Camp Sunshine & Camp Snowflake, Inc.

1133 E. Ridgewood Ave., Saddle River County Park, Wild Duck Pond Area, Ridgewood, NJ 07450, (201)652-1755
Mailing Address: P.O. Box 99, Ridgewood, NJ 07451-0099 Email: campsunsnow@gmail.com
www.sunshine——snowflake.org

2021-2022 Camp Snowflake Volunteer Application

Name: _____ Phone #: _____

Street Address: _____ Email: _____

City/State: _____ Birth Date: _____

Zip Code: _____ Current School/Occupation: _____

Age: _____

In Case of Emergency, Contact: _____ Phone #: _____

Alternate Phone #: _____

Have you Ever Volunteered At Camp Sunshine/Snowflake before? ☐ Yes No ☐ (check one)

If Yes, How many Years? _____

Have You Ever Been Convicted for Any Crime? ☐ Yes No ☐ (check one)

Have You Ever Been Convicted of a Sex-Related or Child Abuse-related Offense? ☐ Yes No ☐ (check one)

Are you currently certified in any of the following (or equivalent)? Please check all the apply.

- ☐ Adult CPR/AED
- ☐ Infant & Child CPR
- ☐ CPR/AED for the Professional Rescuer
- ☐ Standard First Aid
- ☐ Community First Aid & Safety
- ☐ Emergency Response
- ☐ Lifeguard Training
- ☐ Other:

For the 2021-22 season, Camp Snowflake will operate on Saturdays from September 18th 2021, through May 7, 2022. We close for major holidays and for inclement weather, so call ahead for information on an upcoming Saturday.

As a volunteer, I agree to carry out all responsibilities and duties, which include reporting promptly for the days that I am able to attend, and to comply with all staff and program regulations.

Signature: _____ Date: _____

For the parent/guardian of minors:

I give permission for _____ to be given Tylenol for headaches: ☐ Yes No ☐

I give permission for him/her to attend supervised field trips during Camp hours: ☐ Yes No ☐

Major Medical Concerns _____

Signature: _____ Date: _____

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New Jersey State Department Of Health
Standard School/Child Care Center Immunization Records

Name of Child (Last, First M)							Date of Birth (MM/DD/YY) Sex: M F				
Parent Or Guardian	Name:						Telephone #				
	Address:						Name of Doctor:				
							Doctor's Telephone #				
Vaccine Type				Disease Date MM/DD/YY	1st Dose MM/DD/YY	2nd Dose MM/DD/YY	3rd Dose MM/DD/YY	4th Dose MM/DD/YY	5th Dose MM/DD/YY	MM/DD/YY	
Diphtheria, Tetanus, Pertussus (DPT) (If Td or DT*, indicate in corner box)											
Polio-Oral Polio Vaccine (OPV) (If Salk Vaccine, Indicate IPV in corner box)											
Measles, Mumps, Rubella (MMR)											
Measles								or Measles Serology	Date	Titer	
Rubella								or Rubella Serology	Date	Titer	
Mumps								or Mumps Serology	Date	Titer	
Mantoux											
Hepatitis B											
Other (Specify)											
Medication at camp: Dose:		Time:		Medication at camp: Dose:		Time:					
Allergies:											
Haemophilus B (HB)**											
Check One:		Can Receive Tylenol for headaches					Cannot Receive Tylenol for headaches				

*Required Medical Exemption **Not Required

*******Please Note: All Immunizations Must List Month, Day, and Year Completely*******