



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

2022-2023 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 Yes No (check one)

or Child Abuse-related Offense?

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: _____ |

For the 2022-23 season, Camp Snowflake will operate on Saturdays from September 17th 2022, through April 29th, 2023. 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****