



a seriousfun camp
founded by paul newman

Dear Potential Medical Volunteer:

Thank you for your interest in becoming a Camp Boggy Creek Medical Volunteer.!

Please complete and return the following:

- Medical Volunteer Application
- Background Check Forms
- Medical History
- For SUMMER only – Physical Exam

You may return them via:

Mail

Camp Boggy Creek
30500 Brantley Branch Road
Eustis, FL. 32736
Attn: The Patch

FAX

352-483-2959

We look forward to having you as part of our Medical Team. If you have any questions, please contact the Medical Center at 866-Go-Boggy extension 4282, 4270 or 4252 or email drkaren@boggycreek.org or campnurse@boggycreek.org.

Sincerely,

Karen A Bringelsen, MD
Medical Director

Sheri Brown RN
Nursing Director

Camp Boggy Creek

30500 Brantley Branch Road

Eustis, Florida 32736

Phone: (352) 483-4200 x 4282 or 4270 Fax: (352) 483-2959

MEDICAL VOLUNTEER APPLICATION

Name: _____

Male ___ Female ___

Office Address: _____

Home Address: _____

Phone #: (____) _____

Phone #: (____) _____

Fax #: (____) _____

E-mail (required): _____

Please check the appropriate box for the position you are applying for:

<input type="checkbox"/> Nurse
<input type="checkbox"/> ARNP or PA
<input type="checkbox"/> Physician
<input type="checkbox"/> Respiratory Therapist
<input type="checkbox"/> Pharmacist, Pharm Tech, PharmD student

Specialty? _____

Please specify your current certification(s)? (Please attach a copy of the certificate)

Board _____

CPR _____

PALS _____

ACLS _____

Which session would you like to attend?

Medical Licensure:

Florida License #: _____

MD ARNP RN LPN RT RPh

Please attach a copy of your current license.

How did you hear about Camp Boggy Creek? _____

REFERENCES (please provide at least three references other than friends or relatives; Email addresses preferred)

1) Name: _____ **E-mail:** _____

Nature of Relationship: _____ Phone Number: _____

2) Name: _____ **E-mail:** _____

Nature of Relationship: _____ Phone Number: _____

3) Name: _____ **E-mail:** _____

Nature of Relationship: _____ Phone Number: _____

VOLUNTEER AND COMMUNITY SERVICE EXPERIENCE

1) Organization's Name: _____ Position: _____

City: _____ State: _____ Phone number: _____

Nature of work: _____ Time Period: _____

2) Organization's Name: _____ Position: _____

City: _____ State: _____ Phone number: _____

Nature of work: _____ Time Period: _____

EDUCATION

Please give name and city of:

Dates Attended

Diploma or Degree/Area of Concentration

College

Graduate or Medical School

Residency or other Education

Fellowship

EMPLOYMENT EXPERIENCE (*Please attach a copy of your Resume*)

Employer's Name: _____ City: _____ State: _____

Position: _____ Telephone: _____

Supervisor's Name: _____ Time Period _____

Previous Employer's Name: _____ City: _____ State: _____

Position: _____ Telephone: _____

Supervisor's Name: _____ City: _____ State: _____

BACKGROUND INFORMATION

Have you ever been convicted, plead guilty, plead no contest or had adjudication withheld on any misdemeanor or felony charge? Yes No

Are there any criminal charges pending against you? Yes No

Have you ever had any license, certificate or employment suspended, revoked, terminated or adversely affected? Yes No

If yes to any of these questions, provide a full description including dates, circumstances, and authorities involved:

Please Note: Before we can offer any volunteer positions with Camp Boggy Creek, the candidate's background information must be checked. Please fill out the Background Verification and Secure Point Background Form included. MD's are exempt

APPLICANT'S CERTIFICATION AND AGREEMENT

Please read carefully and sign below

I, _____ (Print Name) hereby authorize Camp Boggy Creek to obtain information pertaining to any charges or convictions I may have for federal and/or state criminal or other violations. This information will include, but not be limited to; allegations and convictions committed upon minors, and will be gathered from any law enforcement agency of any state or federal government agency or authority.

I hereby authorize and instruct all persons, public agencies, courts, schools, employer companies and corporations to supply to Camp Boggy Creek verification of the information provided in my application, including without limitation evaluations of my prior performances, and I hereby release them from all liability from their doing so. The above statements are true and complete in all respects. Upon the offer of a staff, volunteer or other position, I understand that I must supply the camp with an updated medical evaluation to be forwarded by my physician.

