

Volunteer Application

**United Cerebral Palsy of Delaware, Inc.
Camp Manito**

(Please Print)

Name: _____ Age: _____

Address: _____ Development: _____

City: _____ State: _____ Zip: _____

Phone Number: _____ Date of Birth: ___/___/___ Sex ___ Male ___ Female

Education	Name and Location	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? _____

If under 18, have parent fill in below:

I give permission for my son/daughter _____, to do
volunteer work with children at Camp Manito.

Please list three references, other than family member:

Name	Address	Relationship	Phone

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

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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 6 to July 31. Please indicate times below.

Monday	Tuesday	Wednesday	Thursday	Friday

**CAMP MANITO
MEDICAL HISTORY**

Name: _____

Address: _____

Phone: _____

In case of emergency, contact: _____ Phone: _____
 _____ Phone: _____

Birthday: ___/___/___ Age: _____ Height: _____ Weight: _____ BP: _____

Do you have a disability YES NO State disability: _____

Have you ever been diagnosed with a serious illness? YES NO

If yes, please explain: _____

Have you had surgery in the last 12 months? YES NO

If yes, please explain: _____

Do you have allergic reactions to: Insect stings Penicillin

If other, please explain: _____

Are you presently under a doctor's care or taking medication? Yes: No:

If yes, please explain: _____

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Permission to receive: Aspirin Tylenol Other: _____

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? _____

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: _____ SSI _____ SSDI _____ Other: _____

Group Number: _____ Type of Contract: _____

Family Physician: _____ Phone: _____

Address: _____

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Return to: **UNITED CEREBRAL PALSY OF DELAWARE, INC.**
700A River Road
Wilmington, DE 19809
(302) 764-2400
(302) 764-8713 (fax)

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: _____