



— 2010  
“Celebrating our 15<sup>th</sup> Anniversary”

Dear Volunteer:

Hispanos Unidos would like to thank you for your interest in Camp Meechimuk 2010, the only statewide sleep-away summer camp for children **affected** by HIV/AIDS. This is the 15<sup>th</sup> year of this project, which every year grows more in demand. From its inception, the camp’s mission has been to provide respite care for parents/guardians living with HIV/AIDS by providing a safe and nurturing “away from home” environment filled with fun and love for their children.

We are planning a carefree week for 60 children (30 boys/30 girls) between the ages of 6 and 15 where the most important focus is that they laugh, have fun and make friends. We will be returning to the Hartford Country 4-H Outdoor Recreation Center in Marlborough and hope to make this a memorable week for all our campers. The camp will be held from August 14<sup>th</sup> to 21<sup>st</sup>, 2010. In order for us to maintain a 1:2 counselor/camper ratio, we need to bring aboard 30 volunteers in addition to 20 staff members. Our dream is to increase the amount of children accepted each year but the number of volunteers we are able to recruit limits us.

As recruitment coordinators, we extend our most heartfelt gratitude for your interest in our camp and look forward to meeting you. As volunteers, the best reward we all receive is the laughter and smiles of our campers whom enjoy a week in which they have the opportunity to be children again, if not for the first time. Your interest in our camp is very important to us but even more important to our children.

Enclosed you will find an application, please complete and return it as soon as possible. ***Application deadline is June 17<sup>th</sup>, 2010.*** Orientation will take place during the weekend of *July 30<sup>th</sup> and August 1<sup>st</sup>.* **This Orientation is MANDATORY.** If you would like to meet with us prior to orientation, please call the agency and leave us a message. We will get back to you in a timely manner.

Thank you again for your interest. Should you have any questions, please feel free to contact our agency, Hispanos Unidos at 203-781-0226 (Tommy Arroyo, Camp Director ext.112 or Luz Gonzalez, Executive Director Ext.101).

Sincerely,

Thomas Arroyo  
Camp Director

Camp Meechimuk



For Office Use Only	Date Received _____
All Forms Complete	_____
Interview	_____
Reference Check	_____
Camp Position:	_____

## **Camp Meechimuk -2010** **VOLUNTEER APPLICATION**

c/o Hispanos Unidos 116 Sherman Ave New Haven, CT. 06511  
Fax: 203-781-0229

(NOTE: You **must** be available at camp 24 hours daily from August 14<sup>th</sup> @ 5:00 pm through August 21<sup>st</sup> @ 4:00pm).  
Staff Orientation is MANDATORY.

***Application deadline is June 17, 2010***

NAME \_\_\_\_\_ Social Security Number: \_\_\_\_\_-\_\_\_\_\_-\_\_\_\_\_  
STREET \_\_\_\_\_ CITY/TOWN \_\_\_\_\_ STATE \_\_\_\_\_  
Zip \_\_\_\_\_

**Additional Mailing Address (where you can be reached after school ends / if different from above):**

STREET \_\_\_\_\_ CITY/TOWN \_\_\_\_\_ STATE \_\_\_\_\_  
Zip \_\_\_\_\_  
Phone # \_\_\_\_\_ Cell # \_\_\_\_\_ E-mail \_\_\_\_\_

Date of Birth \_\_\_\_/\_\_\_\_/\_\_\_\_ Sex: F \_\_\_\_ M \_\_\_\_ Language(s) spoken \_\_\_\_\_

Do you have any medical conditions that may hinder your ability to work with the children at camp? \_\_\_\_ Yes \_\_\_\_ No

If yes, please explain: \_\_\_\_\_  
\_\_\_\_\_

Have you ever had a conviction for child abuse, sex related crime or other criminal offense? \_\_\_\_ Yes \_\_\_\_ No

(Please note that failure to answer this question truthfully is a criminal offense)

If yes, please explain: \_\_\_\_\_  
\_\_\_\_\_

### **A. EMERGENCY CONTACT**

In case of emergency notify: \_\_\_\_\_ Relationship: \_\_\_\_\_

Phone # (day) \_\_\_\_\_ Phone # (evening) \_\_\_\_\_ cell # \_\_\_\_\_

### **B. EDUCATION**

Highest Level of Education completed: \_\_\_\_\_ Where? (School/College/University): \_\_\_\_\_

### **C. EMPLOYMENT**

**Present employment:** (if not employed, last employer and dates)

Employer: \_\_\_\_\_ Address: \_\_\_\_\_

Dates: \_\_\_\_\_ Supervisor: \_\_\_\_\_ Position Held: \_\_\_\_\_

2010

**D. ACTIVITY/SKILLS PROFILE**

Please indicate training, courses, workshops, and/or experience that may have a bearing on this application (i.e. any specific camp or activity skills you have experience/expertise in, i.e. Arts & Craft, sports, ropes, nature, water events, or other volunteer work, administrative experiences, etc.).

