

2010 Camp Discovery And Explorer Counselor Application

To apply please fill out all information and mail to:

Cincinnati Church of Christ

Attn: Shannon Cleghorn

4220 E. Galbraith Rd.

Cincinnati, OH 45236

Applications must be in for **Camp Navigator and Camp Explorer** by: June 1, 2010

Applications must be in for **Camp Explorer** by: July 1, 2010

Name: _____

Address: _____

Phone #: _____ Cellular #: _____

E-mail: _____

Male _____ Female _____ Shirt Size (Circle one) S M L XL XXL

Congregation: _____ Date of Baptism: _____

Please provide one reference contact, preferably local evangelist:

Name: _____ Position _____

Phone #: _____ E-mail: _____

Please list any skills you may have and or activities you would be interested in teaching while at camp:

Camp Experience: _____

Children's Ministry experience (**Each counselor *must* include a copy of your children's ministry interview and contact information of local children's ministry coordinator for reference purposes**)

Dates to remember:

Counselor Training for **Camp Navigator**: June 26th 10 am @ CCOC Building

Counselor Arrival for Camp Navigator is July 1 at 2pm at Camp Graham

Counselor Arrival for Camp Explorer is June 27th at 2pm at King's Domain

Counselor Training for Camp Discovery is July 17th at 10 am @CCOC

Counselor Arrival for Camp Discovery is July 25th at 2pm.

If you have any questions or concerns please contact John or Shannon Cleghorn at 513-793-0240 or 513-615-6899. You can also contact us at jclegy@mac.com

Counselor Health Form

Name: _____

Emergency Contact: _____

Relationship: _____ Phone #: _____

Name of Physician: _____ Phone #: _____

Medical Insurance Company: _____

Policy # _____

Address _____

Phone # _____

Health History

Allergies (Please list all know allergies and how reaction is treated)

Medications (Please list all medications, including over the counter drugs, taken routinely. Be sure you bring enough for the entire week of camp in the original bottle/package that identifies the prescribing physician, dosage and frequency. This will be given to the heath officer upon arrival at camp.)

Please complete the following questionnaire. Circle **Y** for “yes” and **N** for “no”.

Have you:

1. Had any recent injury, illness or infectious disease? **Y** **N**
2. Have a chronic or recurring illness/condition? **Y** **N**
3. Ever been hospitalized? **Y** **N**
4. Ever had surgery? **Y** **N**
5. Have frequent headaches? **Y** **N**
6. Ever had a head injury? **Y** **N**
7. Ever been knocked unconscious? **Y** **N**
8. Wear glasses, contacts or other eyewear? **Y** **N**
9. Prone to frequent ear infections? **Y** **N**
10. Ever been dizzy or passed out after exercise? **Y** **N**
11. Ever had seizures? **Y** **N**
12. Ever had problems with joints? **Y** **N**
13. Have any skin problems? **Y** **N**
14. Have diabetes? **Y** **N**
15. Had mononucleosis in the past year? **Y** **N**
16. Had problems with constipation or diarrhea? **Y** **N**
17. Have problems with sleepwalking? **Y** **N**
18. If female, have and abnormal menstrual history? **Y** **N**
19. Have a history of motion sickness? **Y** **N**
20. Have an eating disorder? **Y** **N**

21. Ever had any emotional difficulties? Y N

Please explain any "yes" answers noting the number of the question (s).

Should it be necessary for me to receive medical treatment while participating in any camp activity, I hereby give permission for the person(s) leading or directing these activities to render medical attention or treatment as the physician/health officer deems appropriate. I also give permission for the person(s) leading or directing these activities to use their best judgment to otherwise render any assistance (i.e. first aid, CPR, etc.) to me in the event of injury or illness. I understand that the Cincinnati Church of Christ and Camp Graham or any other person(s) leading or directing these activities have no insurance coverage for medical or hospital costs for the above mentioned participant, which are associated with injury or illness occurring in the course of these activities. Therefore, any costs incurred for such medical attention/treatment shall be my sole responsibility.

Counselor's signature _____ Date _____

Parent/Guardians signature (if under 18) _____ Date _____