Any falsification, misrepresentation, or incompleteness in this disclosure is alone grounds for disqualification or termination. The information that I have provided may be verified and/or corrected by Camp Boggy Creek by contacting persons or organizations named in this application.

Signature: _____ Date: _____

Print Full Name: _____ Date: _____

Camp Boggy Creek is an Equal Opportunity Employer. All applicants are screened without regard to age, race, religion, creed, national origin, ethnic background or medical condition.

Camp Boggy Creek is a smoke-free, drug-free, alcohol-free facility.

Camp Boggy Creek

BACKGROUND INVESTIGATION CONSENT

I, _____, hereby authorize **Camp Boggy Creek** and/or its agents to make an independent investigation of my background, references, character, past employment, education, credit history, criminal or police records, including those maintained by both public and private organizations and all public records for the purpose of confirming the information contained on my Application and/or obtaining other information which may be material to my qualifications for employment now and, if applicable, during the tenure of my employment with **Camp Boggy Creek**. Please note, Camp Boggy Creek will not investigate the credit history of any applicants for volunteer or summer staff positions.

I release **Camp Boggy Creek** and/or its agents and any person or entity, which provides information pursuant to this authorization, from any and all liabilities, claims or law suits in regards to the information obtained from any and all of the above referenced sources used. The following is my true and complete legal name and all information contained herein is true and correct to the best of my knowledge:

Applicant/Employee Name and Signature

Date

____-____-_____
Social Security Number *

____/____/_____
Date of Birth *

*NOTE: The above information is required for identification purposes only, and is in no manner used as qualifications for employment. **Camp Boggy Creek** is an Equal Opportunity Employer, and does not discriminate on the basis of Sex, Race, Religion, Age, Handicap or National Origin.

MN & Oklahoma Residents please note: In connection with your application for employment, your consumer report may be obtained and reviewed. Under Minnesota and Oklahoma law, you have a right to receive a free copy of your consumer report by checking the appropriate box below.

YES, I am a Minnesota resident and would like a free copy of my consumer report.

YES, I am an Oklahoma resident and would like a free copy of my consumer report.

Printed Name _____

Street Address _____

City, State, Zip _____

FOR OFFICE USE ONLY

Employer please note: If a Minnesota or Oklahoma resident checks "YES", and you do request a consumer report, please fax this form to Secure PointSM at 800-256-5876.

Account Number: _____

CS Note: Corresponding Request submitted electronically.

REV. 1/04

Camp Boggy Creek – Volunteers

Background Request Form

Personal Information...Print capital letters in the boxes. Try not to touch the sides of the boxes.

A	B	C	D	E	F	G	H	I	J	K	L	M	N	O	P	Q	R	S	T	U	V	W	X	Y	Z
---	---	---	---	---	---	---	---	---	---	---	---	---	---	---	---	---	---	---	---	---	---	---	---	---	---

First Name

--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--

Middle Name

--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--

Last Name

--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--

Previous Legal Name

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Year Changed

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Street Address

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City

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State

--	--

Zip Code

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Social Security Number:

			-			-					
--	--	--	---	--	--	---	--	--	--	--	--

Date of Birth: (month-day-year)

		-			-		
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Drivers License Number

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State

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Previous Cities...Most Recent First ** Please DO NOT list any addresses before the age of 18.

City

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State

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Zip (REQUIRED)

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City

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State

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Zip (REQUIRED)

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City

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State

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Zip: (REQUIRED)

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City

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State

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Zip: (REQUIRED)

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Client Name (Requester)

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Account Number

8	6	5	9	5	3	A	A	A
---	---	---	---	---	---	---	---	---

Phone Number

3	5	2	-	4	8	3
---	---	---	---	---	---	---

Extension

4	2	0	0				
---	---	---	---	--	--	--	--

Location Code

--	--	--	--	--	--	--	--

Fax Number

3	5	2	-	4	8	3
---	---	---	---	---	---	---

0	3	5	8
---	---	---	---

SSN Trace

Credit

Employment

Professional License

Car National Criminal

MVR County Criminal

Education

National Sex Offender Registry

A Summary of Your Rights under the Fair Credit Reporting Act

The federal Fair Credit Reporting Act (FCRA) is designed to promote accuracy, fairness, and privacy of information in the files of every "consumer reporting agency" (CRA). Most CRAs are credit bureaus that gather and sell information about you -- such as if you pay your bills on time or have filed bankruptcy -- to creditors, employers, landlords, and other businesses. You can find the complete text of the FCRA, 15 U.S.C. 1681-1681u, at the Federal Trade Commission's web site (<http://www.ftc.gov>). The FCRA gives you specific rights, as outlined below. You may have additional rights under state law. You may contact a state or local consumer protection agency or a state attorney general to learn those rights.

