

## Junior Counselor Job Description

### Job Requirements

Activities are planned in a camp setting for a group (cabin) of 5-10 children aged 7 - 14 years old who are affected by a bleeding disorder. Junior Counselor's roles are:

- ▶ To participate under the supervision of the Camp Directors and Head Cabin Counselor in planning and implementing activities in the safest manner possible.
- ▶ To be a positive role model.
- ▶ To actively interact with the children to promote and encourage their personal growth.

### Requirements

Applicant must be 15 - 17 years old by June 17, 2011. Prior attendance at Camp Hemotion or work with children in a recreational or educational setting is desirable. Must have an interest in leadership skills and willingness to learn and understand organizational skills and group dynamics. Must have an ability for and an interest in leading a variety of recreational activities including sports, games, creative arts, swimming and environmental education. Must have an ability to perform under stress and pressure while remaining flexible. Must have a genuine interest in working with people.

### Job Overview

1. As part of a group, plan and conduct recreational activities for 7-14 year olds in a camping program.
2. Stay with your assigned group at all times unless previous arrangements have been made with the Head Cabin Counselor.
3. In leading activities, encourage children to take responsibility for themselves (i.e., clean up after themselves).
4. Follow all HFNC and program policies, as well as legal guidelines.
5. Attend staff meetings and all staff training events, including **training session that begins on Saturday, June 18, 2011**
6. Follow all Camp Oakhurst Policies and Guidelines.
7. Report all accidents to the Head Cabin Counselor.
8. Assist in maintenance of the camp as needed. This includes sweeping and mopping of floors, wiping off of table, counter tops, putting supplies away, setting up and breaking down equipment.
9. Report to all camp events and meals on time.

### Public Relations

1. Maintain a healthy relationship with all camp personnel. Attempt, with the Head Cabin Counselor, to correct any minor behavior problems before they become serious problems.
2. Act in a courteous and friendly manner when leading the group in camp. Maintain a nonabrasive relationship with all other cabin groups.

### Personal Development

1. Develop skills in planning and implementing activities with children.
2. Be prepared to receive feedback and support from anyone at camp.
3. Maintain a positive and open outlook. Try to work out problems with the rest of the staff. Be sensitive to other staff members' needs.
4. Report and discuss all ongoing problems and concerns with Camp Director.
5. Be a positive role model for the children. Reward and encourage their good behavior with attention and affection.

6400 Hollis Street, Suite 6  
Emeryville, CA 94608  
(510) 658-3324 Phone

## CAMP HEMOTION 2011 JUNIOR COUNSELOR APPLICATION

For identification  
purposes please  
attach your  
photo here.

**General Information** **(ALL APPLICANTS)**

Applicant's First Name \_\_\_\_\_ Last Name \_\_\_\_\_  
 Address \_\_\_\_\_ City \_\_\_\_\_ ST \_\_\_\_\_ Zip \_\_\_\_\_  
 If in school, name of school \_\_\_\_\_ Grade Level in Sep.'10 \_\_\_\_\_  
 Birthdate \_\_\_\_\_ Age \_\_\_\_\_ Height \_\_\_\_\_ Weight \_\_\_\_\_  M  F

**Work Experience** **(ALL APPLICANTS)**

If employed, current employer _____	Job Title _____
Volunteer Experience _____ _____	

**References** (Provide 3 personal, school, and/or employment references. **Do not list relatives**) **(ALL APPLICANTS)**

Last Name	First Name	Relationship	Phone
Last Name	First Name	Relationship	Phone
Last Name	First Name	Relationship	Phone

**Emergency Contact Info** (If you are under 18 this **MUST** be your parent/guardian) **(ALL APPLICANTS)**

Last Name	First Name	Relationship
Day Phone	Evening Phone	Cell Phone

If your parents will be away from home while you are at camp please indicate where they should be reached

Dates Away \_\_\_\_\_ Phone (\_\_\_\_) \_\_\_\_\_

**Siblings (i.e. Brothers, Sisters, Cousins) also attending camp** **(ALL CAMPERS)**

First and Last Name	Age	First and Last Name	Age

**Transportation** **(ALL APPLICANTS)**

Please choose the departure location where you will depart for camp and the arrival location where you will be dropped off after camp. You will receive the exact time for your chosen location in your camper confirmation letter.

