CAMP OKAWEHNA

COUNSELOR APPLICATION

After completing this form, print it before exiting the screen.
Your information will not be saved when you exit the screen.

Attention: "Camp O Processing Dept" Fax # (615) 341-8814

Date _____

NOTE: If you are a prior camper returning as a counselor, you must also complete the Health History Form and Medication Form. Pg. 5-7

Counselor Information

Name (First, Last, MI) _____

Date of Birth _____ Sex _____ SS# _____

Street Address _____

City _____ State _____ Zip _____

Home Phone _____ E-mail _____

Work/Cell Phone _____ T-shirt Size ☐ S ☐ M ☐ L ☐ XL ☐ XXL ☐ XXXL

Staff Preference (select one) ◯ Cabin Counselor ◯ Non-Cabin Counselor ◯ Hemo Staff ◯ PD Staff

City Group

☐ Card. Glennon – St. Louis	☐ Children's Hosp – Alabama	☐ Children's Hosp – Austin
☐ DCI Intern	☐ Lebonheur – Memphis	☐ MUSC – S. Carolina
☐ Nashville	☐ Vanderbilt	☐ NKF of Mississippi
☐ Texas Children's Hosp – Houston	☐ UK – Kentucky	☐ Other _____

Persons to Contact in an Emergency (Please provide two.)

1 Name _____ Relationship _____

Home Phone _____ Work/Cell Phone _____

2 Name _____ Relationship _____

Home Phone _____ Work/Cell Phone _____

Credentials

☐ MD ☐ RN ☐ LPN Occupation _____

☐ CPR Certified? License No _____ Exp Date _____ State _____

Hep Status _____ PPD _____ (Must provide documentation for hep and PPD)

NOTE: If you will be working in the hemodialysis unit, you must submit a copy of your nursing license, CPR certification, current PPD and hepatitis status. If you are a doctor, you need to provide a copy of your medical license.

Do you have previous camp experience? If so, where?

_____

_

_____

CAMP OKAWEHNA

Counselor Information

Name _____ SS# _____

Credentials (cont.)

Why do you want to be a counselor?

_____

_____

_____

_____

Would you like to receive camp photo? ☐ Yes ☐ No

References (not the same as emergency contacts)

1 Name _____ Relationship _____

Home Phone _____ Work/Cell Phone _____

2 Name _____ Relationship _____

Home Phone _____ Work/Cell Phone _____

Health Issues

Health Problems _____

_____

Asthma? ☐ Yes ☐ No

Seizures? ☐ Yes ☐ No

Bp _____

Allergies _____

Medication _____

You will receive a separate email from CareerBuilder Employment Screening regarding your required background check. Please check spam mail if you do not get this email.

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Print Form

COUNSELOR CONTRACT

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A Note to Potential Counselors

Counselor applications will be screened and accepted or rejected by camp directors. Background checks will be checked for all non DCI employee counselors. You will be notified of this decision prior to the start of camp. This process is to ensure that counselors who are approved to attend are committed to share in the work necessary to provide a positive camping experience for the children.

If you are driving, a valid drivers license and proof of insurance must be available. This is part of the application approval process.

Each counselor must complete a counselor application each year. The counselor contract and the rules and responsibilities form must be signed and included with the application. Please remember that we agreed that each city group coming to camp must provide a minimum ratio of **1 male counselor per every 4 male campers from your group**. Please limit your number of female counselors.

There will be a mandatory counselor orientation on Saturday after dinner for new and old counselors. In addition, nightly counselor meetings assignments will be provided in your cabins.

We are glad you are interested in Camp Okawehna. We look forward to seeing you at camp.

Counselor Contract

I have completed and signed my camp counselor application.

I understand the camp history and mission statement. I have read the above note to potential counselors. I realize that my application may be denied and I will be notified accordingly.

I give permission to Dialysis Clinic, Inc (DCI) to take video footage and photographs of me during my time at camp. I understand and agree that the video footage and photographs or any part thereof may be used on television in newspapers, magazines, social media or in any other medium that DCI may choose, and, I, hereby release my likeness for said use by DCI.

I understand that I will not have any ownership or property rights in any video footage, photographs or any products or any product created therefrom. I also understand that I will not receive any compensation or money for the use of the video footage and photographs.

I have had the opportunity to ask questions, and I give my consent freely and voluntarily for DCI to use the video footage and photographs.

I agree to abide by the contract and rules provided to me for review.

Signature _____ **Date** _____

CAMP OKAWEHNA

Print Form

ACKNOWELDGEMENT OF DRIVING RESPONSIBILITES RELATED TO TRANSPORTING CAMPERS

After completing this form, print it before exiting the screen.
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Attention: "Camp O Processing Dept"
Fax # (615) 341-8814

***Only required if transporting campers.**

Driver Information

Name (First, Last) _____

Date of Birth _____

Drivers License No. _____ **State** _____

I understand that driving minor children to and from Camp activities is a serious matter. I agree to adhere to the following driving guidelines that have been established for the safety of the children who reside at Camp Okawehna.

