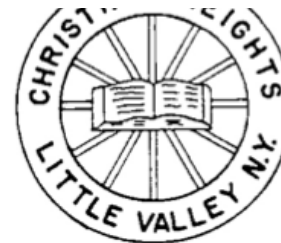


CHRISTIAN HEIGHTS, INC.

9414 Dutch Hill Road, Little Valley, NY 14755
Telephone: (716) 938-6800



Staff Application

RETURN TO: Dianne Fazzolari, 589 Morgan Drive, Lewiston, NY 14092

Name: _____ Circle your T-shirts size: S M L XL XXL
Address: _____ City: _____ State: _____
Zip Code: _____ Phone: (____) _____ Cell Phone: (____) _____ Birthdate: _____
Email: _____ Last Education Completed: _____

How many pre-campers will you pre-register at \$30 each (before June 1)?: _____ Ages: _____
How many campers will you pre-register at \$30 each (before June 1)?: _____ Ages: _____

Camp, or related, experience, special skills, and certificates:

Positions available (Check as many as you are interested in):

- | | | |
|--|--|---|
| <input type="checkbox"/> Assistant Camp Director | <input type="checkbox"/> Health Director | <input type="checkbox"/> Kitchen Coordinator |
| <input type="checkbox"/> Counselor | <input type="checkbox"/> EMT | <input type="checkbox"/> Kitchen Head Cook |
| <input type="checkbox"/> Pre-camper Counselor | <input type="checkbox"/> Registered Nurse | <input type="checkbox"/> Kitchen Staff |
| <input type="checkbox"/> Bible Instructor | <input type="checkbox"/> Water Safety Instructor | <input type="checkbox"/> Kitchen Hygiene Leader |
| <input type="checkbox"/> Chapel Leader | <input type="checkbox"/> Life Guard | <input type="checkbox"/> Kitchen Hygiene Worker |
| <input type="checkbox"/> Chapel Music | <input type="checkbox"/> Maintenance | <input type="checkbox"/> Canteen Overseer |
| <input type="checkbox"/> Campfire Leader | <input type="checkbox"/> Activities Instructor | <input type="checkbox"/> Cell phone Overseer |
| <input type="checkbox"/> Campfire Music | <input type="checkbox"/> Arts & Crafts | |
| <input type="checkbox"/> Overnight Camp-out Leader | <input type="checkbox"/> Sports Instructor | <input type="checkbox"/> Other: _____ |

Which week(s) are you available (Circle): 1st week 2nd week

Have you ever been arrested? _____ If yes, Why? _____
Have you ever been convicted of child abuse? _____

New York State requires that you submit references, which must be contacted, and that the Division of Criminal Justice Services Sex Offender Registry clears your name.
No family members please; Adults only.

Name: _____ Phone:(____) _____ Relationship: _____
Name: _____ Phone:(____) _____ Relationship: _____
Name: _____ Phone:(____) _____ Relationship: _____

Christian Heights Camp is designed to tell children of Jesus' love, to practice Jesus' love and to stimulate growth in his love. Please read and complete the following:

I believe the scriptures: "Truly, truly, I say to you, unless a person is born of water and of the Spirit, he cannot enter into the Kingdom of God." (John 3:5) "For God so loved the world, that he gave his one and only son, that whoever believes in him will not perish, but have everlasting life." (John 3:16)

I am concerned with proclaiming Jesus as Savior and I try to follow God's example in my daily life. I will assume the described responsibilities of my position. I understand that I am to work in close relationship with the Board of Directors of Christian Heights, Inc., and its designees.

I have completed the application above in full. I am in acceptable physical and mental health for camp work and have the energy and emotional stability necessary to fulfill my responsibilities. I understand that I must attend a CHC orientation this year, which includes training on child protection in order to be eligible to work at Camp.

Signed: _____ Date: _____

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CHC STAFF HEALTH FORM (CONFIDENTIAL - FOR MEDICAL DIRECTOR)

STAFF: _____ DATE OF BIRTH ___/___/___ AGE ___ SEX ___
LAST NAME FIRST MI

ADDRESS: _____ TELEPHONE _____

CITY: _____ STATE: _____ ZIP: _____ E-MAIL: _____

PARENTS/GUARDIANS: _____ WORK/CELL PHONE: _____
 (If under 21) _____ WORK/CELL PHONE: _____

HEALTH INSURANCE INFORMATION (please fill in or attach copy of insurance cards)
 INS. CO. 1. _____ CO. 2. _____
 POLICY/ID NO. _____
 GROUP NO. _____
 VERIFICATION PHONE NO. _____

PHYSICIAN'S NAME: _____ TELEPHONE NO.: _____
 ADDRESS _____

EMERGENCY CONTACTS:
 NAME: 1. _____ 2. _____
 RELATIONSHIP: _____
 ADDRESS: _____
 TELEPHONE _____

ALLERGIES

Hay Fever ___ Penicillin ___ Insects ___ Foods _____
 Other _____

MEDICATIONS

Will it be necessary for you to take medications during camp? ___
 If yes, is the medication prescription or non-prescription? _____
 Name of medication(s): _____ Dosage: _____ When taken: _____
 Physician's orders: _____
 Physician's signature: _____ Date: _____

STATE ANY SERIOUS INJURIES OR OPERATIONS: _____
 CHRONIC OR RECURRING ILLNESS: _____
 ANY SPECIFIC ACTIVITIES TO BE ENCOURAGED: _____
 ANY RESTRICTIONS ON ACTIVITIES: _____
 FEMALE STAFF: ARE MENSTRUAL PERIODS NORMAL? ___

IMMUNIZATION RECORD - DATES MUST BE PROVIDED (THE MOST RECENT ONES ARE MOST IMPORTANT):
 DPT 1. ___/___/___ 2. ___/___/___ 3. ___/___/___ POLIO 1. ___/___/___ 2. ___/___/___ 3. ___/___/___
 4. ___/___/___ 5. ___/___/___ 4. ___/___/___ 5. ___/___/___
 MEASLES, MUMPS, RUBELLA: 1. ___/___/___ 2. ___/___/___
 TUBERCULIN TEST: TINE ___/___/___ OTHER: _____/___/___

PARENTS' AUTHORIZATION FOR MINORS: This health history is correct insofar as I know and the person herein described has permission to engage in all camp activities except those noted. In the event I cannot be reached in an EMERGENCY, I hereby give permission to the physician selected by the camp or medical director to hospitalize, secure proper treatment and to order injection, anesthesia or surgery for my child named above.

SIGNATURE: _____ **DATE:** _____