

Counselor Application

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

(Please Print)

Name: _____
 Address: _____ Development: _____
 City: _____ State: _____ Zip: _____
 Phone Number: _____ Date of Birth: ___/___/___ Sex ___ Male ___ Female

Education:	Name and Location:	Years Attended:	Graduated (please circle)	
Middle School			YES	NO
High School			YES	NO
College/University			YES	NO
Other			YES	NO

Camp Manito Experience: Camper _____ Volunteer _____ Staff _____

Camp Experience : When _____ Volunteer _____ Staff _____

Related Work Experience (Please list most recent first)

From Month/Year	To Month/Year	Job Title	Employer and address	Phone Number

CHECK POSITION YOU ARE APPLYING FOR: (1ST, 2ND, 3RD Choice)

Junior Counselor (age 16 and older) _____

Senior Counselor (age 17 and older) _____

Art Director: _____ Sports Director: _____ Swim Director: _____ Lifeguard Director: _____

Other: _____

Have you ever worked as a counselor? Yes _____ No _____

Where: _____

What group do you feel more comfortable to work with? (please check)

3 - 4 yrs ___ 5 - 6yrs ___ 7 - 10 yrs ___ 11 - 13yrs ___ 14 - 17yrs ___ 18 - 21yrs ___ Any ___

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**CAMP MANITO
MEDICAL HISTORY**

Name: _____

Address: _____

Phone: _____

In case of emergency, contact: _____ Phone: _____

_____ Phone: _____

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

Do you have a disability? If so, what is it?

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

If yes, please explain: _____

Have you had an operation or serious surgery in the last 12 months? YES NO

If yes, please explain: _____

Do you have allergic reactions to:

_____ Insect stings _____ Penicillin _____ Other drugs

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

If yes, please explain: _____

Permission to receive: Aspirin Tylenol Other: _____

Have you had basic immunization: Please check:

Diphtheria

Measles

H. Influenza

Mumps

Injectable Polio

Tuberculin Test

Tetanus date _____
(commonly called DPT)

Rubella

Pertussis

(commonly called MMR)

Do you swim: Yes No

Any restrictions or assistance needed? _____

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MEDICAL:

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

If yes, please explain: _____

Is there any physical impairment? (Sight, heart, lungs, allergies) Yes: _____ No: _____

If yes, please explain: _____

Permission to receive aspirin: Yes _____ No _____ Tylenol: Yes _____ No: _____

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Please list any talents or interests you are willing to share with the campers.

REFERENCES

Please provide three references: include name, address, and phone number
(Do not include relatives)

- 1. _____
- 2. _____
- 3. _____

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.

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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: _____

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 employment at Camp Manito.

Signature: _____ Date: _____

Return to: **UNITED CEREBRAL PALSY OF DELAWARE, INC.**
700A River Road
Wilmington, DE 19809
(302)764-2400 ext. 10