Chai Lifeline
Fighting Illness With Love

CAMP SIMCHA • CAMP SIMCHA SPECIAL

151 WEST 30TH STREET, NEW YORK NY 10001 212.699.6661 • FAX 212.894.8225 •

CAMP@CHAILIFELINE.ORG

Staff Application Summer 2012

GIRLS **CAMP SIMCHA SPECIAL June 25 – July 12 • CAMP SIMCHA August 14 – August 28**
BOYS **CAMP SIMCHA July 16 – July 31 • CAMP SIMCHA SPECIAL August 1 – August 13**

Application must be received by Wednesday, December 21, 2011.

Please note that only complete applications (including this form, a completed medical form, and two letters of recommendation) will be considered.
Applicants must be post high school and 18 years of age before the first day of camp.

Position desired: ☐ Counselor ☐ Waiter/Waitress ☐ Lifeguard ☐ Photographer ☐ Newspaper
☐ Mother's Helper ☐ Specialty (Please Specify)_____

Session desired: ☐ Camp Simcha ☐ Camp Simcha Special ☐ Both Sessions

Last Name: _____ First Name: _____ Nickname: _____ ☐ M ☐ F

E-Mail Address: _____ Current grade _____ Year of high school graduation _____

Age _____ Date of Birth: _____ Social Security #_____- _____-_____

Home Address: _____

City _____ State: _____ Zip: _____ Country _____

Home Phone: (_____) _____ Cell Phone: (_____) _____

Father's Name: _____ Mother's Name: _____

Father's E-Mail: _____ Mother's E-Mail: _____

Father's Business: Name _____ Address_____ Phone _____

Mother's Business: Name _____ Address_____ Phone _____

If you are not living at home THIS YEAR, please complete the following:

Current Address:_____ City _____ State_____ Zip: _____ Country _____

Current Phone: (_____) _____

Have you ever had chicken pox? ☐ Yes ☐ No or ☐ Vaccinated (varicella)
Have you ever had the meningococcal vaccination? ☐ No ☐ Yes Date of Vaccination: ___ /___ /___

FOR OFFICE USE ONLY

DATE RECEIVED: ____/____/____
POSSIBLE POSITION:
_____
_____

REFERENCES CHECKED:
YES _____ INITIAL _____

INTERVIEW_____

STATUS: A R W

EDUCATION

☐ High School Name of School: _____

☐ College Name of School: _____

Current year, or expected date of graduation: _____

☐ Other Institutions attended (e.g. seminary): _____

Currently I attend: _____

WORK EXPERIENCE *(List most current employment first)*

Employer: _____ Contact Person: _____ Phone: _____

Date From: ____/____/____ to ____/____/____ Job Description: _____

Employer: _____ Contact Person: _____ Phone: _____

Date From: ____/____/____ to ____/____/____ Job Description: _____

CAMP EXPERIENCE

Camps attended as a camper _____ Years attended _____

Contact Person: _____ Phone: _____

Camps attended as a staff member_____ Years attended _____

Contact Person: _____ Phone: _____

Job Description: _____

Previous Camp Simcha staff member: ☐ YES ☐ NO Position: _____

LANGUAGE SKILLS

☐ I am fluent in Hebrew. ☐ I can communicate in Hebrew. ☐ I am fluent in _____.

☐ I am fluent in Russian. ☐ I can communicate in Russian.

☐ I am fluent in sign language. ☐ I can communicate in sign language.

CERTIFICATIONS – Applicants for lifeguard positions must include photocopies of all applicable cards.

I am currently certified by the American Red Cross in:

☐ CPR Exp. Date ____/____/____ ☐ First Aid __ Exp. Date ____/____/____

☐ Lifeguarding Exp. Date ____/____/____ ☐ WSI _____ Exp. Date ____/____/____

☐ AMAP Exp. Date ____/____/____ ☐ Other _____ Exp. Date ____/____/____

Please list other skills that will enhance the camp experience, for example, videography, computers, pottery, woodworking, ability to play an instrument, artistic or technological skill.

