



# Camp Ammon

**Boy Scouts of America**  
Serving the State of Wisconsin Since 1933  
[www.campammon-bsa.org](http://www.campammon-bsa.org)

January 2009

Dear Fellow Staff Members;

Enclosed please find your 2009 Camp Ammon staff application. Please complete your staff application and **return it no later than June 1<sup>st</sup>**. We expect to complete staffing assignments by the end of June. Michele will be processing the staff applications; if you have scheduling concerns, please contact Michele (michele@justinknash.com or 414-517-4617) to arrange your hours.

**PLEASE return your staff application by June 1<sup>st</sup> to:**

Camp Ammon Staff  
c/o Michele Greenmier  
3508 E. Barnard Ave  
Cudahy, WI 53110

Thinking of being a Tent-Leader this year? If you feel you may be interested in the position, please attach a cover letter to your application to request consideration. Preferences will be given to returning tent leaders, based on performance.

Keep an eye on the website for more camp information or give one of us a call.

As in previous years, we will need your help to increase our camper numbers to appropriate levels. Let us know if you can help with recruitment or if you know of some scouts interested in attending.

Send in your application today! We'll see YOU on Wednesday, August 5<sup>th</sup> at 8:00 a.m.!

Thanks for returning to Camp, we really appreciate your help!

Sincerely,

*Sam*

Sam Santoro Jr.

*Juan*

Dr. Juan Luglio  
Directors

*Michele*

Michele Greenmier





# Camp Ammon – 2009

Milwaukee County Council - Boy Scouts of America

August 5<sup>th</sup> thru August 17<sup>th</sup>

## STAFF APPLICATION

please check appropriate area:  Part Time (20 hr/wk)  Full Time

Last Name \_\_\_\_\_ First Name \_\_\_\_\_ Age \_\_\_\_\_ DOB \_\_\_\_\_

Home Address \_\_\_\_\_ Male  Female

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_ Shirt Size (men's): S M L XL XXL

Home Phone ( ) \_\_\_\_\_ Alt. Ph ( ) \_\_\_\_\_ E-Mail Address \_\_\_\_\_

Drivers License Number \_\_\_\_\_ Do you have auto insurance? yes  no

2008 Duties \_\_\_\_\_

2009 Duty Preferences 1. \_\_\_\_\_ 2. \_\_\_\_\_

Number of Years at Camp: \_\_\_\_\_ (include this year) Scout Unit Affiliation: \_\_\_\_\_

*YOU MUST BE ACTIVELY REGISTERED*

### EMPLOYER/SCHOOL INFO

School and/or Current Employer \_\_\_\_\_ Work Phone ( ) \_\_\_\_\_

Work Address \_\_\_\_\_ Health Insurance Carrier \_\_\_\_\_

### **ATTENTION PART TIME STAFF**

You must be available to work a minimum average of 20 hours per week. On the back of this application list the ACTUAL DATES and TIMES that you will physically be in camp. BE SPECIFIC! (We do not want your personal work schedule.) Use additional paper if necessary and attach.

I hereby apply to be assigned as a staff member of Camp Ammon - BSA. I understand that I must abide by the leadership standards set forth by the Boy Scouts of America, and other requirements as indicated by the Camp Directors, Camp Ammon - BSA.

Signature \_\_\_\_\_ Date \_\_\_\_\_

*see back for additional information*

**STAFF APPLICANTS:** Use the space below to indicate any work restrictions that you may have regarding your availability on staff. Please be specific with days, dates, and times. *Show dates & times when you will physically be in camp.*

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**SET-UP AVAILABILITY & TIMES:**

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**EMERGENCY INFORMATION** (please print)

Last Name \_\_\_\_\_ First Name \_\_\_\_\_ Age \_\_\_\_\_ DOB \_\_\_\_\_

Name of Emergency Contact \_\_\_\_\_ Phone \_\_\_\_\_

Relationship \_\_\_\_\_ Alternate Phone Number \_\_\_\_\_

Please list below any pre-existing medical conditions, medications, and allergies: (voluntary)

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*Medical information on this application is intended for emergency use only and will be kept strictly confidential.*



# PERSONAL HEALTH AND MEDICAL RECORD

## CLASS 1 AND CLASS 2

**Class 1 (update annually for all participants).** Activity: Day camp, overnight hike, or other programs not exceeding 72 hours, with level of activity similar to that of home or school. Medical care is readily available. Current personal health and medical summary (history) is attested by parents to be accurate. This form is filled out by all participants and is on file for easy reference.

