ADULT VOLUNTEER REGISTRATION
Summer Camp 2018

Name: _____ Age: _____

Address: _____

Home Phone: _____ Cell Phone: _____

[ ] Camp 1-3 [ ] Camp 4-6 Position_____

Emergency Contact: _____
Name Area code & number

T-shirt size _____

In order for you to serve at camp you must be approved by your Church and Pastor because you will be representing your Church as well as the Association.

Church Name: _____

_____
Church address Church phone number

_____ _____
Pastor's Name Pastor's Signature

I, _____, understand that as a volunteer at the Desert Pines Baptist Association Children's Camp, I am not being compensated for the volunteer work that I do. I agree that I am coming because I feel led by the Lord to come and serve.

_____ _____
Signature Date

This form is to be completed and returned with medical form to Desert Pines Baptist Association by May 10, 2018.
Address: P. O. Box 297, Snowflake, AZ 85937, phone 928-536-7200

HEALTH FORM 2018

NAME _____
HEALTH CONDITION: Excellent___ Good___ Poor___
Please list any health or medical information about camper that we should be aware:
_____
_____
_____
Date of Last Immunization:_____
DPD or TD Tetanus Polio Measles Rubella Mumps
Please list camper's allergies (not dislikes):
Food:_____
Medication:_____
Insect:_____
Other:_____

IMPORTANT:
Do you carry medical/hospital insurance?____ If so, indicate:_____
Carrier & Group #

Please attach copy of insurance card.

Name of Family Physician_____Phone_____
Area code + number

OVER THE COUNTER MEDICATION PERMIT

Following is a list of over the counter medications, which our camp first aid station keeps in stock. Please mark a line through any item you would **NOT** want used on your child.

Acetaminophen (Tylenol)	Milk of Magnesia	Betadine for wound care
Cepastat throat lozenge	Sudafed (decongestant)	Hydrogen Peroxide
Pepto Bismol	Chlor-trimeton (antihist.)	Neosporin ointment
Tums	Actifed (Antihist./Decon.)	Polysporin for wound
Kaopectate	Robitussin	Caladryl lotion
Mylanta Liquid	Hydrocortisone cream	Camphophenique
Donnagel		

AUTHORIZATION TO MEDICATE MINOR CAMPER OR STAFF MEMBER

MUST BE FILLED OUT IF CAMPER IS BRINGING MEDICATION TO CAMP!

I hereby request and authorize Health Care Personnel to administer the below-listed medication(s) to my child:_____
Name of camper

Please give complete information for each medication camper brings to camp. All Medications must be in original container with prescription instructions in your child's name.

NAME OF MEDICATION	DOSAGE	FREQUENCY	WHAT IT'S FOR

IF THIS FORM IS NOT COMPLETED OUT THE VOLUNTEER WILL BE ASKED TO LEAVE CAMP.

_____ _____
Signature **Date**

Disclosure and Authorization (required 18 and older)

Disclosure: We (*Desert Pines Baptist Association)* will obtain one or more consumer reports or investigative consumer reports (or both) about you for employment purposes. These purposes may include hiring, contract, assignment, promotion, re-assignment, and termination. The reports will include information about your character, general reputation, personal characteristics, and mode of living. We will obtain these reports through a consumer reporting agency. Our consumer reporting agency is backgroundchecks.com (BGC). BGC's address is P. O. Box 353, Chapin, SC 29036. BGC's telephone number is (866) 265-6602. To prepare the reports, BGC may investigate your education, work history, professional licenses and credentials, references, criminal record, lawsuits, driving record, credit history, and any other records with public or private information sources. You may inspect BGC's files about you (in person, by mail, or by phone) by providing identification to BGC. If you do, BGC will provide you help to understand the files, including trained personnel and an explanation of any codes. Another person may accompany you by providing identification. If BGC obtains any information by interview, you have the right to obtain a complete and accurate disclosure of the scope and nature of the investigation performed. The Federal Trade Commission provides a summary statement of your rights on its website at http://www.ftc.gov/credit.

Personal Information: Please print the information requested below to identify you for our agency.

Printed name: _____

First Middle Last Maiden

Other name(s) used: _____

Current Address:

From Mo/Yr	To Mo/Yr	Street	City	State	Zip Code
From Mo/Yr	To Mo/Yr	Street	City	State	Zip Code
From Mo/Yr	To Mo/Yr	Street	City	State	Zip Code

Some government agencies and other information sources require the following information when checking for records. Our agency will not use it for any other purposes.

_____ Date of Birth

_____ Social Security Number

_____ Driver's license number & state

_____ Name as it appears on license

Report Copy: If you are applying for a job or live in California, Minnesota, or Oklahoma, you may request a copy of the report by checking this box: D.

Authorization: By signing below, you authorize: (a) BGC to request information about you from any public or private information source; (b) anyone to provide information about you to BGC; (c) BGC to provide us one or more
reports report based on that information; and (d) us to share those reports with others for legitimate business purposes related to your employment. You acknowledge receiving the Federal Trade Commission's "Summary of Your Rights under the Fair Credit Reporting Act." You acknowledge that a fax, image, or copy of this authorization is as valid as the original. You make this authorization to be valid for as long as you are an applicant or employee with us.

_____ Signature

_____ Date