_____

_____

Are you interested in working on the camp photography staff? ☐ Yes ☐ No

If yes: Have you ever worked with an SLR camera? ☐ Yes ☐ No

Have you ever worked with a professional photographer or company? ☐ Yes ☐ No

If yes, please list contact names and phone numbers._____

List all specific photographic equipment you own or with which you have worked (camera bodies, lenses, strobe/flash equipment, major accessories). _____

_____

Prospective photographers must send a digital portfolio of at least 10 photos either by email (to portfolio@chailifeline.org) or CD (included with application). Label CDs with your name. Send emailed portfolios in a folder titled with your name.

Are you interested in working on the camp newsletter staff? ☐ Yes ☐ No

If yes: Have you ever written a blog? ☐ Yes ☐ No If yes please provide url: _____

Have you ever written for a newspaper, school newspaper or magazine? ☐ Yes ☐ No

If yes, please send a PDF clip or Word file to portfolio@chailifeline.org. Label file with your name.

Are you familiar with:

Microsoft Publisher ☐ Power user ☐ Casual user ☐ Non-user ☐ I use a similar program _____

Adobe Photoshop ☐ Power user ☐ Casual user ☐ Non-user ☐ I use a similar program _____

List all relevant volunteer or work experiences, including community, youth, or medical positions.
Include contact people and phone numbers.

_____

_____

Camp Simcha is part of a year-round program of patient and family support services.

Please indicate the possibility of your availability during the year.

☐ I would like to be a Chai Lifeline Big Brother/Big Sister during the year. ☐ I would like to be a Chai Lifeline volunteer.

☐ I am currently a Chai Lifeline volunteer. ☐ I have been a Chai Lifeline volunteer. *Please describe below.*

_____

_____

If you would like any further information about volunteer programs, please call (212) 699-6641.

Have you ever been convicted of any crime, including sex-related or child abuse related offenses, in any state or country?

☐ Yes ☐ No

If you have a professional license, have you ever been required to surrender your license by the licensing board or professional ethics body? ☐ Yes ☐ No ☐ N/A

Have you ever been found guilty of violation of professional ethics codes, professional misconduct, or unprofessional conduct, in any state or country ☐ Yes ☐ No ☐ N/A

BACKGROUND SEARCH RELEASE AUTHORIZATION

I voluntarily consent to and authorize Camp Simcha/Chai Lifeline to request and receive any consumer reports, investigative reports, or information concerning me. Reports requested may include any of the following: law enforcement, criminal, motor vehicle, civil, employment or rental verification, eviction and/or consumer credit reports.

I authorize any persons, companies, corporations, consumer reporting agencies, courts of law, current or past employer to furnish company and or their assigned agents, associates or consumer reporting agencies with any or all information concerning me. I further agree to release Chai Lifeline/Camp Simcha and or their assigned agents, associated or consumer reporting agencies and all persons and organizations providing information from any and all claims, liability and responsibility arising our of the release of such information in connection with this research.

I understand that I have specific prescribed rights as a consumer under the Federal Fair Credit Reporting Act (FCRA) and may have additional rights under relevant specific state laws. This authorization does not include a release of my medical information.

The above is understood and agreed by:

Signature _____ Print Name: _____ Date: _____

Please select the most appropriate t-shirt size:

T-Shirt Size: ☐ Adult Small ☐ Adult Medium ☐ Adult Large ☐ Adult XL ☐ Adult XXL

Camp Simcha is both brief and intense. You will be required to be in camp from the beginning to the end of the camp session. If there is some extraordinary reason for which you have to leave camp, you must receive permission from the Camp Administration prior to the start of camp.

Please write a short essay about yourself, and why you would be a good addition to the staff. Describe your fears, aspirations, and goals for the summer. *Please use only the allotted space for your essay. Please do not attach any additional papers.*

Completed applications are reviewed carefully, but because of the large number of applications received every year, we are not able to offer every applicant an interview. You will be contacted by the camp office if you have been chosen for an interview.