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**E. CERTIFICATION**

<input type="checkbox"/> Lifeguard	<u>Expiration Date</u>	<u>Agency</u>
<input type="checkbox"/> Water Front Certification	_____	_____
<input type="checkbox"/> Small Craft Instructor	_____	_____
<input type="checkbox"/> Ropes Course Instructor	_____	_____
<input type="checkbox"/> First Aid Certification	_____	_____
<input type="checkbox"/> CPR ___ ARC ___ AHA (check one)	_____	_____
<input type="checkbox"/> Nursing	_____	_____
<input type="checkbox"/> Canoeing/Row Boat	_____	_____

**F. CAMP COUNSELING EXPERIENCE: (If none, proceed to next section).**

Please list camps and dates attended: attach sheet if necessary

CAMP	DATES ATTENDED

Tell us about your experience working with youth:

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How did you find out about our camp?

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**G. POSITION**

Please check the position(s) that you are applying for.

- |   |   |  |
|---|---|--|
| <input type="checkbox"/> Camp Director              | <input type="checkbox"/> Arts & Craft Director            | <input type="checkbox"/> Sports Director           |
| <input type="checkbox"/> Assistant Camp Director    | <input type="checkbox"/> Assistant Arts & Crafts Director | <input type="checkbox"/> Assistant Sports Director |
| <input type="checkbox"/> CIT Director               | <input type="checkbox"/> Nature Director                  | <input type="checkbox"/> Waterfront Director       |
| <input type="checkbox"/> Counselor                  | <input type="checkbox"/> Nature Assistant Director        | <input type="checkbox"/> Life Guard                |
| <input type="checkbox"/> Health Director (RN)       | <input type="checkbox"/> Ropes Director                   |  |
| <input type="checkbox"/> Program Director           | <input type="checkbox"/> Assistant Ropes Director         |  |
| <input type="checkbox"/> Assistant Program director |   |  |

**H. REFERENCES**

Provide **two** personal references that we may contact on your behalf (no relatives). REFERENCES WILL BE CHECKED.

Name _____	Years known _____
Tel: (Day) _____ (Cell) _____	(Evening) _____
Name _____	Years known _____
Tel: (Day) _____ (Cell) _____	(Evening) _____

**I. MISCELLANEOUS**

Shirt Size: \_\_\_ Small \_\_\_ Medium \_\_\_ Large \_\_\_ X large \_\_\_ XXL

**J. SIGNATURE**

In the event of accident or injury I understand that I will assume **FULL** responsibility for my medical expenses and that, as a volunteer I will have **no right to claim** Workers Compensation to Camp Meechimuk 2007 or the sponsoring organizations.

I hereby swear that all statements and information given above are true. I understand that any falsified information is grounds for immediate dismissal.

Signature of Applicant: _____	Date: _____
Parent/Guardian: _____ <i>(If applicant is under 18 or CIT)</i>	Date: _____

**K. EMERGENCY AUTHORIZATION**

*This health history is correct as far as I know, and the person herein described has permission to engage in all prescribed camp services except as noted.*

**Emergency Authorization:** *I hereby give permission to the medical personnel selected by the camp director to order X-rays, routine tests, and treatment for me/my child. In the event I cannot be reached in an emergency. I hereby give permission to the physician selected by the camp director to hospitalize, secure proper treatment for, and to order injection and/or anesthesia and/or surgery for me/my child as named above. I will assume FULL responsibility for all medical expenses incurred. This form may be photocopied for use out of camp.*

Signature of Volunteer, Parent or Guardian: \_\_\_\_\_

Witness: \_\_\_\_\_ Date: \_\_\_\_\_

NAME OF MINOR: \_\_\_\_\_

*\*If for religious reasons you cannot sign this, then the camp should be contacted for a legal waiver, which must be signed for attendance.*

**This form must be COMPLETED by June 117<sup>th</sup> 2010. All forms must be mailed to:**

***Hispanos Unidos***  
116 Sherman Ave New Haven, CT. 06511  
Fax: 203-781-0229

**YOUTH CAMP HEALTH EXAM/RECORD  
FOR CAMPERS AND STAFF**  
Physical Exams Are Valid For 3 Years  
From Date of Last Examination

