Statewide Overnight
Asthma Camp

Counselor Application

July 19 – 25, 2008

(Please type or print)

Name____
Last *First* *MI*

Phone (H) _______________ Phone (W) _______________ Phone (C) ________________

E-Mail ____

Address ____
Number *Street* *City* *State* *Zip code*

Employer ____

Address ____
Number *Street* *City* *State* *Zip code*

Age ______ Sex ______ T-Shirt Size _______

State any physical restrictions ____

____

Are you certified in these or other areas?

R.T. License Number _________________ CPR _____ First Aid _____

Lifesavings ______ Other ________________________

If yes to any of the above, please provide a copy of your certification.

Education Circle the highest level of education completed:

High School College 1 2 3 4 Masters Degree Ph.D.

List degrees and/or certificates: ____

____

CAMP-RELATED AREAS OF KNOWLEDGE, SKILL, AND EXPERTISE

List below some recreational activities, hobbies, sports, etc. in which you possess knowledge, skill, or expertise that we could utilize in organizing and conducting camp programs and activities. In the blank after each activity place a (1) if you are certified as an instructor in that area. Place a (2) in the blank if you possess sufficient skill and experience to assist in teaching the activity. Place a (3) in the blank if the activity is one you have participated in and you feel you could contribute in some way to the organization and supervisor of the activity.

ACTIVITY

1. ____

2. ____

3. ____

If you have received some special experience or training in the last year that you feel could contribute to the overall success of the camp, please describe it below.

____

____

I hereby declare that the information provided by me in this application is true, correct, and complete to the best of my knowledge. I understand that any mis-statements or omissions of fact on this application shall be considered a cause for dismissal.

Signature: ____

All applicants are subject to criminal investigation (paid for by ALAM) prior to acceptance.

Applications can be faxed at 410-560-0829 or e-mail hdougherty@marylandlung.org.

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Asthma Camp

Counselor Health History

July 19 – 25, 2008

Name_________________________________ Date of Birth_____________

Home Address ____

City/State/Zip ____

Home Phone ______________ Work Phone ______________ Cell Phone ______________

Email Address _________________________________

Emergency Contact Person(s) ____

Home Phone ______________ Work Phone ______________ Cell Phone ______________

Primary Physician _________________________ Phone Number _____________________

Health History *(check those that apply):*

___ Frequent colds
___ Frequent sore throats
___ High blood pressure
___ Abscessed ears
___ Bronchitis
___ Fainting spells
___ Stomach aches
___ Constipation
___ Smoking
___ Serious Ivy, Oak or Sumac poisoning
___ (Other) ____

___ Kidney trouble
___ Bed wetting
___ Heart trouble
___ Convulsions
___ Athlete's foot
___ Sleep walking
___ Chickenpox
___ Tuberculosis
___ Epilepsy

___ Measles
___ German Measles
___ Mumps
___ Polio
___ Whooping cough
___ Rheumatic fever
___ Diabetes
___ Asthma
___ Sinusitis
___ Depression

Operations or serious injuries. Describe ____

____

____

Allergic Reactions: Bee sting ____ Antibiotics ____ Food ___________

Please describe any of the above ____

____

Do you use ANA Kit or Epipen? Yes ___ No ____ : If yes, please bring it.

Will you be taking medications at camp? Yes ___ No ___

Medications	Dosage	Time Taken
______________________________	___________________	___________
______________________________	___________________	___________
______________________________	___________________	___________

Restrictions from any activities ____
Have you received a vaccination for hepatitis B (HBV)? Yes □ No □

____/____/____ 1st shot (0 mo.) ____/____/____ 2nd shot (1 mo.) ____/____/____ 3rd shot (6 mo.)

Date of last Tetanus __________

<u>IMPORTANT:</u> PLEASE NOTIFY THE CAMP IF YOU ARE EXPOSED TO ANY COMMUNICABLE DISEASE DURING THE THREE WEEKS IMMEDIATELY PRIOR TO CAMP ATTENDANCE.

Do you consider yourself to be in sound physical health? Yes □ No □
Do you consider yourself to be in sound mental health? Yes □ No □

If no please explain ____

<u>MEDICAL CONSENT FORM:</u>

I/we, the undersigned ____do hereby authorize the American Lung Association of Maryland staff, to get in contact with my emergency contact in order for them to make any of the following decisions: x-ray examination, anesthetic, medical or surgical diagnosis or treatment and hospital care which is deemed advisable by, and is to be rendered under the general or special supervision of, any physician and/or surgeon licensed under the provisions of the Medicine Practice Act on the medical staff of a licensed hospital, whether such diagnosis or treatment is rendered at the office of said physician or at said hospital.

It is understood that this authorization is given in advance of any specific diagnosis, treatment, or hospital care being required but is given to provide authority and power on the part of our aforesaid family member to give specific consent to any and all such diagnosis, treatment, or hospital care which the aforementioned physician, in the exercise of his/her best judgment may deem advisable.

Your Name ____

Signature ______________________________________ Date ___________________________

Please complete below if under 18 years of age:

Are you registered in the Maryland School System? Yes □ No □
(If no, then provide a copy of your immunization record)

Name of School ______________________________

Legal Guardian's Signature __________________________ Date _______________________