



2014 CIT APPLICATION

****SECTION 1****

CIT APPLICANTS MUST FILL OUT THIS SECTION ON THEIR OWN.

NAME: _____ GENDER: M / F AGE: _____ BIRTHDAY(M) ____/(D)____/(YR)____

SCHOOL _____ GRADE: _____ HOME PHONE: (_____) _____ - _____

ADDRESS: _____ CELL PHONE: (_____) _____ - _____

CITY: _____ STATE: _____ ZIP: _____ E-MAIL ADDRESS: _____

CHURCH: _____ PASTOR: _____ YRS ATTENDED: _____

WHY DO YOU WANT TO BE INVOLVED IN THE INDIANA YEARLY MEETING YOUTH MINISTRIES CAMPING PROGRAM AS A COUNSELOR IN TRAINING?

****SECTION 2****

ALL PARENTS & CIT'S MUST SIGN ON THE RESPECTIVE LINES FOR PARENT & CIT AGREEMENT!

For Parent to Sign (Parent's signature required for minors and requested for youth campers who are not minors. Campers who are not legal minors may sign their own forms.) This section must be completed for attendance at camp. The health history on this form is correct so far as I know, and the person herein described has permission to engage in all prescribed camp activities except as noted, **including boating, water and challenge course activities.**
Authorization for Treatment: I hereby give permission to the medical personnel selected by the camp director to order X-rays, routine tests, administer treatment, administer "over the counter" medications and/or arrange necessary transportation for me/my child. In the event I cannot be reached in an emergency, I hereby give my permission to the physician selected by the camp director to secure and administer treatment, including hospitalization, for my child as named above. The completed forms may be photocopied for trips out of camp.

PARENT Signature _____ Date _____

For CIT Applicants to Sign. This section must be completed for attendance to camp. I commit to being the best possible influence as a Counselor-In-Training (CIT). I commit to being on time to ALL activities, I commit to listening to the Camp Director, DYCM, Counselors & Interns, I commit to not being a distraction to campers and I commit to serving in this role knowing that I have already had my own camping experience and want to help offer the best possible experience for the campers in my cabin. I also realize that I'm a CIT and have no authority over the Director, Interns or Counselors.

COUNSELOR-IN-TRAINING Signature _____ Date _____

PLEASE CHECK WHICH CAMP YOU ARE APPLYING FOR TO BE A CIT:

_____ ADVENTURE CAMP (JULY 6TH – 11TH)
-GRADES 5TH & 6TH

_____ LITTLE FRIENDS CAMP (JULY 20TH – 23RD)
-GRADES 2ND, 3RD & 4TH

****SECTION 3****

ALL APPLICATIONS WILL BE REVIEWED BY THE DIRECTOR OF EACH IYM SUMMER CAMP AND THE DIRECTOR OF YOUTH & CAMPING MINISTRIES. FINAL SAY FOR STAFFING WILL BE GIVEN BY THE DIRECTOR OF YOUTH & CAMPING MINISTRIES.

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ALL CIT'S ARE EXPECTED TO REPORT TO QHC THE SUNDAY CAMP STARTS BY 1:30 PM. NO EXCEPTIONS WILL BE MADE UNLESS SPECIAL PERMISSION IS GRANTED BY THE DIRECTOR OF YOUTH & CAMPING MINISTRIES (AARON HUGHS – CURRENT DYCM).

PLEASE LIST THE NAMES AND PHONE NUMBERS OF THREE NON-RELATED REFERENCES BELOW:

NAME: _____ PHONE: (_____) _____ - _____ RELATIONSHIP: _____

NAME: _____ PHONE: (_____) _____ - _____ RELATIONSHIP: _____

****SECTION 4****

**ALL CIT'S WHO ARE UNDER THE AGE OF 18 MUST HAVE THE MEDICAL FORM BELOW
FILLED OUT TO ATTEND KIDS CAMP AND/OR JUNIOR CAMP AS A CIT.**

Medical Form

HEALTH CARE INFORMATION

Name of family physician _____ Phone _____
Name of dentist/orthodontist _____ Phone _____
Other doctors _____ Phone _____
Is this applicant covered by medical/hospital insurance? ☐ YES ☐ NO
Insurance carrier _____ Policy Number _____ Group Number _____
Responsible Party _____ Relationship _____ SSN _____
Address (if different than Custodial Parent) _____

MEDICAL HISTORY

Please indicate approximate dates

_____ Chicken Pox	_____ Epilepsy	_____ Mononucleosis	_____ Diabetes
_____ Hypertension	_____ Frequent Ear Infections	_____ Heart Defect/Disease	_____ Bleeding/Clotting Disorder
_____ Operations	_____ Allergies	_____ Serious Injury	
_____ Psychiatric Counseling or Hospitalization	_____ Chronic or recurring illness or medical condition		

Explain each one marked above

Immunization History Vaccines - Tetanus Booster (must be within last ten years) _____ date required

For Females: Has this person menstruated? _____ If not, has she been told about it? _____ If so, is her menstrual history normal? _____
Special consideration: _____

Our goal is to provide a complete camping experience for all of our campers. To aid us in accomplishing this goal, we ask all of our applicants to inform us if they have any disabilities or impairments. We use this information to establish appropriate staffing levels and to ensure that potential accommodations are available. Accordingly, please note in the space below any impairments or disabilities.

IF POSSIBLE, please have this part filled out by a licensed physician or attach a copy of a recent physical (within past two years). IF NOT POSSIBLE FOR A DOCTOR TO FILL OUT, A PARENT/GUARDIAN MUST COMPLETE THIS SECTION.

The applicant is under the care of a physician for the following condition(s): _____

Current treatment: _____
Is this treatment to be continued at camp? _____
List Current Medications and Instructions _____
Any medically prescribed meal plan or dietary restrictions? _____
Allergies (medications, food, & insects, etc.)? _____
Specific activities to be encouraged or limited for medical reasons? _____
Any additional health information for camp personnel? _____

For Licensed Physician to Sign :

I have examined the above camp applicant on date _____ which is within the past two years. In my opinion, the above's condition _____ does _____ does not preclude his/her participation in an active camp program.

Licensed Physician's Signature _____
Address _____ Phone _____
Date of Form Completion _____ By _____

PLEASE MAIL BACK BY MAY 16 TO:

**AARON HUGHS
ATTN. 2014 CIT APPLICATION
4715 N WHEELING AVE
MUNCIE IN, 47304**