- **You must be told if information in your file has been used against you.** Anyone who uses information from a CRA to take action against you -- such as denying an application for credit, insurance, or employment -- must tell you, and give you the name, address, and phone number of the CRA that provided the consumer report.
- **You can find out what is in your file.** At your request, a CRA must give you the information in your file, and a list of everyone who has requested it recently. There is no charge for the report if a person has taken action against you because of information supplied by the CRA, if you request the report within 60 days of receiving notice of the action. You also are entitled to one free report every twelve months upon request if you certify that (1) you are unemployed and plan to seek employment within 60 days, (2) you are on welfare, or (3) your report is inaccurate due to fraud. Otherwise, a CRA may charge you up to eight dollars.
- **You can dispute inaccurate information with the CRA.** If you tell a CRA that your file contains inaccurate information, the CRA must investigate the items (usually within 30 days) by presenting to its information source all relevant evidence you submit, unless your dispute is frivolous. The source must review your evidence and report its findings to the CRA. (The source also must advise national CRAs -- to which it has provided the data -- of any error.) The CRA must give you a written report of the investigation and a copy of your report if the investigation results in any change. If the CRA's investigation does not resolve the dispute, you may add a brief statement to your file. The CRA must normally include a summary of your statement in future reports. If an item is deleted or a dispute statement is filed, you may ask that anyone who has recently received your report be notified of the change.
- **Inaccurate information must be corrected or deleted.** A CRA must remove or correct inaccurate or unverified information from its files, usually within 30 days after you dispute it. **However, the CRA is not required to remove accurate data from your file unless it is outdated (as described below) or cannot be verified.** If your dispute results in any change to your report, the CRA cannot reinsert into your file a disputed item unless the information source verifies its accuracy and completeness. In addition, the CRA must give you a written notice telling you it has reinserted the item. The notice must include the name, address and phone number of the information source.
- **You can dispute inaccurate items with the source of the information.** If you tell anyone -- such as a creditor who reports to a CRA -- that you dispute an item, they may not then report the information to a CRA without including a notice of your dispute. In addition, once you've notified the source of the error in writing, it may not continue to report the information if it is, in fact, an error.
- **Outdated information may not be reported.** In most cases, a CRA may not report negative information that is more than seven years old; ten years for bankruptcies.
- **Access to your file is limited.** A CRA may provide information about you only to people with a need recognized by the FCRA -- usually to consider an application with a creditor, insurer, employer, landlord, or other business.

- **Your consent is required for reports that are provided to employers, or reports that contain medical information.** A CRA may not give out information about you to your employer, or prospective employer, without your written consent. A CRA may not report medical information about you to creditors, insurers, or employers without your permission.
- **You may choose to exclude your name from CRA lists for unsolicited credit and insurance offers.** Creditors and insurers may use file information as the basis for sending you unsolicited offers of credit or insurance. Such offers must include a toll-free phone number for you to call if you want your name and address removed from future lists. If you call, you must be kept off the lists for two years. If you request, complete, and return the CRA form provided for this purpose, you must be taken off the lists indefinitely.
- **You may seek damages from violators.** If a CRA, a user or (in some cases) a provider of CRA data, violates the FCRA, you may sue them in state or federal court.

The FCRA gives several different federal agencies authority to enforce the FCRA:

FOR QUESTIONS OR CONCERNS REGARDING:

PLEASE CONTACT:

CRA's, creditors and others not listed below

Federal Trade Commission
Consumer Response Center - FCRA
Washington, DC 20580
202-326-3761

National banks, federal branches/agencies of foreign banks
(word "National" or initials "N.A." appear in or after bank's name)

Office of the Comptroller of the Currency
Compliance Management, Mail Stop 6-6
Washington, DC 20219
800-613-6743

Federal Reserve System member banks (except national banks,
and federal branches/agencies of foreign banks)

Federal Reserve Board
Division of Consumer & Community Affairs
Washington, DC 20551
202-452-3693