I will ensure that all children are restrained in the car according to Tennessee state law which states that children under four years old or forty pounds must be in a car seat. I will ensure that all other children are wearing a seatbelt. I will not put a child in the front seat of a car if there is a front seat airbag.

I understand that campers may only be transported on camp grounds by vehicles either owned or rented by Dialysis Clinic, Inc. (DCI) or a company under the same management umbrella as DCI. DCI owned or rented vehicles must be driven by DCI employees only.

*I understand that City groups that rent their own vehicles may drive their campers (originating from their city group) on the camp grounds, but may not transport campers from outside their city group.

I will only drive a minor child or other Camper off the Cedarcrest property to attend an approved off-site camp activity or to seek emergency medical treatment, with the company of another adult.

I will only use a rental vehicle, not a personal vehicle, for transporting residents of Camp Okawehna. I verify that I have a valid driver's license and liability auto insurance that covers personal injury and damage to other property. I understand that if I am driving and involved in an automobile accident, that injures someone or causes property damage, then my personal auto insurance will be the primary coverage for the vehicle. I understand that DCI will reimburse the insured's deductible amount for the claim up to $500.00.

I understand that I may not drive residents of Camp Okawehna unless I sign this form and attach my valid drivers license and proof of auto insurance. This form and attachments will be provided to Shannon Jamison, Director of Insurance & Worker's Compensation for Dialysis Clinic, Inc.

Signed:

_____
Camp Driver (Print Name)

_____
Signature of Camp Driver

_____
Date

CAMP OKAWEHNA

HEALTH HISTORY FORM (Required from Counselors that are former Campers ONLY)

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Attention: "Camp O Processing Dept"
Fax # (615) 341-8814

Counselor Information

Counselor Name _____ SS#/ID _____

Health Information to be completed by Dialysis Health Care Provider

Lab Date _____ Hbg _____ Hct _____ K+ _____ BUN _____ CR _____

FK _____ Prograf _____ Cya _____ Rapimmune _____ Neoral _____

Transplant Date _____

Current Dialysis Modality ☐PD ☐HD Date Started _____

Date of Last Hospitalization _____ Reason for Hospitalization _____

Diet _____ Allergies _____

Special Diet Needs _____ Etiology CRF _____

I am the dialysis health care provider for the individual listed as Counselor. I agree that I have accurately provided the above medical information for this individual.

Signed:

_____
Name of Dialysis Health Care Provider Company (printed)

_____
Name & Title of Person Completing this Form (printed)

_____
Signature of Person Completing this Form

_____
Date

Specific Health Information Contact:

_____
Contact Name

_____
Contact Phone Number

*****INSURANCE CARD MUST ACCOMPANY HEALTH INFORMATION*****

CAMP OKAWEHNA

Counselor Information (Required from former Campers ONLY)

Counselor Name _____ SS#/ID _____

Health Information to be completed by the applicant and verified by Health Care Provider

NOTE: If you are a hemo dialysis patient, you must also sign the hemodialysis consent form.

Please check all that apply:

☐ History of seizures?	Date of Last Seizure _____	How Treated _____
☐ History of heart disease?	☐ On medication	Describe _____
☐ Problems breathing?	☐ Inhaler _____	☐ Sp. Equipment _____
☐ Learning disabilities?	☐ Unable to read	☐ Language barrier
☐ Social/Behavioral Issues?	☐ Overnight stay w/o parent/family	☐ Medication (list on Medication Form)
☐ Hearing problems?	☐ Hearing Aid ☐ Left ☐ Right	☐ Reads lips ☐ Sign language
☐ Vision impairment?	☐ Glasses ☐ Contacts	

Primary Language _____

Physical Limitations

Describe _____

_____

_____

☐ Growth hormone

☐ Can walk up hills? ☐ Walk ½ mile?

☐ Uses wheelchair? ☐ Uses crutches?

☐ Can take own meds? ☐ Assist ☐ Give ☐ Req. special food/liq _____

☐ Can swim? ☐ Can't swim but enjoys water

Special Needs/Cares

☐ Dressings/Wound Care _____

☐ Diabetic ☐ Oral ☐ Insulin ☐ Pump

☐ Incontinent ☐ Catheter – self/assist ☐ Bed Wets ☐ Diaper

☐ Freq. nausea/vomiting ☐ Diarrhea/constipation

☐ Tube feeding: what/frequency _____

I have accurately provided this information. I understand that DCI will make treatment decisions based on the information I have provided on this form.

Signed:

_____
Counselor's Name (printed)

_____

_____
Counselor's Signature

_____
Date

Health Care Provider Verification:

_____
Name, Title

_____
Contact Phone Number

_____
Date

Counselor's Name_____

Medication Information

Please enter dosage as strength (i.e. – 500 mg) instead of amount (i.e. – 1 tablet). Specify the exact time. Do not use "take 2 a day" or "AM PM". See examples below.

Medication	Classification	Dosage	Time to Administer (HH:MM am/pm)	Special Instructions
EXAMPLE #1 **Renagel**		**336 mg**	**5AM 12PM 5PM**	**Take 6 tablets**
EXAMPLE #2 **Prednisone**	**Steroid**	**2.5 mg**	**8AM 8PM**	**Take 2.5 tablets – 1 mg**