



Camp Staff Application

United Cerebral Palsy of DE, Inc.
 700A River Road, Wilmington, DE 19809
 302-764-2400 ext. 10

Camp Manito

(Please Print)

Name: _____ Date: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone Number: _____ Date of Birth: ___/___/___ Sex ___ Male ___ Female

Email: _____

Education:	Name:	Years Attended:	Graduated (please circle)	
Middle School			YES	NO
High School			YES	NO
College/University			YES	NO
Other			YES	NO

Camp Manito Experience: Camper _____ Volunteer _____ Staff _____

Other Camp Experience: Camp Name: _____ When _____ Volunteer or Staff? _____

Related Work Experience (Please list most recent first)

From Month/Year	To Month/Year	Job Title	Employer and address	Phone Number

CHECK POSITION YOU ARE APPLYING FOR: (1ST, 2ND, 3RD Choice)

Junior Counselor (age 16 and older) _____

Senior Counselor (age 17 and older) _____

Art Director: _____ Sports Director: _____ Swim Director: _____ Camp Director: _____

Assistant Camp Director: _____ Other: _____

Have you ever worked as a counselor? Yes _____ No _____

Where: _____

What group do you feel more comfortable to work with? (please check)

3 - 4 yrs ___ 5 - 6yrs ___ 7 - 10 yrs ___ 11 - 13yrs ___ 14 - 17yrs ___ 18 - 21yrs ___ Any ___

Camp Staff Application

**CAMP MANITO
MEDICAL HISTORY**

Name: _____

Address: _____

Phone: _____

Birthday: ___/___/___ Age: _____ Height: _____ Weight: _____

In case of emergency, contact: _____ Phone: _____
 _____ Phone: _____

Have you had surgery in the last 12 months? YES NO

If yes, please explain: _____

Do you have allergic reactions to: Insect stings Penicillin Food: _____
 If other, please explain: _____

Are you presently under a doctor's care or taking medication? Yes: No:
 If yes, please explain: _____

Permission to receive: Tylenol, Advil, Motrin, Benadryl, Other: _____
 Please initial here: _____

Have you had basic immunization: Please check

- | | | |
|---|---|--|
| <input type="checkbox"/> Diphtheria | <input type="checkbox"/> Measles | <input type="checkbox"/> H. Influenza |
| <input type="checkbox"/> Mumps | <input type="checkbox"/> Injectable Polio | <input type="checkbox"/> Tuberculin Test |
| <input type="checkbox"/> Tetanus date _____ | <input type="checkbox"/> Rubella | <input type="checkbox"/> Pertussis |

Do you swim: Yes No

Any restrictions or assistance needed? _____



Camp Staff Application

CAMP MANITO

Waiver for Camp Staff and Volunteers

The form is to be signed by staff and/or volunteer. If the person is under age 18 it is to be signed by the person's parent or guardian.

I (or if under 18 the parent and/or guardian of the applicant) knowingly and voluntarily release any and all claims and waive any legal rights the applicant may have to assert any claims against United Cerebral Palsy of Delaware, Inc. ("UCP"), its employees, officers, directors, volunteers, and agents for any and all causes that may arise in connection with my (or son/daughter's) work at camp or other activities as a UCP staff person and/or volunteer.

If the person is age 18 and over, _____ (check) in the event of an emergency, I hereby give permission to the physician selected by the UCP camp director to order X-ray, routine tests, and treatment, and I hereby give permission to the physician selected by the camp director to secure proper treatment including hospitalization, medication, anesthesia, and/or surgery.

If the person is under age 18, _____ (check) in the event of an emergency, I hereby give permission to the physician selected by the UCP camp director to order X-ray, routine tests, and treatment, for the health of my child, and in the event that I cannot be reached in an emergency, I hereby give permission to the physician selected by the camp director to secure proper treatment for my son/daughter including hospitalization, medication, anesthesia, and/or surgery.

Parent/Guardian Signature: _____ Date: _____

Signature of Applicant: _____ Date: _____

Insurance: _____ Other: _____

Group Number: _____

Family Physician: _____ Phone: _____

Address: _____

REFERENCES

Please provide three references: include name and phone number
(Do not include relatives)

1. _____
2. _____
3. _____

I authorize the investigation of all statements in this application. I give permission to contact all references. I understand that false or misleading statements in this application will be sufficient cause for the termination of employment at Camp Manito.

Signature: _____ Date: _____



Camp Staff Application

Please list any talents or interests you are willing to share with the campers.

_____	_____	_____
_____	_____	_____
_____	_____	_____

T-shirt size: Adult- S M L XL

IMAGE AND/OR VOICE CONSENT & RELEASE FORM

I consent to the use, by United Cerebral Palsy of Delaware, Inc., of my image or voice, as recorded on a video, photo, audio, or digital device and/or other medium. This consent is granted whether my image or voice is used for fund raising, advertising, publicity, or any other purpose.

I waive all claims for compensation or damages based upon the use of my image or voice by United Cerebral Palsy of Delaware, Inc., or its agents, successors, or assigns.

I waive any right to inspect or approve the finished product or the particular use made of my image or voice. I understand that my image or voice may be modified or retouched, and I release United Cerebral Palsy of Delaware, Inc. and its agents, successors and assigns from any liability by virtue of any blurring, distortion, alteration, misnaming, mislabeling, or other modification that might occur.

I understand this consent is perpetual, that I may not revoke it, and that it is binding on me and my heirs and assigns.

I represent and warrant that I am of legal age, and that I have the capacity and right to execute this consent. I further warrant that I have read this consent and understand its contents.

Printed Name: _____

Signature: _____

Parent/Guardian Name*: _____

Parent/Guardian Signature*: _____

*A parent or legal guardian must sign if the employee is under the age of 18.

Delaware law states that all staff and volunteers over the age of 18, who work with children, are required to be fingerprinted

Return to: **UNITED CEREBRAL PALSY OF DELAWARE, INC.**
700A River Road
Wilmington, DE 19809
(302)764-2400 ext. 10