

# Project DREAM Camp

## SUPPORT STAFF APPLICATION REQUIREMENTS

1. Must be 16 years of age or older.
2. Provide a resume (updates only for former staff).
3. Provide three letters of recommendation (for new staff) – can be mailed in separate from application.
4. Return a completed application as soon as possible.
5. If selected, required to attend a staff training.
6. Required to sign a release for a criminal background check.

### Project DREAM Camp SUPPORT STAFF APPLICATION (due back by May 15<sup>th</sup>)

Name: _____	Age range:	16-18	18-21	22-30
		31-40	41-50	51 & up
Current Address: _____	_____	_____	_____	_____
<small>Address</small>	<small>City</small>	<small>State</small>	<small>Zip Code</small>	
Summer Address: _____	_____	_____	_____	_____
<small>Address</small>	<small>City</small>	<small>State</small>	<small>Zip Code</small>	

1. How did you receive this application? \_\_\_\_\_
2. Why do you want to become a Support Staff member? \_\_\_\_\_  
\_\_\_\_\_
3. What background do you have that you feel would be particularly helpful in working with the children of addicted families that attend these camps? \_\_\_\_\_  
\_\_\_\_\_
4. What do you consider your special talents and or skills that would benefit the camping program at DREAM Camp? \_\_\_\_\_
5. Are you a certified lifeguard? YES NO    A musician? YES NO
6. If not included in your resume, what experience have you had or hope to have in working with children?  
\_\_\_\_\_  
\_\_\_\_\_
7. Have you ever been arrested and/or convicted of a felony and if so, for what and when: Explain circumstances: \_\_\_\_\_  
\_\_\_\_\_
8. Have you ever been involved in criminal activity involving children: YES NO
9. Are you interested in receiving a college credit – undergraduate/graduate (available to camp staff through FHSU)? YES NO
10. Camp dates preferred (listed on flyer). 1. \_\_\_\_\_ 2. \_\_\_\_\_

*If more space is needed for your responses, please use the back side of this form.*

# DREAM Camp Medical Form – Staff

Name of staff: \_\_\_\_\_

Insurance card information: (a copy of your card, front and back)

Name of physician: \_\_\_\_\_ Phone number: \_\_\_\_\_

Preferred hospital: \_\_\_\_\_ Phone number: \_\_\_\_\_

I have brought the following medications for my own use. (All medications must be in the original bottles):

\_\_\_\_\_

I give my permission for DREAM, Inc. to seek emergency medical assistance for me if I am unable to do so, from qualified professionals.

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

## Medical History

Birth Date: \_\_\_\_\_ Phone number: \_\_\_\_\_

Current Address: \_\_\_\_\_  
Address City State Zip Code

Emergency Address: \_\_\_\_\_  
Address City State Zip Code

Emergency phone number: \_\_\_\_\_ Emergency work number: \_\_\_\_\_

Date of last **tetanus immunization**: \_\_\_\_\_

**Asthma**? YES NO Treated with medication? YES NO Type of medication: \_\_\_\_\_

**Diabetes**? YES NO Treated with medication? YES NO Type of medication: \_\_\_\_\_

Do you have **seasonal allergies**? If yes, please list: \_\_\_\_\_

Are you allergic to **bee stings**: YES NO **Poison Ivy**? YES NO **Penicillin**? YES NO

Do you have a history of **convulsions/seizures**? YES NO Frequent **ear infections**? YES NO

Have you had any treatment for **psychological disorders**? If yes, please list: \_\_\_\_\_

Do you have a **disability**? If yes, please list: \_\_\_\_\_

Is there any additional medical information that we need to be made aware of? If yes, please list: \_\_\_\_\_

\_\_\_\_\_

I hereby give my permission to the physician selected by the camp directors to hospitalize or secure proper treatment (including surgery, injections, anesthesia, etc...)

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