Summer Camp Volunteer Application 2020

Please return to Renae Murphy: rmurphy@FAR-therapy.org

Please check the camp(s) you would like to volunteer for…

[ ] **Camp Sing Out**: July 6th – 17th, 2020

[ ] **FAR Explorers**: August 10th-12th, 17th-19th, 2020

[ ] **Camp FAR Out**: July 20th – 31st, 2020

A **mandatory orientation is required for EACH camp**

______________________________ Legal Name

______________________________ Nickname

[ ] Male [ ] Female

_____/_____/________ Date of Birth

T Shirt Size: [ ] Small [ ] Medium [ ] Large [ ] XL [ ] 2XL [ ] 3XL

______________________ Street Address

______________________ City

______________ Zip Code

______________ Home Phone

______________ Cell Phone

______________ Driver's License Number

______________________ E-Mail Address

______________________ Place of Employment / Title

______________________________ Emergency Contact

______________ Phone number

Will you be receiving credit for volunteering at camp? [ ] Yes [ ] No

______________________________ Volunteer Coordinator

______________ Phone number

How did you learn about FAR? ______________________________

Have you worked at a FAR camp or any other summer camps in the past? [ ] Yes [ ] No

Do you have experience working with persons with special needs? [ ] Yes [ ] No

If yes, list experiences ______________________________

____

How comfortable do you feel with the following age groups of campers?

RATE YOUR COMFORT LEVEL WITH THE FOLLOWING AGES - 1 IS VERY UNCOMFORTABLE 5 IS VERY COMFORTABLE					
4-7	8-10	12-14	15-16	17-20	20-25
_____	_____	_____	_____	_____	_____

FAR Therapeutic Arts and Recreation
1669 West Maple Road Birmingham, MI 48009 • Phone: 248.646.3347 • Fax 248.646.4480
E-mail: camp@FAR-therapy.org • Website: www.FAR-therapy.org

REFERENCES

Please provide two references who can vouch for any experience you have had with children with special needs.

Name ______________________________ Phone ______________

Relationship ______________________ Email ______________________

Name ______________________________ Phone ______________

Relationship ______________________ Email ______________________

PHOTO RELEASE

I, ______________________________ hereby grant FAR Therapeutic Arts and Recreation permission to publish my/my child's photograph(s), video and audio in agency publications in print, electronic communications or on the agency website located at www.far-therapy.org.

FAR is a 501(c)(3) nonprofit agency.

By signing below, I acknowledge my understanding of the above and grant my permission for use of the photograph(s), video or audio.

____

(*Please print name*)

SIGNATURE ______________________ DATE ______________

PARENT'S SIGNATURE, IF UNDER 18 YEARS OF AGE ______________________ DATE ______________

BACKGROUND CHECK

I acknowledge the fact that a criminal records search will be performed by the FAR office.

SIGNATURE ______________________ DATE ______________

PARENT'S SIGNATURE, IF UNDER 18 YEARS OF AGE ______________________ DATE ______________

Office Use Only

Interview notes / comments:

____

____

License: [ ] Yes [ ] No • Cleared: [ ] Yes [ ] No • SSC: [ ] Yes [ ] No

Interviewed by: ______________________________ Date:____/____/____

Confidentiality Policy

FAR Therapeutic Arts and Recreation ("FAR") maintains records of all clients that are confidential in nature and for FAR use only. All volunteers are required to maintain such information in strict confidence.

Confidentiality is the preservation of privileged, personal information and, while private information will be disclosed to you as a necessary part of the services you provide to our clients, all information concerning clients and former clients of FAR is to be treated as confidential. "Confidential" means that you are free to talk about FAR and about your position, but you are not permitted to disclose clients' names, diagnosis, or talk about them in ways that will make their identity known. FAR expects you to respect the privacy of the clients we serve and to maintain their personal information as confidential at all times both during and after your service to FAR. This is a basic component of client care and business ethics. Disclosure of any confidential information is a direct violation of this policy. Should an occasion arise in which you are unsure of your obligations under this policy, it is your responsibility to consult with your FAR supervisor.

By signing this Confidentiality Policy, I agree to maintain professional confidentiality for all persons served by FAR Therapeutic Arts and Recreation as outlined above. I also agree to inform my FAR supervisor immediately if I believe any violation (unintentional or otherwise) of the policy has occurred. I understand that violation of this policy will lead to disciplinary action, up to and including termination of my service with FAR.

Signature ____________________________ Date ______________________________

Name________________________________

Staff Witness__________________________ Date ________________________________

Name_______________________________

Revised 8/14/2018

Staff Initials: _________

Volunteer Medical Policy and Consent Form

FAR staff is dedicated to creating a fun and safe therapeutic environment for our clients, families, and volunteers. To ensure that everyone has a safe experience, please review the following medical policy.

1. All FAR staff is certified in CPR and basic First Aid and will intervene on behalf of you/your child in the event basic care is required. In the event of any incident, your emergency contact/you will receive a phone call from a FAR staff member and a written Incident Report.

2. In the event of a medical emergency, FAR will call 911 on behalf of you/your child; **FAR, however, holds no financial responsibility for any medical services requested or rendered**. A staff member will provide basic care as needed until professional help arrives. Your emergency contact/you will immediately be contacted by a FAR staff member and provided with a written Incident Report.

3. **FAR staff is not authorized to dispense OTC or prescription medication to minor children or anyone under guardianship**. Should you/your child require medication of any kind while at FAR, it must be administered by a **parent, legal guardian, or professional medical personnel.**

I consent to the above FAR policy for me/my child regarding any such medical circumstances, including any accident or illness, which may necessitate medical treatment and authorize any such treatment or medical response that FAR's staff, in its sole discretion, may deem necessary. I further acknowledge that I understand the above policy and agree to abide by its terms.

______________________________	______________________________	___________________
Name of Volunteer (over 18)	Signature	Date
______________________________	______________________________	___________________
Name of Volunteer (under 18)	Signature	Date
______________________________	______________________________	___________________
Parent/Guardian (if under 18)	Signature	Date
______________________________	______________________________	___________________
Emergency Contact (Please print)	Phone Number	Relationship

Revised 8/14/2018

Staff Initials: _________