Pickup for camp location       Emeryville Amtrak Station       Sacramento Amtrak Station       Fresno Amtrak Station

Return from camp location       UCSF     Oakland Children's Hospital     Lucile Packard Children's Hospital     Davis/Sacramento Medical Center     Stockton     Modesto     Madera Children's Hospital

## Interests, Qualifications & Certifications

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Activity	Interested in		Qualified to Lead	
Archery Lessons	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Archery Supervision	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Arts and Crafts	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Drama	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Fishing	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Fishing Lessons	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Hiking/Nature Walk	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Song Leading	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Guitar	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Other instruments you may bring with you	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Ropes Course	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Swimming Lessons	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Swimming Supervision	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> No

Preferred Age Group Assignment (Rate 1 - 3, 1 being the best)			(ALL APPLICANTS)
Ages 7 to 9	Ages 9 to 11	Ages 12 to 14	
<input type="radio"/> 1 <input type="radio"/> 2 <input type="radio"/> 3	<input type="radio"/> 1 <input type="radio"/> 2 <input type="radio"/> 3	<input type="radio"/> 1 <input type="radio"/> 2 <input type="radio"/> 3	

Red Cross Certifications			(ALL APPLICANTS)
WSI	<input type="checkbox"/> Yes <input type="checkbox"/> No	____/____/____ Expiration Date	
Advanced Life Saving	<input type="checkbox"/> Yes <input type="checkbox"/> No	____/____/____ Expiration Date	
Life Guard Training	<input type="checkbox"/> Yes <input type="checkbox"/> No	____/____/____ Expiration Date	
CPR	<input type="checkbox"/> Yes <input type="checkbox"/> No	____/____/____ Expiration Date	
Standard First Aid	<input type="checkbox"/> Yes <input type="checkbox"/> No	____/____/____ Expiration Date	

Do you have any physical limitations that may limit your job performance?	<input type="checkbox"/> Yes <input type="checkbox"/> No
If yes, please explain _____ _____ _____	

X \_\_\_\_\_ Date \_\_\_\_\_ Print Name \_\_\_\_\_  
 Parent/Guardian Signature  
**(SIGNATURE IS MANDATORY)**



# Parent Provided Medical History

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

Name of Hemophilia Treatment Center & Physician <span style="float: right;">(ALL APPLICANTS)</span>	
Affected Junior Counselor	Unaffected Junior Counselor
Hematologist	Pediatrician/Other
Hemophilia Treatment Center	Institution
Address	Address
Phone	Phone

**Immunization Dates** (Complete below or include copy of Immunization Records) (ALL APPLICANTS)

Diphtheria/Pertussis/Tetanus \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_  
 Tetanus Booster \_\_\_\_\_ MMR \_\_\_\_\_ / \_\_\_\_\_  
 Hepatitis A \_\_\_\_\_ / \_\_\_\_\_ Hepatitis B \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_  
 Have you had chicken pox vaccine? Yes \_\_\_\_\_ Date \_\_\_\_\_ No \_\_\_\_\_  
 Have you had chicken pox disease? Yes \_\_\_\_\_ Date \_\_\_\_\_ No \_\_\_\_\_  
 Was this diagnosed by a physician? Yes \_\_\_\_\_ No \_\_\_\_\_ Verified by titer? Yes \_\_\_\_\_ No \_\_\_\_\_

**Other Medical Conditions** (ALL APPLICANTS)

ADD/ADHD  Allergies  Asthma  Hay Fever  Trouble Sleeping  Other \_\_\_\_\_

**Drug / Clotting Factor Allergies** (ALL APPLICANTS)

Drug / Clotting Factor: Name \_\_\_\_\_ Type of reaction \_\_\_\_\_ Name \_\_\_\_\_ Type of reaction \_\_\_\_\_  
 Food Allergies: Name \_\_\_\_\_ Type of reaction \_\_\_\_\_ Name \_\_\_\_\_ Type of reaction \_\_\_\_\_

Factor Therapy	Dose of Factor	Frequency
Prophylactic Therapy		
Minor bleeds/soft tissue of muscle		
Joint bleeds		
Major bleeds		
Trauma or Head Injury		

**Medications** (ALL APPLICANTS)

All medications administered at Camp (including over-the-counter and vitamins) must appear on your child's medical form. You should send all medications, clotting factor, Stimate, and any other supplies necessary for your child while at Camp. The medical staff will store and administer medications as directed by you. This includes allergy meds, anti-depressants and vitamins.

