

CAMP STAFF APPLICATION

(Please check all camps that apply.)

_____ BROWN CITY CAMP _____ HAPPY TIME CAMP _____ MANCELONA YOUTH

PERSONAL INFORMATION: (PLEASE PRINT)

NAME: _____ DRIVERS LIC. #: _____

BIRTHDATE: _____
(MONTH, DAY, YEAR)

CURRENT ADDRESS: _____
(STREET, CITY, ZIP CODE)

ADDRESS AFTER JUNE 1st (If different than above.): _____
(STREET, CITY, ZIP CODE)

HOME TELEPHONE (_____) _____ WORK/COLLEGE PHONE (_____) _____

CELL PHONE (_____) _____ E-MAIL ADDRESS _____

PERSON TO CONTACT IN EMERGENCY: _____ PHONE (_____) _____

YOUR AGE: _____ DO WE HAVE YOUR PERMISSION TO DO A POLICE CHECK? _____

WILL YOU AGREE TO COMPLETE ANY NECESSARY TRAINING? _____

DO YOU USE ALCOHOL, TOBACCO OR NARCOTICS? _____

HAVE YOU EVER BEEN CONVICTED BY CIVIL AUTHORITIES? (circle) YES, NO - IF YES, EXPLAIN:

LIST ANY PREVIOUS CAMP COUNSELING, INCLUDING DATE(S) AND PLACE(S). LIST TRAINING, EDUCATION AND EXPERIENCE RELATED TO CAMPING AND THE POSITION FOR WHICH YOU ARE APPLYING: _____

LIST **THREE** REFERENCES: Reference #1 should be your Pastor. References #2 & #3 should not be someone from your immediate family. Please have references fill out the reference forms.

REFERENCE #1

(NAME, TELEPHONE NUMBER WITH AREA CODE)

REFERENCE #2

(NAME, TELEPHONE NUMBER WITH AREA CODE)

REFERENCE #3

(NAME, TELEPHONE NUMBER WITH AREA CODE)

WRITE A BRIEF TESTIMONY OF YOUR RELATIONSHIP TO CHRIST AND HOW HE IS WORKING THROUGH YOUR LIFE (PLEASE USE OTHER SIDE).

RETURN TO: THE MISSIONARY CHURCH DISTRICT OFFICE ◊ 1091 CREEKWOOD TRAIL ◊ BURTON, MI 48509

**EMPLOYEE
HEALTH HISTORY RECORD
MICHIGAN DEPARTMENT OF SOCIAL SERVICES**

Name _____ Sex _____ Birth date _____ Position _____

Address _____
(street, city, state and zip code)

Telephone No. () _____ Name of Camp: _____

Medication Needed or Used (including Psychiatric)

	Kind	Frequency	Dosage	Currently Being Taken
1.	_____	/ _____	/ _____	/ _____
2.	_____	/ _____	/ _____	/ _____
3.	_____	/ _____	/ _____	/ _____

Special conditions to be watched for such as Allergy (Reaction to food, Penicillin or other drugs)

Do you currently have or have you been recently exposed to any infectious disease? _____ Yes
_____ No If yes, please explain:

Activity restrictions because of any physical defect or illness? _____ Yes _____ No
If yes, explain degree of restriction:

I certify that this information is true to the best of my knowledge:

Signature: _____ Date: _____