**Please Return Completed Form to Camp**

Name \_\_\_\_\_ Date of Birth \_\_\_\_\_ Phone \_\_\_\_\_  
 Guardian \_\_\_\_\_ Address \_\_\_\_\_  
 Telephone Work: \_\_\_\_\_ Cell: \_\_\_\_\_ Home: \_\_\_\_\_  
 Emergency Contact \_\_\_\_\_ Telephone Home: \_\_\_\_\_ Cell/Work \_\_\_\_\_

**TO BE COMPLETED BY THE SPECIFIED MEDICAL PRACTITIONER:**

**Date of Exam** \_\_\_\_\_

\_\_\_\_\_ May participate in all camp activities  
 \_\_\_\_\_ May participate except for: \_\_\_\_\_

Medical information pertinent to routine care and emergencies: \_\_\_\_\_

Is this individual taking prescription medication?     YES     NO  
 If yes, list prescription(s) and complete attached **Authorization for Administration of Medication Form**: \_\_\_\_\_

Does the individual have allergies?             YES     NO    Explain: \_\_\_\_\_

Is the individual on a special diet?  YES     NO    Explain: \_\_\_\_\_

This camper/staff is up-to-date on all the following routine childhood immunizations currently recommended by the American Academy of Pediatrics and National Advisory Committee on Immunization Practices:

	Yes	No		Yes	No
Measles			Hepatitis B		
Mumps			Diphtheria		
Rubella			Pertussis		
Chickenpox			Polio		
Tetanus					

Comments: \_\_\_\_\_

Print name of medical care provider: \_\_\_\_\_

Medical care provider's address: \_\_\_\_\_

Medical care provider's: City/Town \_\_\_\_\_ ST \_\_\_\_\_ Zip Code \_\_\_\_\_

\_\_\_\_\_  
Signature of Physician, APRN or PA

\_\_\_\_\_  
Date

\_\_\_\_\_  
Telephone Number

**AUTHORIZATION FOR THE ADMINISTRATION OF MEDICATIONS**

If a Youth Camp chooses to administer medications, the Connecticut State Law and Regulations require an authorized prescriber (M.D., P.A, APRN) or dentist's written order and parent or guardian's authorization for a nurse or camp personnel with current Medication Administration Training to administer medications. **Medications must be in pharmacy prepared containers and labeled with the name of the child, name of the drug, strength, dosage, frequency, authorized prescriber or dentist's name and date of the original prescription. Over the counter medication must be in the original container and labeled with the child's name.**

**AUTHORIZED PRESCRIBER OR DENTIST'S ORDER:**

Date \_\_\_\_/\_\_\_\_/\_\_\_\_

Name of Child \_\_\_\_\_ Date of Birth \_\_\_\_/\_\_\_\_/\_\_\_\_  
Street Address \_\_\_\_\_ City/Town \_\_\_\_\_ State \_\_\_\_\_

Condition for which drug is being administered during camp hours \_\_\_\_\_  
\_\_\_\_\_

DRUG: Name of Drug, Dose and Method of Administration \_\_\_\_\_  
\_\_\_\_\_

Times of Administration: \_\_\_\_, \_\_\_\_, \_\_\_\_ Medication shall be administered from \_\_\_\_/\_\_\_\_/\_\_\_\_ - \_\_\_\_/\_\_\_\_/\_\_\_\_  
\_\_\_\_\_

Relevant side effects to be observed, if any \_\_\_\_\_  
\_\_\_\_\_

If there are side effects, plan for management \_\_\_\_\_  
\_\_\_\_\_

Is this a controlled drug? \_\_\_\_\_

Allergies, reaction to, or negative interaction with food or drugs? If YES, list \_\_\_\_\_  
\_\_\_\_\_

The authorized prescriber or Dentist Name \_\_\_\_\_ Phone # (\_\_\_\_) \_\_\_\_\_  
(Type or Print)

Street Address \_\_\_\_\_ City/Town \_\_\_\_\_ State \_\_\_\_\_

Authorized Prescriber or Dentist Signature \_\_\_\_\_  
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**Authorization by Parent/Guardian for the administration of the above medication:**

Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

I hereby request that the above medication, ordered by the authorized prescriber/dentist for my child \_\_\_\_\_, be administered by the nurse or by camp personnel with current medication administration training. I understand that I must supply the Youth Camp with the prescribed medication in the original container dispensed and properly labeled by an authorized prescriber, dentist or pharmacist. Over the counter medication shall be in the original container labeled by the parent with the child's name. I understand that this medication will be destroyed if it is not picked up within one (1) week following termination of the order.

Name of Parent or Guardian \_\_\_\_\_ Signature \_\_\_\_\_  
(Print Name)

Relationship to child \_\_\_\_\_ Street Address \_\_\_\_\_  
City/Town \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_ Phone (\_\_\_\_) \_\_\_\_\_