

# CAMP HOT SHOTS

## Volunteer Application

Platte River State Park  
June 6<sup>th</sup> - June 8<sup>th</sup>, 2012

Camp Hot Shots, Inc.  
P.O. Box 1731  
Council Bluffs, IA 51502-1731  
Phone: (712) 352-0883

[www.camphotshots.org](http://www.camphotshots.org)

**APPLICATION DEADLINE: MAY 1, 2012**      **REFERRED BY:**

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Date of application: \_\_\_\_\_ Social Security Number: \_\_\_\_\_

Name: \_\_\_\_\_

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

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Phone Number: \_\_\_\_\_ Cell Number: \_\_\_\_\_

E-Mail Address: \_\_\_\_\_

T-shirt size: S \_\_\_ M \_\_\_ L \_\_\_ XL \_\_\_ XXL \_\_\_

Transportation to and from camp will be provided at Westside Community Education Center (3534 S. 108<sup>th</sup> St.). Departure time is 8:15 a.m., and we will return at 4:45 p.m. daily.

Will you need transportation to and from camp? \_\_\_Yes \_\_\_No

I will be able to attend the **mandatory** orientation meeting on Tuesday June 5 and three days of camp:  
\_\_\_ Yes \_\_\_ No

### Have you previously served as a camp volunteer for Camp Hot Shots?

\_\_\_ **Yes**, If you have moved in the last year. Please provide changes in information **only** on this application.  
\_\_\_ **No**, please complete this application.

What type of camp position are you seeking?

- Counselor (ages 16 and older)       Camp Dietician  
 Camp Physician       Camp Nurse

Are you at least 18 years of age? \_\_\_Yes \_\_\_No, **if NO state your age** \_\_\_\_\_, **DOB:** \_\_\_\_\_

*Camp Staff under the age of 18 must attach a note signed by their parent or guardian verifying their age.*

Do you have any physical or mental disabilities that might prevent you from performing the essential functions of the position for which you are applying? \_\_\_Yes \_\_\_No

If YES, do you have specific suggestions as to how we could accommodate your mental or physical disability?  
If yes describe:

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**Education:**

	School	Year Graduation	Major
High School/GED			
Associate			
BS/BA			
Other			

**Past Employment (list past two years, use additional paper if needed)**

Date: To: \_\_\_\_\_ From: \_\_\_\_\_ Employer: \_\_\_\_\_

Address: \_\_\_\_\_ Phone: \_\_\_\_\_

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

Reason for Leaving: \_\_\_\_\_

Date: To: \_\_\_\_\_ From: \_\_\_\_\_ Employer: \_\_\_\_\_

Address: \_\_\_\_\_ Phone: \_\_\_\_\_

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

Reason for Leaving: \_\_\_\_\_

**Relevant Camp, Volunteer, or Child Care Experience:**

Dates	Camp or Organization	Supervisor	Phone	Camper or Staff? Note position held if staff

**References: Provide names/addresses of 3 persons not related to you who have knowledge of your character, experience, and ability.**

Name	Address	Phone (including area code)

**What contributions do you think you can make at camp in lives of children with diabetes?**

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**Describe your experiences with special needs children and/or children with diabetes.**

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**Please list name of medication, dosage, and time of day needed, this includes insulin:**

<b>MEDICATION</b>	<b>DOSAGE</b>	<b>TIME(S) OF DAY</b>

**Are you allergic to ANY medications? \_\_\_\_Yes \_\_\_\_No**

**If yes, please describe:**

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**For Medical Staff Only:**

What license do you hold? \_\_\_\_\_

**Please attach a copy of your current license for the state in which camp occurs.**

What states are you licensed in? \_\_\_\_\_

Has your license ever been revoked? \_\_\_\_Yes \_\_\_\_No

If YES, please explain: \_\_\_\_\_

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Do you have malpractice insurance covering your service at camp? \_\_\_\_Yes \_\_\_\_No

**INSURANCE:**

In the event of any need for medical care outside of the camp setting, insurance information specific for you and/or your child may be needed. Please complete the following.

Insurance Company Name \_\_\_\_\_

Address \_\_\_\_\_

Policy # \_\_\_\_\_

Name of Insured Family Member \_\_\_\_\_

Insured Member's Social Security Number \_\_\_\_\_

Insured Member's Place of Employment \_\_\_\_\_

Is pre-authorization required? \_\_\_Yes \_\_\_No Pre-authorization # \_\_\_\_\_

**CONSENT:**

If I have diabetes I hereby give my consent for adjusting insulin dose, performing blood tests, or any medical care deemed necessary by **camp physicians and nurses. I also consent to photography** to be used to publicize and raise funds for Camp Hot Shots. I will not hold liable Camp Hot Shots, Hot Shots Foundation, Inc. or any individual associated with the Camp, for accidental injury or illness resulting from attendance and activities at camp. I hereby agree to obey all rules and regulations of Platte River State Park, Camp Hot Shots and Hot Shots Foundation, Inc. I further agree to obey the instruction of camp counselors, physicians, nurses, and assistants pertaining to the camp activities, medical needs or practices and all related matters. I also agree to inform the appropriate camp personnel of any matter or activity which I believe to be harmful or which creates the risk of accident or injury to myself or any other participant at the camp.

Signature of Volunteer: \_\_\_\_\_ Date: \_\_\_ / \_\_\_ / \_\_\_

Signature of Parent/Guardian: \_\_\_\_\_ Date: \_\_\_ / \_\_\_ / \_\_\_  
(if under 18 years of age)

**RETURN APPLICATION:**

**CAMP HOT SHOTS**  
**P.O. Box 1731**  
**Council Bluffs, IA 51502-1731**  
[www.camshots.org](http://www.camshots.org)

**"Hot Shots Foundation is committed to making a difference in the lives of children and young adults who have diabetes TODAY so they have the opportunity to live a healthy life."**