



P. O. Box 42, Navarre, MN 55392-0042, 952-903-0520 <http://minnesota.camp-quest.org>

Counselor in Training (CIT) Application

Thank you for your interest in becoming a Counselor in Training with Camp Quest of Minnesota, the secular summer camp. The camp will be held at Voyageur Environmental Center, a leased residential Boys and Girls Clubs facility in Minnetrista, Minnesota. CIT participation dates are July 24-July 31, 2010. The campers will arrive on July 25, allowing CITs a day for training and organization with the adult staff. We plan to have 40 campers ages 8-15.

Please complete, sign, and return this application and deposit at your earliest convenience. Applications will be reviewed by the Camp Quest Volunteer Committee. Please also include a physical exam form from a physical exam occurring on or after 7/25/2008. All information will be held in the strictest of confidence.

Feel free to contact us if you have any questions. **Unless other arrangements have been made, CITs must arrange for their own transportation to and from the site. Please bring your own bed and bath linens.** Once there, a bed, mattress, and meals will be provided.

Name: _____

Street Address: _____

City, State, Zip Code: _____

Telephone: _____

Cell phone: _____

E-mail: _____

Fax: _____

Age & Date of Birth: _____

Gender: Female Male (circle one)

General State of Health: _____

Emergency Contact Name and Number: _____

1. Why do you want to be a CIT at Camp Quest?

2. What prior experience have you had with participating or volunteering at a camp?

3. What prior experience do you have working with children ages 8-15?

4. What experience have you had with atheism, agnosticism, humanism, freethought or other labels typically associated with disbelief in the supernatural?

5. Do you have any health problems, special needs, or dietary requests (such as vegetarian meals)?

6. Do you have any training and/or current certifications for first aid, CPR, or water safety, first responder or EMT? Please include expiration dates.

7. Are there any specific activities that you wish to coordinate or supervise at Camp Quest? What qualifies you in these areas?

References

Please provide three references who are not family members. Include contact information and a brief statement of how you know each one. Teachers, work supervisors, or other adults who know you well are examples of the references you should list. Add more sheets if necessary.

Name of Reference #1: _____

Street Address: _____

City, State, Zip Code: _____

Telephone: _____

Relationship: _____

Name of Reference #2: _____

Street Address: _____

City, State, Zip Code: _____

Telephone: _____

Relationship: _____

Name of Reference #3: _____

Street Address: _____

City, State, Zip Code: _____

Telephone: _____

Relationship: _____

Permission to Engage in Specific Activities

I (we) am (are) the _____ of _____, a
Counselor In Training at Camp Quest of Minnesota.

Understanding that certain activities have a degree of risk and uncertainty involved, and understanding that all reasonable efforts will be made by the staff of Camp Quest of Minnesota to see that these activities are carried out and supervised in a competent and responsible manner, permission is hereby given, or denied, as individually indicated below, for the CIT above named to participate in the activity. Because of circumstances that may or may not be within our control, it may not be possible to offer all activities listed below.

Archery

Comment: CITs will have the opportunity to participate in supervised archery practice. While every precaution will be taken to assure the safety of everyone involved, archery involves flying projectiles and is therefore a potentially dangerous activity.

Permission Granted Permission Denied

High Ropes Course (tentative)

Comment: This activity will be conducted by an outside vendor in cooperation with Camp Quest staff. While every precaution will be taken to assure the safety of everyone involved, the course involves climbing on ropes and is therefore a potentially dangerous activity.

Permission Granted Permission Denied

Swimming

Comment: This activity will be supervised by the professional staff of Voyager Environmental Center in cooperation with Camp Quest staff. During designated swimming times, there will be at least one lifeguard fully qualified in Red Cross Waterfront Lifeguarding, and at least one other adult supervisor. The swimming will be at a beach at the camp.

Permission Granted Permission Denied

Boating/Canoeing

Comment: This activity is offered by the staff of Voyager Environmental Center. It is scheduled and conducted by them in cooperation with the staff of Camp Quest. After a training session, one gets in a boat/canoe and rows/paddles about on the lake (wearing a life jacket, of course). During designated times, boating will be supervised by a qualified lifeguard.