We will not responsible for lost applications or applications received after the deadline.
Please leave sufficient time for your application to be received.

Please be aware that we will NOT accept any faxes. You may confirm that your application was received by calling the camp office at 212-699-6661 or e mailing camp@chailifeline.org

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Staff Medical Form – Summer 2012

This form must be completed to the satisfaction of our camp medical director. Incomplete forms may invalidate your application.

Last Name: _____ First Name (Nickname): _____ Legal Name: _____

☐ M ☐ F Age ____ Date of Birth: ___/___/___ Social Security #_____-_____ - _____

Address _____

City _____ State _____ Zip _____

Home Phone (_____) _____ E mail _____

Father's Name _____ Mother's Name_____

Personal Physician's Name _____ Phone (_____) _____

Persons to be contacted in case of emergency:

Name _____ Relationship to staff member _____

Home Phone (_____) _____Work Phone (_____) _____Cell Phone (_____) _____

Name _____ Relationship to child_____

Home Phone (_____) _____Work Phone (_____) _____Cell Phone (_____) _____

Previous medical problems, operations, injuries _____

Illnesses, operations, injuries in the past year _____

List all medications currently taking *(all medications must be stored in the infirmary)* _____

Are you allergic to any medications? (please list) _____

Any psychological disorder (ie: depression, anorexia, etc) Explain_____

Consulted a psychologist/psychiatrist: ☐No ☐Yes Date _____ Explain _____

Have you ever had

Asthma ☐No ☐Yes Date _____ Chicken Pox ☐No ☐Yes Date _____

Diabetes ☐No ☐Yes Date _____ Seizures ☐No ☐Yes Date _____

Malignancy ☐No ☐Yes Date _____ Type _____

Heart Disease/Arrthymia ☐No ☐Yes Date _____ Explain_____

FOR OFFICE USE ONLY DATE SENT TO MEDICAL TEAM: ____/____/____ MEDICALLY APPROVED: YES ___ NO ___ STATUS: A R

IMMUNIZATIONS *(most recent doses)*	1st Dose	2nd Dose	3rd Dose	4th Dose	5th Dose
MENINGOCOCCAL *(mandatory)*	_____	_____	_____	_____	_____
DPT-DT- DTAP-TD	_____	_____	_____	_____	_____
DTP/HIB	_____	_____	_____	_____	_____
POLIO	_____	_____	_____	_____	_____
MEASLES	_____	_____	_____	_____	_____
MUMPS	_____	_____	_____	_____	_____
RUBELLA	_____	_____	_____	_____	_____
HIB	_____	_____	_____	_____	_____
HEPATITIS B	_____	_____	_____	_____	_____
VARICELLA	_____	_____	_____	_____	_____
TUBERCULIN	Date _____	Result _____	Date _____	Result _____	

Date of last Tetanus booster _____

Health changes in the past year:	☐ No Change ☐ Unsure	
Weight change (over 10 lbs.):	☐ No ☐ Yes	Specify:_____
Persistent change in energy:	☐ No ☐ Yes	Specify:_____
Change in vision or hearing:	☐ No ☐ Yes	Specify:_____
Frequent cough/hoarseness:	☐ No ☐ Yes	Specify:_____
Shortness of breath:	☐ No ☐ Yes	Specify:_____
Pain/pressure in chest/palpitations:	☐ No ☐ Yes	Specify:_____
Depression:	☐ No ☐ Yes	Specify:_____
Glasses:	☐ No ☐ Yes	Specify:_____
Contact lenses:	☐ No ☐ Yes	Specify:_____
Prosthetic device:	☐ No ☐ Yes	Specify:_____
Change in bowel habits:	☐ No ☐ Yes	Specify:_____
Black/bloody stools/ diarrhea:	☐ No ☐ Yes	Specify:_____
Burning/ blood in urine:	☐ No ☐ Yes	Specify:_____
Muscle/ joint pain:	☐ No ☐ Yes	Specify:_____
Sores/ lumps/ skin rash:	☐ No ☐ Yes	Specify:_____
Unsteady gait or tremors:	☐ No ☐ Yes	Specify:_____
Fainting/ severe dizziness:	☐ No ☐ Yes	Specify:_____
High or low blood pressure:	☐ No ☐ Yes	Specify:_____
Seizures:	☐ No ☐ Yes	Specify:_____
Difficult or painful periods (if applicable):	☐ No ☐ Yes	Specify:_____

