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.

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