Permission Granted Permission Denied

Signed _____ Date _____

Parent and CIT Statement of Understanding of Camp Quest Policy

The following is Camp Quest policy information for the safety and protection of each child. Please read, sign, and return to Camp Quest with your registration form.

We (CIT and parent) understand that it is the responsibility of each CIT to participate in the whole program, including activities of work, play, values sharing and living together. We understand and support camp policies prohibiting anyone from bringing weapons to camp, and from possessing or using tobacco products, alcoholic beverages or non-prescription drugs while at camp. We recognize that CITs must follow safety instructions, remain in areas designated by staff, refrain from behavior that is harmful to themselves or others, and otherwise act in a manner that maintains a safe, tolerant, and fun atmosphere for all campers. Failure to adhere to camp policies may cause the Camp Director to dismiss a CIT, without refund of camp fees.

I (parent) understand that I am not to leave my child at Camp Quest unless an adult camp staff member is there to receive and supervise my child.

I understand that my child will not be allowed to leave the camp or camp activities with an unauthorized person. Any person other than a parent will not be allowed to pick up the CIT unless prior arrangements have been made by calling the Camp Quest office to inform them.

CITs may bring electronic devices such as MP3 players or cells phones. These are to be used only during limited times designated by the camp staff. Failure to adhere to this policy may result in the Camp Director taking and holding the device in safekeeping until the CIT departs. Camp Quest is not responsible for lost or stolen items.

I am aware that my child will have the opportunity to participate in camp activities which may involve a degree of risk, and I approve his/her participation in such activities. I understand that accidents can occur. Recognizing that the camp will do its best to ensure a safe and enjoyable camping experience, I hereby release Camp Quest and its operator, Camp Quest, Inc., from any and all responsibility and liability of any nature resulting from my child's participation in any camp activity.

I have read and understand *The Affirmations of Humanism: A Statement of Principles and Values* and *The Mission Statement of Camp Quest of Minnesota* attached to this form and recognize them as fundamental to the philosophy of Camp Quest.

I understand that my child will be photographed, and consent to the photographs being used for camp promotional purposes. Camp Quest of Minnesota uses only CITs' first names in photo captions and articles.

Parent/Guardian Signature

Date

CIT Signature

Date

M/F (Circle One)

Medical/Health History Form

_____ Age

CIT's Name: _____, _____, _____
Last First MI

_____ Date of Birth

ALLERGY ALERT: **No Allergies** **Allergies:** List any allergies to medications, foods, poison ivy, bee stings, or hay fever. Please specify the reaction to each allergy.

Address: _____ Phone: _____

Parent(s) or Guardian: _____ Phone: _____

Home Address: _____ Phone: _____

Business Address: _____ Phone: _____

Emergency Contact: _____ Relation: _____

Address: _____ Phone: _____

Second Emergency Contact: _____ Relation: _____

Address: _____ Phone: _____

Name of CIT's Physician: _____ Phone: _____

Name of CIT's Dentist: _____ Phone: _____

Is the CIT covered by medical/hospital insurance plan? YES ___ NO ___

If so, Indicate: Carrier _____

Policy or Group #: _____ I.D. # _____

MEDICATION (to be completed by parent or guardian)

Many basic over-the-counter (OTC) medications are supplied by camp and may be administered by the camp nurse under physician approved standing orders. These may be useful to treat minor conditions, such as a headache. The Camp Nurse or Camp Director will always call you in case of more serious conditions. Please check the medications below which you do not want given to your child:

- Antibiotic Ointment/Spray
- Acetaminophen (Tylenol)
- Calcium Carbonate (Antacids)
- Diphenhydramine (Benadryl)
- Ibuprofen
- Hydrocortisone Cream
- Lactase (Lactaid)
- Loratadine (Claritin)
- Loperamide (Imodium)
- Menthol (Cough Drops)
- Pseudoephedrine
- Simethicone (Mylicon)
- Sunscreen
- Do not administer any medications to my child

Please send all medications in the original container. Please do not send OTC medications that are listed above. If it is not necessary for your child to continue taking supplements while at camp, consider keeping these at home for the week. Please refrain from taking a "holiday" from any ADD or ADHD medications during camp.