		What days while at camp?							
Clotting Factor Brand Name? (if used)	Dose	Sun	Mon	Tue	Wed	Thu	Fri	Sat	As Needed
Will you infuse your child Saturday night/Sunday morning before she/he gets on the bus for camp? <input type="checkbox"/> Yes <input type="checkbox"/> No									
Other medications including over-the-counter	Dose	Sun	Mon	Tue	Wed	Thu	Fri	Sat	As Needed
Vitamins	Dose	Sun	Mon	Tue	Wed	Thu	Fri	Sat	

Have there been any stressful life events in the past year?  Yes  No

If yes, please explain \_\_\_\_\_

# INDEMNIFICATION

**Authorization to Provide Emergency Medical Treatment (ALL APPLICANTS)**

JC Name: \_\_\_\_\_ D.O.B. \_\_\_\_\_

I hereby authorize the Medical Director of Camp Hemotion or such designee or designees as the Medical Director may appoint, to provide for the giving of emergency medical care or treatment, including medicines, immunizations, x-rays, tests, dental and minor surgical treatment, hospitalization, general anesthesia or other medical treatment as may be appropriate while the JC is in the care of Camp Hemotion. Notification of the parent will always be attempted. I understand that information pertaining to the JC may be shared with/released to appropriate personnel for the purpose of treating and/or supervising my child (including, but not limited to camp staff, referral centers and/or insurance companies). I further agree that this authorization includes the administration of all prescribed medications and treatments previously listed in this application and shall be effective until revoked.

X \_\_\_\_\_  
 Parent/Guardian Signature Address  
 (SIGNATURE IS MANDATORY)

\_\_\_\_\_ Date \_\_\_\_\_ City State Zip Tel

Insurance Information - MANDATORY (ALL APPLICANTS)	
Name of Insurance Company	If MediCal, specify number
Address	
Phone Number	
Policy Number or CIN#	If group insurance, specify company
Prescription plan (Co, ID#)	Name of primary person insured

**Indemnification / Photo Release / Educational Program Permission (ALL APPLICANTS)**

**CONSENT TO PHOTOGRAPH**

I/We hereby authorize the Hemophilia Foundation of Northern California to photograph the above named individual in connection with his/her presence at Camp Oakhurst. The photograph(s) may appear in hospital, Hemophilia Foundation, and/or public newspaper camp publicity.  Yes  No

**CONSENT FOR EDUCATIONAL PROGRAMS**

I/We hereby give consent for my child to participate in any educational sessions offered at the Hemophilia Foundation summer camp. This consent includes planned HIV/AIDS and age appropriate sex education programs for the older campers and general hemophilia education for the younger campers. I understand that if my child does not participate in the planned education program, he/she will be offered an alternative activity.  Yes  No

**INDEMNIFICATION**

I/We agree to hold harmless, indemnify and forever discharge the Hemophilia Foundation of Northern California, the hemophilia treatment centers, Camp Oakhurst, their employees or agents any claims which may arise as a result of or in connection with the participation of the child in this camp or its activities. This includes any representatives acting on my behalf or on the behalf of my estate.

**DURATION OF STAY**

I/We hereby acknowledge that Camp Hemotion is a 7 day residential program and that attendance for the entire period is required. I/We understand that the only exemption to this duration of stay is by medical necessity and I/We will not attempt to withdraw this camper prior to the end of camp for any other reason.

X \_\_\_\_\_ Date  
 Parent/Guardian Signature (SIGNATURE IS MANDATORY)

# What To Bring -- Check List

## Must Have Items -- Check List

- |   |   |   |                                       |
|---|---|---|---------------------------------------|
| <input type="checkbox"/> Towels for swimming & showering            | <input type="checkbox"/> 2 Pairs Pajamas          | <input type="checkbox"/> Underwear/Socks for 6 days   | <input type="checkbox"/> Pillows      |
| <input type="checkbox"/> Sleeping Bag (or Sheets & Blankets)        | <input type="checkbox"/> 3 Pairs Shorts / Cutoffs | <input type="checkbox"/> 6 Pairs Long Pants/ Sweat Pants /Jeans   | <input type="checkbox"/> Comb & Brush |
| <input type="checkbox"/> Lace up tennis shoes (2 pairs recommended) | <input type="checkbox"/> Bathing Suit             | <input type="checkbox"/> Warm Jacket  | <input type="checkbox"/> Sun Screen   |
| <input type="checkbox"/> Bug Repellent                              | <input type="checkbox"/> Toiletries               | <input type="checkbox"/> Sweater / Sweatshirt   | <input type="checkbox"/> Soap         |
| <input type="checkbox"/> 6 Short Sleeved Shirts / T-Shirts          | <input type="checkbox"/> Toothbrush/ Toothpaste   | <input type="checkbox"/> Extra Pair of Shoes for water fight. Can be lace up or sandal with ankle strap. NO FLIP FLOPS! |                                       |