INSURANCE INFORMATION

Insured's Name _____ Patient Relationship to Insured: ☐ Self ☐ Spouse ☐ Child ☐ Other

Address _____

City _____ State _____ Zip _____ Phone (_____) _____

Insured's Date of Birth ____/____/____ Insured's ID Number _____

Social Security No. _____ - _____ - _____ Group ID Number _____

Employer Name _____ Employer Address _____

City _____ State _____ Zip _____ Phone (_____) _____

Insurance Company Name _____ Address _____

City _____ State _____ Zip _____ Phone (_____) _____

ATTACH A COPY OF INSURANCE CARD HERE (FRONT)

ATTACH A COPY OF INSURANCE CARD HERE (BACK)

ATTACH A COPY OF PRESCRIPTION CARD HERE (FRONT)

ATTACH A COPY OF PRESCRIPTION CARD HERE (BACK)

I hereby authorize the Camp Simcha/Simcha Special medical staff to render necessary care and/or arrange for me to receive any x-rays, anesthetic, medical, dental, or surgical diagnosis, treatment and/or hospital care deemed advisable. In the event that emergency evaluation or treatment is deemed necessary, Camp Simcha/Simcha Special will notify my parent or guardian as soon as possible.
I agree to accept full financial responsibility for all medical costs incurred on behalf of myself during the camp session, including but not limited to any routine and/or emergency laboratory tests, medical, surgical, ambulance service, prescription or non prescription drugs and/or hospital costs. In the event that my insurance carrier will not cover any or all medical costs, or that any hospital requires a deposit I agree to take full responsibility for all costs.
In accordance with HIPAA regulations, I give permission to Rabbi A. Kunstlinger, Camp Director, the Medical Director or any member of the Chai Lifeline and/or Camp Simcha/Simcha Special administration, to exchange information with my physician and/or medical providers and to obtain any medical information necessary for the care of myself while at camp.
I attest to the accuracy of all the information on this medical form.

Signature: _____Date: _____

Parent/Guardian Signature on behalf of my child *(if under 18 years of age)* _____

THIS PAGE MUST BE COMPLETED AND SIGNED BY YOUR PERSONAL PHYSICIAN.
ALL QUESTIONS MUST BE ANSWERED.

Name _____ Age _____ Examination Date _____

Weight _____ Height _____

Blood Pressure _____ Abdomen _____

Nose/Throat _____ Tonsils _____

Heart _____ Lungs _____

Teeth _____ Lymph Nodes _____

Nutrition _____ Orthopedic _____

Skin _____ Speech _____

Hernia _____ Scoliosos _____

Eyes/Glasses (Contact Lenses) ☐ No ☐Yes Last Changed _____

Any Hearing Difficulty? ☐ No ☐ Yes Describe _____

Any Previous medical problems, operations, injuries? ☐ No ☐ Yes Age:_____ Type:_____

_____

Any Personality or Psychological Disorders? ☐No ☐Yes Age:_____ Type: _____

Consulted a psychologist/psychiatrist? ☐No ☐Yes Age:_____ Explain: _____

_____

Any Eating Disorders ☐No ☐ Yes Age:_____ Explain: _____

Any Allergies ☐ No ☐ Yes Type: _____

_____

List all medication currently taking: *(all medications must be stored in the infirmary)* _____

_____

May participate in active sports? ☐ No ☐ Yes

Name of Physician _____

Signature of Physician _____ Date _____

Office Phone (_____) _____ Emergency Phone (_____) _____ Fax (_____) _____