



Volunteer 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: \_\_\_\_\_ Age: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Phone Number: \_\_\_\_\_ Date of Birth: \_\_\_/\_\_\_/\_\_\_ Sex: M F

Email Address: \_\_\_\_\_

Education	School Name	Attended	Graduated	
			Please Circle	
Middle School			YES	NO
High School			YES	NO
College/University			YES	NO
Other			YES	NO

Camp Manito Experience: Camper (When) \_\_\_\_\_ Volunteer (When) \_\_\_\_\_  
 Staff (When/Position) \_\_\_\_\_

**Other Experience:**

Camp: \_\_\_\_\_ Camper: \_\_\_\_\_ Volunteer: \_\_\_\_\_ Staff: \_\_\_\_\_  
 When: \_\_\_\_\_

How did you become interested in volunteering at Camp Manito? \_\_\_\_\_

All applicants must be 14 years old by July 2, 2012 in order to volunteer.

(If under 18, have parent fill in below):

I give permission for my son/daughter \_\_\_\_\_, to do volunteer work with children at Camp Manito. **I understand that the position of a volunteer is provisional and not guaranteed for the duration of Camp.** I understand that my child's work performance will be evaluated by the Camp Director, and their status as a volunteer will be discussed at that time.

Parent Signature: \_\_\_\_\_



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## CAMP MANITO

Please list three references, other than family members:

Name	Address	Relationship	Phone

Do you have any family member attending the camp? \_\_\_\_\_  
 If yes, who: \_\_\_\_\_

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

_____	_____	_____
_____	_____	_____
_____	_____	_____

Please list dates and times you will be available and willing to volunteer at Camp Manito. Our camp hours are Monday thru Friday from 7:00 a.m. until 6:00 p.m. from July 5 to August 12. Please indicate times below.

Monday	Tuesday	Wednesday	Thursday	Friday

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 services at Camp Manito.

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

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

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## CAMP MANITO MEDICAL HISTORY

Name: \_\_\_\_\_

Address: \_\_\_\_\_

Phone: \_\_\_\_\_

In case of emergency, contact: \_\_\_\_\_ Phone: \_\_\_\_\_  
\_\_\_\_\_ Phone: \_\_\_\_\_

Birthday: \_\_\_/\_\_\_/\_\_\_ Age: \_\_\_\_\_ Height: \_\_\_\_\_ Weight: \_\_\_\_\_

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? \_\_\_\_\_



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## 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: \_\_\_\_\_ Type of Contract: \_\_\_\_\_

Family Physician: \_\_\_\_\_ Phone: \_\_\_\_\_

Address: \_\_\_\_\_

\_\_\_\_\_



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## CAMP MANITO

### 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 volunteer is under the age of 18.

**Please circle a T-shirt size for volunteer:** Youth S M L  
Adult S M L XL

\*\*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  
(302) 764-8713 (fax)