FORT FAITH BAPTIST CAMP **PERSONNEL RECORD**

GROUP: _____ DATE**:** _____

NAME: _____ **AGE:** _____

ADDRESS: _____

City: _____ State: _____ Zip: _____

PHONE: _____ **OTHER PHONE**: _____

POSITION WITH ORGANIZATION: _____

POSITION AT CAMP (i.e. vol., staff, member) _____

PLEASE IDENTIFY TRAINING AND CERTIFICATIONS RECEIVED AND THE ORGANIZATION THAT DEVELOPED THE COURSE (i.e. Red Cross, YMCA, and BSA: (ATTACH COPIES))

EXPIRATION DATE	*LENGTH OF COURSE*	*ORGANIZATION*	
_____	_____	_____	ADVANCED LIFE SAVING
_____	_____	_____	CPR
_____	_____	_____	LIFEGUARD
_____	_____	_____	BASIC WATER SAFETY
_____	_____	_____	WATER SAFETY INSTRUCTOR
_____	_____	_____	FIRST AID
_____	_____	_____	OTHER
_____	_____	_____	OTHER

PLEASE LIST NUMBER OF PREVIOUS CAMP EXPERIENCES:

Experience as an adult leader at a summer camp? ____WEEKENDS ____WEEKS ____YEARS ____SEASONS

Experience as a camper at camp? ____WEEKENDS ____WEEKS ____YEARS ____SEASONS

Have you ever been convicted of anything other than a minor traffic violation? ____YES ____NO

Please explain:

_____

_____

REFERENCES:

Name: _____ Phone: _____

Address: _____

Name: _____ Phone: _____

Address: _____

Name: _____ Phone: _____

Address: _____

I HAVE REVIEWED A COPY OF AND UNDERSTAND THE POLICIES CHECKED BELOW.

____Job Description ____Child Protection Law ____Discipline Policy

____Emergency Procedures ____Other _____

ADHERENCE TO POLICIES:

I have reviewed and read the above stated policies and understand them fully and agree to adhere to the policy as stated. I also state that the information above is correct to the best of my knowledge.

Signed: _____ Date: _____

FORT FAITH BAPTIST CAMP **Health History Record**

STAFF MEMBER'S NAME: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone: _____ Birthdate: _____ Sex: M F

PERSONAL PHYSICIAN'S NAME: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone: _____

May we contact your physician regarding your physical condition? Yes No

CURRENT HEALTH ISSUE AND HISTORY:

List any allergies you have: _____

_____

_____

_____

List any health conditions you have, including current infectious diseases: _____

_____

_____

_____

List physical limitations, if any: _____

_____

_____

_____

List any medication you take regularly:

Name	*Frequency*	*Dosage*
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

TB Skin Test Results:

Date: _____ Type: _____ Results: _____

EMERGENCY CONTACT:

First Contact: _____ Phone: _____

Relationship to you: _____

Alternate Contact: _____ Phone: _____

Relationship to you: _____

This health history is correct insofar as I know. I'm capable of performing the essential functions of my job and participating in assigned work duties. I understand my health information will be used by the camp nurse in providing care to me and may be reviewed by the Director or others as deemed necessary.

Signature of Staff Person: _____ Date: _____