## Might Want to Have Items -- Check List

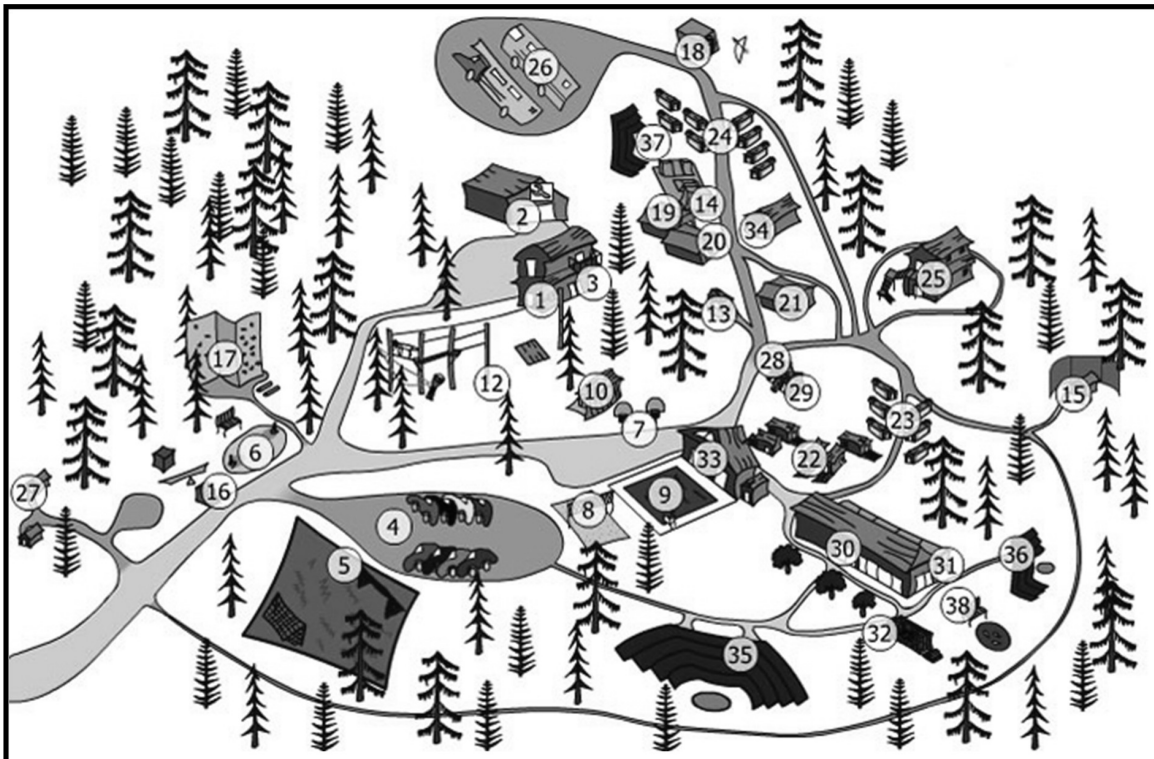
- |  |   |   |   |
|--|---|---|---|
| <input type="checkbox"/> Musical Instruments | <input type="checkbox"/> Writing Paper, Pen, Stamps | <input type="checkbox"/> Costumes / Props         | <input type="checkbox"/> Sun Hat                  |
| <input type="checkbox"/> Light Weight Robe   | <input type="checkbox"/> Rubber Sandals for shower  | <input type="checkbox"/> Flashlights & Head lamps | <input type="checkbox"/> Sports / Field Equipment |

## Things To Leave At Home

- |                  |               |                 |                           |        |
|------------------|---------------|-----------------|---------------------------|--------|
| Money            | Knives Pocket | Portable TV's   | BoomBoxes                 | Radios |
| iPods/MP3 Player | B-B guns      | Pets or Animals | Candy or food of any kind |        |