List all medications (prescription and OTC) that your child will need to take at camp:

Medication Name	Dose	Time(s)	Reason

HEALTH HISTORY/AUTHORIZATION: (to be completed by parent or guardian)

Does the camper have epilepsy (seizures, convulsions)? YES NO

Does the camper have diabetes? YES NO

Does the camper have any chronic illness or disability? YES NO

(Please describe) _____

Has the CIT ever had problems with: (Give approximate dates and describe below)

- | | | |
|--|---|---|
| <input type="checkbox"/> Asthma (wheezing) | <input type="checkbox"/> Heart disease | <input type="checkbox"/> Nosebleeds |
| <input type="checkbox"/> Bed wetting | <input type="checkbox"/> Sleep walking | <input type="checkbox"/> Ear infections |
| <input type="checkbox"/> Skin disease | <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Headaches |
| <input type="checkbox"/> Orthopedic (bones & joints) | <input type="checkbox"/> Emotional and/or behavioral problems | |
- _____

Does the CIT have any specific food preferences or have any dietary requirements (such as vegetarian meals, or lactose intolerance)?

This health history is correct to the best of my knowledge, and my child has permission to engage in all prescribed camp activities except as noted.

Authorization to administer routine over the counter medications: I authorize the Camp Nurse to administer routine over the counter (OTC) medications to my child. I have indicated in the above Medications section which, if any, OTCs are not allowed or which will require my permission at the time of administration.

Authorization to contact emergency contacts: In the event I cannot be reached in a non-medical emergency, I hereby give permission to the Camp Director or volunteer authorized by the Camp Director to contact the emergency contacts listed above regarding my child.

Authorization for treatment: I hereby give permission to the medical personnel selected by the Camp Director of Camp Quest to order x-rays, routine tests, treatment, and necessary transportation for me and/or my child. In the event I cannot be reached in an emergency, I hereby give permission to the physician selected by the Camp Director to secure and administer all necessary treatment, including hospitalization, for my child named above. The completed forms may be photocopied for trips out of camp.

Signature of Parent or Guardian

Date

Camp Fees: \$198 per CIT

Optional Fees:

T-shirts: One Camp Quest T-shirt is included in the camp fee. Additional shirts are available for \$10 (each). Please indicate sizes and quantity below.

Size: (Child) _____ 7-8 _____ 10-12 _____ 14-16
(Adult) _____ Sm. _____ Med. _____ Lg. _____ X-Lg. _____ XX-Lg.

Basic Fee	_____	\$198.00
Additional T-Shirt(s) (\$10 ea.)	+ _____	Indicate how many of each size above.
Voluntary Contribution	+ _____	Contributions are tax deductible.
Total Amount	= _____	

Registration fee of \$100 must accompany application.
(This portion of the fee is refundable only if we decline your application to be a CIT.)

Balance of all fees is due two months in advance of the camp start date (May 25, 2010). If slots remain, registration will continue after this date.

**Make checks payable to “Camp Quest of Minnesota”
-OR-
Use PayPal at our web site <http://minnesota.camp-quest.org>**

Mail this completed form and the camp physical form with payment to:

**Rick Rohrer, Registrar
Camp Quest of Minnesota
P.O. Box 42
Navarre, MN 55392-0042**

-OR-

Send the completed forms as a legible scanned .pdf or .tif file to
rick.rohrer@mchsi.com

**Telephone: 952-903-0520
E-mail: mncampquest@comcast.net**

Mission Statement of Camp Quest of Minnesota

- Promote a sense of belonging to a large freethought community among the youth participants
- Encourage critical thinking in young people to enable them to draw their own conclusions
- Promote respect for others with different viewpoints, values, and beliefs
- Provide a safe and fun environment for personal and social development



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Physical Exam Form

**Physical Examination --TO BE COMPLETED BY LICENSED PHYSICIAN
(exam must be done within two years prior to camper's arrival at camp)**

NAME: _____ Date of Birth: _____

Height: _____ Weight: _____ Blood Type: _____ Blood Pressure: _____

I have examined the camper named above on _____ The exam was essentially normal with the following exceptions: _____

Date of most recent tetanus immunization: _____

Allergies (please specify): _____

Restrictions and/or recommendations:

Special diet: _____

Medications: _____

Strenuous activity: _____

Swimming and/or diving: _____

Other: _____

Chronic illnesses or disease: _____

Operations: _____

Signature of Examining Physician:

_____ Date: _____

Address: _____

Phone: _____