SKY Camp Volunteer Application 2017
June 23 – 25

********Application Due: April 14, 2017***

Date: _____

Name:_____ ☐ Male ☐ Female

Address: _____ City: _____ State: ____ Zip:_____

SS# _____ Date of Birth:_____ E-Mail address:_____

Home Phone: (____)_____ Work Phone: (____)_____ Cell Phone: (____)_____

Employed by: _____ Position: _____

Student: _____ Major: _____

☐ High School Education ☐ College Education Degree: _____

Personal Reference (Relative): _____

Address: _____ City:_____ State:____ Zip:_____

Relationship: _____ Home Ph (____)_____ Work Ph (___)_____ Cell Ph (___) _____

Personal Reference (Not a Relative): _____

Address: _____City: _____ State:___ Zip:_____

Relationship: _____ Home Ph (____)_____ Work Ph (___)_____ Cell Ph (___) _____

Have you ever been convicted of a felony? ☐ Yes ☐ No

If yes, explain completely:_____

Volunteer experience: _____

_____

How did you learn about SKY Camp? _____

In case of emergency, notify: _____ Relationship: _____

Home Phone: (____)_____ Work Phone: (____)_____ Cellular Phone: (____)_____

SKY Volunteer Training will be held at the Kindred Hospice office on the dates below. If you are unable to attend all training sessions, notify Allison Rankin, SKY Camp Coordinator at 806-341-1468.

☐ **April 22 (9:00-2:30) New Volunteers; (11:30-2:30) Returning Volunteers** ☐ **June 13 (5:30-8:30)**

Please check one for the Camp T-shirt: (adult sizes) ☐ Small ☐ Medium ☐ Large ☐ X-Large ☐ XX-Large ☐ XXX-Large

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One of our SKY Camp traditions is to honor our loved ones by wearing a bead(s) on our nametag to represent their love in our life. Please indicate below the loss(es).

Bereavement History

Relationship	Date of Death	Age at Death	Cause of Death

Kindred Hospice ● 3232 Hobbs Rd. ● Amarillo, TX 79109 ● (806) 372-7696 ● Fax (806) 372-2825

Let us know your preferences writing a 1, 2 or 3 on the line beside your top three areas of interest:

___ **Buddy** (Weekend) Age Preference ____

___ **Group Counselor** (Weekend)

___ **RN** (weekend)

___ **Shifts** Saturday 9am-3pm; 3pm -9pm)

(help as needed)

___ **Music/Guitar** (campfire Friday evening)

___ **Recreation** (Saturday 5:30 – 9pm)

___ **Photographer** (weekend)

___ **Administrative** (mailings, phone calls)

___ ***Registration** (Friday at camp)

___ **Other**_____

- **Buddies** are responsible for the safety and supervision of assigned campers.
- **Group counselors** facilitate grief support groups. (Counseling, social work or education experience preferred)

***Registration** is Friday 2:00 - 5:00 p.m.at Ceta Canyon.

TO INSURE A QUALITY CAMP EXPERIENCE FOR THE CHILDREN, THE CAMP COMMITTEE RESERVES THE RIGHT TO PLACE CAMP VOLUNTEERS WHERE THEY ARE MOST NEEDED.

CAMP VOLUNTEER RULES

1. All volunteers wishing to help at camp **must attend** the SKY Volunteer Training sessions at Kindred Hospice. Please notify Allison Rankin if you have a scheduling conflict.
2. Remember, we are counting on you for the **entire weekend** of SKY Camp. Late cancellations create staffing challenges and may be a disappointment to the campers. Please make sure you can honor your commitment.
3. Alcohol and tobacco is STRICTLY PROHIBITED at SKY Camp. No alcohol or tobacco is to be present or consumed. Anyone found with alcohol or tobacco will be asked to leave immediately.

RELEASE OF LIABILITY

In consideration for attending SKY Camp on June 23 – 25, 2017, I understand and agree that Kindred Gentiva Hospice Foundation, their Board of Directors, Officers, Employees, and Volunteers are released from any legal responsibility and/or liability for negligence arising out of any personal injuries, either physical or emotional, known or unknown, and/or injury to property, real or personal, sustained by me or my property during my attendance at SKY Camp, whether the injury is caused by negligence or any other fault.