Savings associations and federally chartered savings banks (word
"Federal" or initials "F.S.B." appear in federal institution's name)

Office of Thrift Supervision
Consumer Programs
Washington, DC 20552
800-842-6929

Federal credit unions (words "Federal Credit Union" appear in
institution's name)

National Credit Union Administration
1775 Duke Street
Alexandria, VA 22314
703-518-6360

State-chartered banks that are not members of the Federal
Reserve System

Federal Deposit Insurance Corporation
Division of Compliance & Consumer Affairs
Washington, DC 20429
800-934-FDIC

Air, surface, or rail common carriers regulated by former Civil
Aeronautics Board or Interstate Commerce Commission

Department of Transportation
Office of Financial Management
Washington, DC 20590
202-366-1306

Activities subject to the Packers and Stockyards Act, 1921

Department of Agriculture
Office of Deputy Administrator - GIPSA
Washington, DC 20250
202-720-7051



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MEDICAL HISTORY FORM- Part 1 **Camp Dates:** _____

All Volunteers/Staff Members **MUST** complete this three part form and **submit 1 week prior to arrival** in order to attend camp.
All records are held confidential.

Name: _____ DOB: _____ SEX: M F
Home Phone: _____ Cell Phone: _____ Email: _____

INSURANCE:

Insurance Carrier: _____
Phone # for Claims: _____
Policy #: _____
Prescription #: _____

*Please attach a copy of your insurance card (front and back)
*Camp Boggy Creek recommends that you have insurance coverage, as you will be responsible for all medical bills incurred while at camp.

EMERGENCY CONTACT:

Name: _____
Address: _____
Relationship to you: _____
Home Phone: _____
Work/Cell Phone: _____

GENERAL MEDICAL HISTORY:

Allergies: Please list all medications, foods, insect bites, etc.

Past and Current Medical Conditions: Please list all surgeries, hospitalizations, injuries and illnesses (greater than the common cold or flu).

Special Nutritional Needs: Please be specific.

Do you have or have you ever had ...?

- | | |
|---|--|
| <input type="checkbox"/> Asthma | <input type="checkbox"/> High Blood Pressure |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Fainting or Dizzy During/After Exercise |
| <input type="checkbox"/> Back Pain or Injury | <input type="checkbox"/> Headaches/Migraines |
| <input type="checkbox"/> Chest Pain | <input type="checkbox"/> Heart Attack |
| <input type="checkbox"/> Injury to Joint or Extremity | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Shingles | |

Physical restrictions or limitations to activities:

Mental and Emotional Health:

The physical and emotional well-being of all staff and campers is important to Camp Boggy Creek. Due to the high emotional demands of this job, is there anything Boggy Creek needs to be made aware of to ensure that you and your campers are physically and emotionally sound?

Note: Family Weekend volunteers must complete the 2 page medical history form, complete the immunization form and submit immunization records. Summer volunteers and staff must also complete a physical.

While at Camp Boggy Creek, our medical staff will be available to provide first aid and initial treatment of minor illnesses while camp is in session. **However, you will be expected to make arrangements for ongoing medical care and treatment for chronic medical conditions, especially those usually cared for by specialists, in the local medical community.** CBC will assist you in providing those resources.

MEDICAL HISTORY FORM- part 2

Name: _____

MEDICATIONS:

Please list all medications that you take regularly, including vitamins, supplements, over-the-counter and prescription medications. (All staff will be required to turn in ALL meds when camp is in summer session. This list must match the medications turned in).

Prescription Medications: _____

All Other Medications: _____

FOR NEW STAFF & VOLUNTEERS:

A PPD Tuberculosis Test is required before your first time of service. It must have been done within the last 12 months.

Date: _____ Result: Positive* _____ Negative _____

* If positive, please include a copy of your chest x-ray and clearance from your physician.

FOR RETURNING STAFF & VOLUNTEERS:

TUBERCULOSIS RISK QUESTIONNAIRE

- Have you spent time with a person with infectious TB or someone with a prolonged productive cough (more than 2 weeks)?
- Have you had any of the following symptoms for greater than 2 weeks: chronic fatigue, persistent cough, bloody sputum or night sweats?
- Do you have an immune deficiency or HIV infection?
- Have you visited a country where TB disease is very common, such as in Latin America, the Caribbean, Africa, Russia or Eastern Europe or Asia?
- Do you live or work somewhere in the U. S. where TB disease is common, such as prisons and jails, homeless shelters, migrant farm camps or nursing homes?
- Do you inject drugs not prescribed by a doctor?