**Class 2 (required once every 36 months for all participants under 40 years of age).** Activity: Resident camp or any other activity such as backpacking, tour camping, or recreational sports involving events lasting longer than 72 consecutive hours, with level of activity similar to that at home or school. Medical care is readily available.

**Note:** Some states require an **annual** precamp medical evaluation. Your BSA local council service center can advise you about the requirements for your state.

If your child has had a medical evaluation (**physical examination**) within the last 36 months, a copy of the results of this examination must be attached to the health history for all participants in a camping experience lasting longer than 72 consecutive hours. If a copy is not available, a physical examination (using the Class 2 section of this form) must be scheduled by a \*licensed health-care practitioner. This medical evaluation (physical examination) also is required if your child is currently under medical care, takes a prescribed medication, requires a medically prescribed diet, has had an injury or illness during the past 6 months that limited activity for a week or more, has ever lost consciousness during physical activity, or has suffered a concussion from a head injury.

\*Examinations conducted by licensed health-care practitioners, other than physicians, will be recognized for BSA purposes in those states where such practitioners may perform physical examinations within their legally prescribed scope of practice.

**THIS FORM IS NOT TO BE USED BY ADULTS OVER 40, BY HIGH-ADVENTURE PARTICIPANTS (USE FORM NO. 34412A), OR FOR NATIONAL SCOUT JAMBOREE (USE FORM NSJ-34412-97).**

### CLASS 1 PERSONAL HEALTH AND MEDICAL HISTORY

(To be filled out annually by all participants)

To be filled out by parent, guardian, or adult participant. Please print in ink.

#### IDENTIFICATION

Name \_\_\_\_\_ Date of birth \_\_\_\_\_ Age \_\_\_\_\_ Sex \_\_\_\_\_

Name of parent or guardian \_\_\_\_\_ Telephone \_\_\_\_\_

Home address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Business address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

If person named above is not available in the event of an emergency, notify

Name \_\_\_\_\_ Relationship \_\_\_\_\_ Telephone \_\_\_\_\_

Name \_\_\_\_\_ Relationship \_\_\_\_\_ Telephone \_\_\_\_\_

Name of personal physician \_\_\_\_\_ Telephone \_\_\_\_\_

Personal health/accident insurance carrier \_\_\_\_\_ Policy No. \_\_\_\_\_

I give permission for full participation in BSA programs, subject to limitations noted herein.

**In case of emergency,** I understand every effort will be made to contact me (if participant is an adult, my spouse or next of kin). In the event I cannot be reached, I hereby give my permission to the licensed health-care practitioner selected by the adult leader in charge to secure proper treatment, including hospitalization, anesthesia, surgery, or injections of medication for my child (or for me, if participant is an adult).

Date \_\_\_\_\_ Signature of parent/guardian or adult \_\_\_\_\_

**Some hospitals require the parent/guardian signature to be notarized. Check with your BSA local council.**

NAME

TROOP

CAMP SITE

Check all items that apply, **past or present**, to your health history. Explain any "Yes" answers.