**If ANY of these items are brought to camp, they will be confiscated by the Camp Director and held until the end of camp.**

## Camp Oakhurst



1. Administrative Building
2. Maintenance Building
3. Friendship Conf. Room
4. Main Parking Lot
5. Ball Field
6. Horseshoe Pit
7. Basketball Court
8. Volleyball Court

9. Pool
10. Staff Lounge
11. Frisbee Golf
12. High Ropes Course
13. Bike Shed
14. Skate Park
15. Paint Ball Course
16. Low Ropes Course

### DIRECTORY

17. Climbing Wall
18. Archery
19. Wright Cabin
20. McCoy Cabin
21. Heinrich Cabin
22. Chalet Cabin

23. Alpine Cabins 1-6
24. Alpine Cabins 7-14
25. Cedar Lodge (Meeting Rm)
26. R.V. Sites
27. Staff Housing
28. Snack Shack
29. Gift Store
30. Dining Hall (Meeting Rm)

31. Outdoor Dining
32. BBQ Pit
33. Pool Bathhouse
34. Back Bathhouse
35. Main Amphitheater
36. Oak Glen Amph.
37. Back Amph.
38. Koi Pond

CAMP OAKHURST MEDICAL AND LIABILITY RELEASE FORM



Hemophilia Foundation of Northern California

Name of Church or Group \_\_\_\_\_ Dates attending \_\_\_\_\_

Last Name \_\_\_\_\_ First \_\_\_\_\_ (Camper / Leader / Speaker / Volunteer, etc.)

Address \_\_\_\_\_ City \_\_\_\_\_ ST \_\_\_\_\_ Zip \_\_\_\_\_

In Emergency, notify: \_\_\_\_\_ Relationship \_\_\_\_\_ (Parent or Guardian's)

Home Phone \_\_\_\_\_ Work \_\_\_\_\_ Cell \_\_\_\_\_

e-mail address: \_\_\_\_\_

Birthdate \_\_\_\_\_ Age \_\_\_\_\_ Gender \_\_\_\_\_ Allergies \_\_\_\_\_

Date of last Tetanus Shot \_\_\_\_\_ Food Restrictions \_\_\_\_\_

Activity Restrictions \_\_\_\_\_

Physician \_\_\_\_\_ Phone Number \_\_\_\_\_

MEDICAL RELEASE: This health history is correct so far as I know and this person has permission of the undersigned to engage in all camp activities except as noted. In case of illness or injury, Camp Oakhurst has my permission to procure medical treatment for the above named (minor, if applicable). I understand Camp Oakhurst does not provide medical insurance or reimbursement for medical fees or prescriptions and that I am responsible for any / all such fees and charges arising from illness or injury that may occur.

LIABILITY RELEASE: The undersigned, for himself or herself and on behalf of his or her child(ren) or ward(s) and their personal representatives assigns or heirs, (hereinafter referred to as Releasors,) hereby releases and agrees and covenants not to sue Camp Oakhurst, their owners, directors, stock holders, agents, successors, or any employee, (herein after referred to as Releasees,) from any and all liability for loss, damage, injury, death, or any other claim whatever to the person or property of any guest or participant whether caused by negligence of Releasees or any other person or thing while participating in activities sponsored by or associated with Camp Oakhurst. The undersigned elects to participate and / or allow his or her child(ren), ward(s), to participate voluntarily and assumes all risk of loss, damage, injury or death, known or unknown, foreseen or unforeseen, that may be sustained.

**YOU HAVE THE OPTION TO OR ALLOW YOUR CHILD, CHILDREN, WARD OR WARDS NOT TO PARTICIPATE IN ANY ACTIVITY WHERE YOU DO NOT WISH TO WAIVE LIABILITY. IT SHALL BE YOUR RESPONSIBILITY TO INSURE THAT YOUR CHILD, CHILDREN, WARD OR WARDS DO(ES) NOT PARTICIPATE IN THE ACTIVITIES FOR WHICH YOU CHOOSE NOT TO BEAR LIABILITY.**

The undersigned has read and voluntarily signs this medical release and waiver of all liability.

