer Agreement as stated above, regardless of age or camp responsibilities. I understand that if I violate any of the provisions of this agreement I am subject to dismissal. I also understand that Camp ReCreation reserves the right, to re-invite me back next year as a volunteer based on my performance at Camp by way of evaluations and my compliance with the Volunteer Agreement.

_____
Signature of Volunteer

_____
Date

_____
Signature of parent / guardian if volunteer is under age 18

_____
Date

Health Agreement

THE ORIGINAL CAMP ReCREATION OF CATHOLIC CHARITIES OF ORANGE COUNTY SINCE 1978

Please initial next to each paragraph and sign at the bottom.

_____ Due to the sensitive nature of our camper's health and well-being, the Director will be taking precautions to prevent the spreading of harmful germs, colds and flu throughout camp. Upon my arrival, I understand I will have to check in immediately with a nurse. If my vitals show any sign of concern, I will be asked to leave Camp and will only be allowed to return with doctor's authorization.

_____ I understand that when I arrive and check in with the nurse, I will need to check in all medications, vitamins, supplements, etc. If I am found to have kept my medicines in my room, I understand I will immediately be asked to leave and will not be allowed back to Camp.

_____ If I have any symptoms of a cold, flu or other injury or illness within 48 hours prior to Camp, I will call the director as soon as possible to discuss my attendance at camp.

_____ When at Camp, if I show signs of a cold or flu, I will be asked to see the nurse, and may be asked to leave camp early. I understand that by withholding my signs or symptoms from my team leader or the Director's might not only make me sicker, but may also infect campers which may lead to more serious health consequences for them. If I am found to have hidden an illness while I camp, I understand that this is grounds for immediate dismissal from camp without return to camp or future camps.

_____ If I have a sprain, broken bone or tear that is in a brace, cast, etc., I will not be allowed to attend camp due to the physical requirements while on campus.

_____ I recognize the Director understands the disappointment I will have by not being able to attend or having to leave Camp early, I understand the health, safety and well-being of our Campers and other volunteers are the number one priority.

_____ I understand that I need to sleep and take care of my own physical and mental wellbeing. I know that if I start to feel as if I need a mental break or nap, all I need to do is ask.

I, _____, agree to abide by the provisions of the Health Agreement as stated above, regardless of age, tenure or camp responsibilities. I understand that if I violate any of the provisions of this agreement I am subject to dismissal. I also understand that Camp ReCreation reserves the right, to re-invite me back next year as a volunteer based on my performance at camp by way of evaluations and my compliance with the Volunteer Agreement

_____

Signature of Volunteer and Date

_____

Signature of parent / guardian if volunteer is under age 18 and Date

Volunteer Health History, Immunizations & List of Medications

Name of Volunteer: _____

Do you have a history of the following?
Give approximate dates:

Ear Infection _____
Allergies:
Rheumatic fever _____
Insect Stings _____
Seizures _____
Epi pin _____
Diabetes _____
Penicillin _____
Chicken Pox _____
Poison Ivy _____
Measles _____
Mumps _____
Asthma _____
Positive TB Test _____
Hay fever _____
Other _____

Immunizations:
(UTD: Up to date, or give most current date)

DPT _____
Chest X-Ray _____
Tetanus _____
TB Skin test _____
Polio _____
Measles _____
Rubella _____
Mumps _____
Other _____

Operations or other serious injuries, include dates:
_____
_____

Chronic or recurring illness(es): _____

Are you currently taking any medication? _____Yes _____No
If Yes, please list on the back

Private Insurance Company _____

Policy Number _____

MediCal/Medical number/Group number _____

Physician Name _____

Phone ( ) _____
Address _____
Street City Zip

Medication:

Physicians may find it necessary to prescribe medication during the time you are at Camp. Such medication MUST BE IN IT'S ORIGINAL CONTAINER with the participant's name, the name of the prescribing doctor, and the name and dosage of the medication. Vitamins, ointments and all other OTC drugs must also be listed with the dosage and must be turned into the nurse during check in on the first day of Camp

Medications for: _____

Name of Medication Dosage Time of Day

1. _____ _____ Breakfast ____ Lunch ____ Dinner ____ Bed____
2. _____ _____ Breakfast ____ Lunch ____ Dinner ____ Bed____
3. _____ _____ Breakfast ____ Lunch ____ Dinner ____ Bed____
4. _____ _____ Breakfast ____ Lunch ____ Dinner ____ Bed____
5. _____ _____ Breakfast ____ Lunch ____ Dinner ____ Bed____
6. _____ _____ Breakfast ____ Lunch ____ Dinner ____ Bed____
7. _____ _____ Breakfast ____ Lunch ____ Dinner ____ Bed____
8. _____ _____ Breakfast ____ Lunch ____ Dinner ____ Bed____
9. _____ _____ Breakfast ____ Lunch ____ Dinner ____ Bed____
10. _____ _____ Breakfast ____ Lunch ____ Dinner ____ Bed____
11. _____ _____ Breakfast ____ Lunch ____ Dinner ____ Bed____
12. _____ _____ Breakfast ____ Lunch ____ Dinner ____ Bed____