**ALLERGIES:** Food, medicines, insects, plants Yes  No  Explain: \_\_\_\_\_

<b>GENERAL INFORMATION:</b>		Yes	No		Yes	No		Yes	No	
ADHD (Attention-Deficit)										
Hyperactivity Disorder	<input type="checkbox"/>	<input type="checkbox"/>		Convulsions/seizures	<input type="checkbox"/>	<input type="checkbox"/>		Hemophilia	<input type="checkbox"/>	<input type="checkbox"/>
Asthma	<input type="checkbox"/>	<input type="checkbox"/>		Diabetes	<input type="checkbox"/>	<input type="checkbox"/>		High blood pressure	<input type="checkbox"/>	<input type="checkbox"/>
Cancer/leukemia	<input type="checkbox"/>	<input type="checkbox"/>		Heart trouble	<input type="checkbox"/>	<input type="checkbox"/>		Kidney disease	<input type="checkbox"/>	<input type="checkbox"/>

Explain: \_\_\_\_\_

Please list ALL medications taken in the 30 days **prior** to arrival at the Scouting activity where this form is to be used: \_\_\_\_\_

List any medications to be taken at camp: \_\_\_\_\_

List any physical or behavioral conditions that may affect or limit full participation in swimming, backpacking, hiking long distances, or playing strenuous physical games: \_\_\_\_\_

List equipment needed such as wheelchair, braces, glasses, contact lenses, etc.: \_\_\_\_\_

**Immunizations:** (Give date of last inoculation.)

Tetanus toxoid _____	Measles _____	Polio _____
Diphtheria _____	Mumps _____	_____
Pertussis _____	Rubella _____	_____

### CLASS 2 MEDICAL EVALUATION

(Read additional requirements outlined on front of form.)

Name \_\_\_\_\_ Age \_\_\_\_\_

**NOTE TO LICENSED HEALTH-CARE PRACTITIONERS\*:** The person being evaluated will be attending one or more weeks of camp that may include sleeping on the ground and participating in strenuous activities such as hiking, boating, and vigorous group games. Please review the health history with the participant for any interim changes. **Explain any "abnormal" evaluations.**

**PHYSICAL EXAMINATION** (To be filled out by a licensed health-care practitioner\*)

Height \_\_\_\_\_ Weight \_\_\_\_\_ BP \_\_\_\_\_ / \_\_\_\_\_ Pulse \_\_\_\_\_

VISION: Normal \_\_\_\_\_ Glasses \_\_\_\_\_ Contacts \_\_\_\_\_

HEARING: Normal \_\_\_\_\_ Abnormal \_\_\_\_\_ Explain \_\_\_\_\_

Check box:	N	Abn		N	Abn		N	Abn
Growth development	<input type="checkbox"/>	<input type="checkbox"/>	Teeth	<input type="checkbox"/>	<input type="checkbox"/>	Genitalia	<input type="checkbox"/>	<input type="checkbox"/>
Skin	<input type="checkbox"/>	<input type="checkbox"/>	Cardiopulmonary system	<input type="checkbox"/>	<input type="checkbox"/>	Musculoskeletal	<input type="checkbox"/>	<input type="checkbox"/>
HEENT	<input type="checkbox"/>	<input type="checkbox"/>	Hernia	<input type="checkbox"/>	<input type="checkbox"/>	Neurobehavioral	<input type="checkbox"/>	<input type="checkbox"/>

Explain: \_\_\_\_\_

#### Limitations

Activity restrictions \_\_\_\_\_

Diet restrictions \_\_\_\_\_

Signature \_\_\_\_\_ Date \_\_\_\_\_

Address \_\_\_\_\_ Licensed health-care practitioner\* \_\_\_\_\_ Phone \_\_\_\_\_

City, State, Zip \_\_\_\_\_

**\*Examinations conducted by licensed health-care practitioners, other than physicians, will be recognized for BSA purposes in those states where such practitioners may perform physical examinations within their legally prescribed scope of practice.**

INTERVAL RECORD	SCREENING EXAMINATION	
Date, Time, Place, Etc.	(Findings, diagnoses, treatment, instructions, disposition, etc.)	By
#34414A		
<b>730176344140</b>	PHOTOCOPING THIS FORM IS PERMITTED.	