Signature:_____ Date: _____

PUBLICITY PERMISSION

I hereby consent that Kindred Hospice, The Kindred Gentiva Hospice Foundation or programs approved by Kindred Hospice be authorized to use my name, title, portrait, picture, video image, photograph, or any reproduction likeness of me or quotation of my remarks, for public information, fund-raising purposes and use of the other hospice programs as approved by Kindred Hospice.

Permission is hereby granted to use personal information about myself, my family and the circumstances of my relationship with Kindred Hospice as deemed appropriate by Kindred Hospice or the above named entities for the same purposes.

Signature:_____ Date: _____

SKY CAMP 2017
CONFIDENTIALITY AGREEMENT

All staff and volunteers shall respect the confidentiality of camper/family interactions and communication.

1. Staff and volunteers shall inform all campers and families that information is shared among camp staff and confidentiality is respected by these members. All matters discussed will remain confidential, except those matters related to instances of harm or threat of harm to any person, child abuse or child neglect.

2. In the event that I discover instances of harm or threat of harm to any person, or instances of child abuse or child neglect, I understand that I am under an affirmative duty to disclose such instances to Kindred Hospice.

3. "Child abuse" means

    a. the physical injury of a child by any parent or other person who has permanent or temporary care or custody or responsibility for supervision of a child, or by any household or family member, under circumstances that indicate that the child's health or welfare is significantly harmed or at risk of being significantly harmed; or

    b. sexual abuse of a child, whether physical injuries are sustained or not.

4. "Neglect" means the leaving of a child unattended or other failure to give proper care and attention to a child by the child's parents, guardian, or custodian under circumstances that indicate that the child's health or welfare is significantly harmed or placed at risk of significant harm.

5. Clear suicide threats and concerns about suicide risk must be shared with camp staffers to enable a team plan to be developed.

6. Release of information from the camper/family record may be carried out with written permission from the camper/family.

7. Staff and volunteers shall be aware of visitors and telephone callers and use discretion in discussing campers/families in public areas.

8. Camp medical records shall be maintained in the Kindred Hospice office and held confidential. Documentation and other paperwork carried by camp staffers shall be maintained in such a way as to protect confidentiality.

9. Security measures shall be taken in storing camp records to safeguard both the record and its informational content against loss, defacement, tampering, unauthorized disclosure, and use by unauthorized persons.

10. Staff and volunteers shall respect the professional boundaries of camper/family relationships. Personal and confidential information about oneself, family, or other staff members shall not be discussed with campers, families, or others known through these professional relationships.

11. All information I receive whether obtained by:

    Direct contact with campers and families;
    Exchange of information during staff meetings;
    Interaction with camp staffers;
    Camper and family records;
    is to be held in strict confidence in order to protect the rights of campers and families.

I hereby agree, by signing below, that I have read this document, understand its full meaning, and agree to adhere to the confidentiality agreement described above.

Signature: _____ Date: _____

MEDICAL CONSENT

I give permission for SKY Camp Medical Staff to administer First Aid, if needed.

Signature:_____ Date: _____

HEALTH HISTORY

Dates of Camp Attendance: June 23 – 25, 2017.

The information on this form is not part of the staff acceptance process, but is gathered to assist us in identifying appropriate care in an emergency situation.

Name:_____ Date of Birth:_____

HEALTH INFORMATION

Please list any drug allergies:

_____ _____ _____

Please provide any necessary medical information about your health that would be helpful for us to know.

_____

NAME OF FAMILY PHYSICIAN _____

Address _____Phone #_____

Name of family dentist/orthodontist_____

Address _____Phone #_____

INSURANCE INFORMATION

Is the participant covered by family medical/hospital insurance? ☐ Yes ☐ No

If so, indicate carrier or plan name _____ Group#_____

Carrier address_____

Name of insured_____

Relationship to participant_____

Social security number of policyholder or insurance ID number_____

I CERTIFY THAT THE INFORMATION GIVEN FOR THE SKY CAMP VOLUNTEER APPLICATION IS COMPLETE AND TRUE.

Signature:_____ Date: _____

All new volunteers will be interviewed and volunteers will receive notification if they are found to be a good match for the requirements of SKY Camp. Thank you for your commitment to SKY Camp and its mission to serve grieving children and families in our community.