Signature \_\_\_\_\_ Date \_\_\_\_\_ (Parent or Guardian)

IMAGE AND INFORMATION USE PERMISSION

I give permission to Camp Oakhurst to use images (still photography or video footage) of the above mentioned person for future promotional materials, including but not limited to, brochures and web site postings, without expectation of compensation. I also give permission to Camp Oakhurst to use my mailing and e-mail addresses for Camp Oakhurst mailings and information only.

Yes  No \_\_\_\_\_ Signature (Parent or Guardian if under 18) \_\_\_\_\_ Date \_\_\_\_\_

# Physician's Form



**TO BE COMPLETED BY HEALTH CARE PROVIDER (PHYSICIAN/NURSE)**

Name of patient \_\_\_\_\_ Date Of Birth \_\_\_/\_\_\_/\_\_\_

Date of Last Exam \_\_\_\_\_ Weight \_\_\_\_\_  Male  Female

Affected by bleeding disorder?  Yes  No (If NO, Please skip to Section 5 below)

## 1. Diagnosis

Factor VIII deficiency \_\_\_\_\_ Factor IX deficiency \_\_\_\_\_ Factor Activity Level \_\_\_ %  
 VWD Type I \_\_\_\_\_ II \_\_\_\_\_ III \_\_\_\_\_ Inhibitor? Yes \_\_\_ No \_\_\_ Inhibitor Titer \_\_\_\_\_  
           IIA \_\_\_\_\_ IIB \_\_\_\_\_ IIM \_\_\_\_\_ IIN \_\_\_\_\_ Date of last inhibitor test \_\_\_/\_\_\_/\_\_\_  
 Carrier VIII \_\_\_\_\_ IX \_\_\_\_\_ Immune Tolerance?  
 Other factor deficiency (type) \_\_\_\_\_  On it  On it  Never  
 Platelet dysfunction (type) \_\_\_\_\_  now  in the past  on it

## 2. Treatment

What brand of factor is used? \_\_\_\_\_  
 Does this child self-infuse?  Yes  Yes, with assistance  No  No, but would like to learn  
 Target joints \_\_\_\_\_

3. Factor Therapy	Minor		Major	
	Factor	Dose	Frequency	Frequency
Prophylactic Therapy				
Minor bleeds/soft tissue of muscle				
Joint bleeds				
Major bleeds				
Trauma or Head Injury				

4. Other Meds for Bleeding Episodes	Dose	Frequency

## 5. Other Medications including over-the-counter

Drug Name and Strength	Dose	Frequency

## 6. Psychosocial Development

Is the child's development appropriate for his/her age?  Yes  No  
 If No, at what approximate age does the child function? \_\_\_\_\_  
 Pertinent Psychosocial Information (Any member of medical team may complete) \_\_\_\_\_

# Physician's Form

**TO BE COMPLETED BY HEALTH CARE  
PROVIDER (PHYSICIAN/NURSE)**

Patient Information		
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Patient Name _____	Date of Birth ____/____/____
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	Normal	Abnormal	Explain Abnormalities
Head & Neck	<input type="checkbox"/>	<input type="checkbox"/>	
Eyes & Ears	<input type="checkbox"/>	<input type="checkbox"/>	
Nose & Throat	<input type="checkbox"/>	<input type="checkbox"/>	
Dental	<input type="checkbox"/>	<input type="checkbox"/>	
Chest	<input type="checkbox"/>	<input type="checkbox"/>	
Heart	<input type="checkbox"/>	<input type="checkbox"/>	
Abdomen	<input type="checkbox"/>	<input type="checkbox"/>	
Extremities	<input type="checkbox"/>	<input type="checkbox"/>	
Neurological	<input type="checkbox"/>	<input type="checkbox"/>	
Skin	<input type="checkbox"/>	<input type="checkbox"/>	
Psychological	<input type="checkbox"/>	<input type="checkbox"/>	
Height/Weight	<input type="checkbox"/>	<input type="checkbox"/>	

Drug / Clotting Factor / Food Allergies				
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	Name	Type of reaction	Name	Type of reaction
Drug/Clotting Factor				
Food Allergies				

If the child had any hospitalizations in the past year please give dates and reasons \_\_\_\_\_

\_\_\_\_\_

Please list any ongoing other problem(s) / Other Diagnosis
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Any General Restrictions?
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Signature of Provider	Print Name
<b>(SIGNATURE IS MANDATORY)</b>	

Address

Clinic / Day Phone	Emergency / On Call Phone	Date
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