Other PRN medications

1. _____ _____ Breakfast ____ Lunch ____ Dinner ____ Bed____
2. _____ _____ Breakfast ____ Lunch ____ Dinner ____ Bed____
3. _____ _____ Breakfast ____ Lunch ____ Dinner ____ Bed____
4. _____ _____ Breakfast ____ Lunch ____ Dinner ____ Bed____
5. _____ _____ Breakfast ____ Lunch ____ Dinner ____ Bed____

Authorization for Medical Care

For minors under age 18 and adults with court –appointed guardians.

(I) (We), the undersigned, parent(s) or guardian(s) of _____, do hereby authorize Camp ReCreation to consent to any x-ray examination, anesthetic, medical, surgical or dental diagnosis and treatment and hospital care which is deemed advisable by, and is rendered under the general or special supervision of any physician, surgeon or dentist licensed under the provisions of the Medical Practice Act or the Dental Practice act, and selected by the aforesaid agent(s), whether such diagnosis or treatment is rendered at the office of a physician, dentist, hospital or other health facility. It is understood that this authorization is given in advance of any specific diagnosis, treatment or hospital care being required and is given as a precautionary measure to provide authority and power on the part of our aforesaid agent(s) to give specific consent to any and all such diagnosis, treatment or hospital care which the aforementioned physician, surgeon, or dentist in the exercise of his/her best judgment may deem advisable. It is further understood that the aforesaid agent(s) will make every effort to contact the parent(s)/guardian(s) in the event of emergency or extensive treatment prior to authorizing such treatment. This authorization is given pursuant to the provisions of Section 25.8 of the Civil Code of California.

It is understood that the above named agent(s) assumes no liability of any kind or character, financial or otherwise, for acting pursuant to the above authorization. This authorization shall be in effect as long as the above-named client remains in the care of the aforesaid agent(s), unless sooner revoked in writing delivered to said agent(s).

A photocopy of this authorization is as valid as the original.

PLEASE SIGN BELOW:

_____

Guardian Signature

_____

Date

Camp ReCreation Volunteer Waiver and Release

Event/Program: **Camp ReCreation and Camp ReCreation Jr.**
Location: Vanguard University
Date(s) and Time: June 27-30, 2019 and July 7-10, 2019

Volunteer's Name: _____
Date of Birth _____
Volunteer's Residence Address: _____
Home/Cell Phone #: _____
Work Phone #: _____

Emergency Contact Name: _____
Phone #: _____
*Physician:*_____
Phone #: _____
Insurance Company: _____
*Policy #:*_____

Allergies/Medical Problems/Disabilities: _____

I wish to participate as a volunteer in the event described above, and as a condition of my being allowed to do so I hereby release and discharge Camp ReCreation and Catholic Charities of Orange County, a California nonprofit corporation, and all of its officers, directors, employees, agents and volunteers from any and all claims for personal injuries or property damage I may suffer as a result of my participation in this event, whether or not such injuries or damages are caused by the negligence, active or passive, of any of the entities and individuals named or described above. I hereby warrant and represent that I am physically fit and capable of participating in this event and of supervising, directing, and caring for the safety and well-being of its participants. I agree to abide by the rules governing this event and to obey the instructions and directions given by the event directors or persons having supervision and control over this event. I agree that if I am injured as a result of my volunteer participation in this event, whether or not caused by the negligence, active or passive, of the entities and individuals herein named or described, recourse for the payment of any resulting hospital, medical or dental treatment or related costs and expenses will be against any accident, hospital, medical or dental insurance or any available benefit plan I may have. I hereby give permission to the physician, nurse, dentist or licensed care staff selected by the supervisory personnel then present to render medical, dental or other appropriate treatment deemed necessary by the physician, nurse, dentist or licensed care staff. I hereby authorize the making of photographs, motion pictures, video tapes, recordings or other memorializing of my image at this event and my participation therein, and the publication and duplication or other use thereof. I hereby waive any rights to compensation or any right that I otherwise might have to limit or control such making or use.

Volunteer Signature: _____ *Date:* _____

(In the case of minors)
Parent/Guardian Signature: _____ *Date:* _____