YOUTH VOLUNTEER APPLICATION FOR DPBA SUMMER CHILDREN'S CAMP June 3 – JUNE 9, 2018

Name_____ Age_____

Address_____

Phone_____ T-shirt size_____

Emergency Contact Name_____

Emergency Contact Phone_____

Parent's Approval _____
Signature & Date

Church Attending_____
Church Address_____
Church Phone_____
Pastor's Name_____
Pastor's Signature_____

I understand that I am volunteering to serve at the DPBA Summer camp located in Burton, AZ and will **not** be compensated financially for this service. I agree that I am coming because I feel led by the Lord to come and serve. I will carry out all tasks assigned by the Camp Director (who will be my boss during the duration of the camp) to the best of my ability as unto the Lord. I know that I will be there to serve and not be served and that any time available for me will only occur after all the work is done. I will arrive at 3:00 p.m. June 5, 2016 and will not leave until the camp is clean and have received permission from the Camp Director, on June 11, 2016 (except in case of an emergency).

_____

Your Signature Date

Please medical sheet and return to: DPBA P.O. Box 297, Snowflake, AZ 85937

HEALTH FORM 2018

NAME _____
HEALTH CONDITION: Excellent___ Good___ Poor___
Please list any health or medical information about camper that we should be aware:
_____
_____
_____
Date of Last Immunization:_____
DPD or TD Tetanus Polio Measles Rubella Mumps
Please list camper's allergies (not dislikes):
Food:_____
Medication:_____
Insect:_____
Other:_____

IMPORTANT:
Do you carry medical/hospital insurance?____ If so, indicate:_____
Carrier & Group #

Please attach copy of insurance card.

Name of Family Physician_____Phone_____
Area code + number

OVER THE COUNTER MEDICATION PERMIT

Following is a list of over the counter medications, which our camp first aid station keeps in stock. Please mark a line through any item you would **NOT** want used on your child.

Acetaminophen (Tylenol)	Milk of Magnesia	Betadine for wound care
Cepastat throat lozenge	Sudafed (decongestant)	Hydrogen Peroxide
Pepto Bismol	Chlor-trimeton (antihist.)	Neosporin ointment
Tums	Actifed (Antihist./Decon.)	Polysporin for wound
Kaopectate	Robitussin	Caladryl lotion
Mylanta Liquid	Hydrocortisone cream	Camphophenique
Donnagel		

AUTHORIZATION TO MEDICATE MINOR CAMPER OR STAFF MEMBER

MUST BE FILLED OUT IF CAMPER IS BRINGING MEDICATION TO CAMP!

I hereby request and authorize Health Care Personnel to administer the below-listed medication(s) to my child:_____
Name of camper

Please give complete information for each medication camper brings to camp. All Medications must be in original container with prescription instructions in your child's name.

NAME OF MEDICATION **DOSAGE** **FREQUENCY** **WHAT IT'S FOR**

_____
_____
_____
_____

IF THIS FORM IS NOT COMPLETED OUT THE VOLUNTEER WILL BE ASKED TO LEAVE CAMP.

_____ _____
Parent's Signature **Date**