Charles Campbell Camp Counselor Dates July 13 – 19, 2019
COUNSELOR APPLICATION

Name_____ Age_____ Birth date_____
Address_____ _____
City_____ State_____ Zip_____ Male/Female_____
Home phone_____ Cell Phone_____ Parent work phone_____
E-mail address_____

Height_____ Weight_____ Camp is physically strenuous and this information helps us place you.
Camp Experience_____
Have you attended the Charles Campbell Camp before? Yes___ No___ Year_____
Personal References: (Not Immediate Family, if you have not attended this camp prior)
Name_____ Phone_____
Name_____ Phone_____
Do you have CPR/First Aid certification: Yes_____ No_____

Use the back to briefly list any special skills, experience, and other information that may be beneficial.
Known Allergies:
Medications:_____
Food:_____
Other:_____
Physician_____ Hospital preference_____
Date of last Tetanus shot_____
Medical conditions (ex. Diabetes, Seizures, etc) Please be specific and list all conditions that impact.
_____
_____
_____
Prescription medications: Please list each medication you will be bringing to camp:
_____
_____
All prescriptions will be kept in the locked cabinet in the Kitchen but will be available for you to self administer.
Insurance Carrier_____ policy number_____

Emergency consent form for Dates: _____
I hereby affirm that I am the parent/guardian of_____ and give my permission to any physician/member of hospital medical staff to perform emergency medical treatment and procedures for_____ as he/she deems necessary, and to continue treatment and procedures until such time as the undersigned shall dismiss or engage another physician. This permission includes admission to the local hospital if deemed necessary.
I consent that photographs, videos, or any other Media reproduction of same taken of him/her may be used by the Camp Director, Staff, and or the Billing's Lions Club to advertise or publicize in any manner.
I give my permission to participate in the camp program sponsored by the Billing's Lions Club and release the Lions Club and the camp staff from any liability resulting from such activity.
Parent/Guardian/your Signature_____ Date_____
(If you are 18 or older your signature is required instead of parent)
Daytime Phone #_____ Evening Phone #_____
Emergency Contact (if parents are unavailable)
Name_____ Relationship_____ Phone #_____

Return to: Charles Campbell Camp PO Box 23342 Billings, MT 59104 (406) 670-2496
E-mail address: campbellcamp@msn.com Doug and Sue Hanson Directors