



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

2017 Camp Sunshine Volunteer Application

Name: _____ Phone #: _____

Street Address: _____ Alt. Phone #: _____

City/State/Zip Code: _____ Email: _____

School/Occupation: _____ Birth Date: _____ 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.

- | | |
|---|---|
| <input type="checkbox"/> Adult CPR/AED | <input type="checkbox"/> Community First Aid & Safety |
| <input type="checkbox"/> Infant & Child CPR | <input type="checkbox"/> Emergency Response |
| <input type="checkbox"/> CPR/AED for the Professional Rescuer | <input type="checkbox"/> Lifeguard Training |
| <input type="checkbox"/> Standard First Aid | <input type="checkbox"/> Other: _____ |

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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Standard School/Child Care Center Immunization Records

Name (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 last box)									
Polio-Oral Polio Vaccine (OPV) (If Salk Vaccine, Indicate IPV in last 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:		Medication at camp:							
Dose: Time:		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*******