Have you answered YES to any of the above questions? _____

If you have answered YES to any of the above, you are at risk for Tuberculosis infection, and it is your obligation to provide documentation of an updated negative PPD test before you volunteer.

I certify that I have answered "no" to all of the above questions.

Signature

If you have answered "yes" to any of the above or have any questions, please contact Dr. Karen Bringelsen MD drkaren@boggycreek.org

Medical Release

I hereby grant permission to the medical staff of Camp Boggy Creek, or such designees as the medical staff may appoint, to provide medical services as may be necessary. In the event of an emergency arising from a serious illness or injury, if the staff member is unable to give consent, the camp medical staff or consulting physician is authorized to carry out any medical or surgical procedures which he/she deem necessary for the well-being of the staff member. Staff members assume financial responsibility for any and all medical expenses incurred while at Camp Boggy Creek.

I have read, understand and agree to abide by the above. I also attest that I am physically and mentally fit for camp, and there are no medical restrictions that would limit my ability to perform the essential function of my job. I understand that Camp assumes no responsibility for any preexisting injury or illness.

Print Staff/Volunteer Name

Signature

Date

IMMUNIZATIONS

We in the Patch want to welcome you to Camp Boggy Creek! Know that we are here to help you and our Campers have a healthy and fun experience.

PREVENTION IS THE BEST MEDICINE. Preventive health care starts with Immunizations. Sixteen life threatening diseases can be PREVENTED with immunizations.

Many of our campers, because of their illnesses, are not able to be immunized against some of these viruses and bacteria. And because of their illnesses, if they are exposed to these germs and become ill, they are more likely than others to become extremely ill and possibly not survive.

For this reason, it is very important for all staff who come to Camp Boggy Creek to be fully immunized. In so doing, we can all rest assured that we are not putting the lives of our campers at risk.

*****PLEASE ATTACH A COPY OF YOUR IMMUNIZATION RECORD*****

REQUIRED IMMUNIZATIONS

- **Measles, Mumps & Rubella (MMR) – 2 doses**
- **Chicken pox (Varicella) – 1 dose or history of chicken pox illness**

Please fill in the dates:

MMR 1 _____ 2 _____
Chicken pox (Varicella) vaccine _____ or Date of illness _____

Exceptions:

- If you cannot obtain the dates of your immunizations, a blood test can be done by your doctor to verify immunity to the disease.
- If you were born before 1957
- If a person has an immune deficiency and an immunization is contraindicated, a statement of medical exemption can be provided by a physician. No other exemptions will be accepted.

RECOMMENDED IMMUNIZATIONS

Tetanus, Diphtheria and Pertussis booster (Tdap) – within last 10 years

Meningococcal vaccine (Menactra)

Influenza vaccine

Hepatitis A

Hepatitis B

If you are not fully immunized, you can receive these vaccines through your doctor, your college health center, or your local county health department.



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SUMMER- Physical Exam

Camp Dates: _____

To be completed by a physician

NAME: _____ DOB: _____ SEX: M F

PLEASE NOTE: This completed form must be returned to Camp Boggy Creek ONE WEEK prior to your arrival for summer. No staff will be accepted until this form has been received and reviewed by our Medical Director. **(THIS FORM IS ONLY REQUIRED FOR SUMMER CAMP!)**

Current and Chronic Medical Concerns: _____

Past Medical and Surgical History: _____

Medications: _____

Allergies: _____

Physical Exam

VITAL SIGNS: _____
HEENT: _____
CARDIOVASCULAR: _____
CHEST / LUNGS: _____
ABDOMEN: _____
NEUROLOGICAL: _____
PSYCH / EMOTIONAL: _____
MUSCULOSKELETAL: _____
OTHER: _____

Activity Restrictions: _____

I have examined this person and find him/her physically fit to work at a residential camp. I am aware that this work would include supervision of children on the lakefront, in the pool, on a horse trail, exposure to farm animals, high ropes, excessive heat, long hours, and exposure to stressful situations, both emotional and physical. There are no restrictions that would limit his/her ability to perform the essential functions of his/her job, except as outlined above.

Signature MD/DO Print Name Date

Address _____ Phone: _____
_____ Fax: _____