MOUNTAINVIEW CHRISTIAN CAMP
Personnel Record
for staff/faculty 18 and older

1. Name _____Date_____
   Address_____
   City_____State_____Zip_____
2. Phone Number_____Date of Birth _____Date of Baptism_____
3. Home Church _____
4. Summary of Education Background (schools, colleges, degrees, etc.)_____
   _____
5. What special skills, talents, qualifications, abilities, certifications, and/or experience do you bring to the week of camp for which you are volunteering _____
   _____
   _____
6. Physical or emotional handicaps you need assistance with _____
7. Please notify in case of emergency
   Name_____ Phone _____
   Address_____
   City_____State_____Zip_____
8. Any chronic or recurring illness you want the nurse or medical facility to be aware of if you become unable to speak for yourself? _____
   If so, explain:_____
   Presently on Medication: _____
   Allergies: _____
   _____
9. Names & addresses of two (2) character references: At least one a Minister, Youth Minister, or Elder
   Name_____Name_____
   Address_____Address_____
   City/State/Zip_____City/State/Zip_____
10. Have you ever been convicted of or accused of child abuse, or any crime involving children? Yes_____No_____
    If yes, explain_____
11. For staff under their parents health insurance: Please list insurance company and policy number_____
    _____
    _____
12. Immunization history: The required immunizations below are determined by the New York State Health Department. You must list the month and year for all immunizations.
    COVID-19 _____
    DTP: _____, _____ ,_____, Booster_____
    Polio: _____, _____, _____, Booster_____
    MMR: _____, _____
    Hep B _____
    Tuberculin Test: _____ Varicella:_____ Meningitis:_____

Signed: _____Date _____

INFORMATION ABOUT CHILDREN WITH STAFF MEMBERS

If bringing a babysitter, they have to be over 18 years to supervise children. All children, including staff children, are supervised as campers and cannot be left without adult visual and auditory supervision at all times. If handing off responsibility to other adults, assure your child knows who they are to remain with.

Child #1

1. Name _____
2. Date of Birth_____ Present Age _____
3. Any chronic or recurring illness you want the nurse or medical facility to be aware of if the parent and child becomes unable to speak for themselves? _____
   If so, explain:_____
   Presently on Medication: _____
   Allergies: _____
4. Immunization History: Required immunizations must be determined locally. This is a record of basic immunization and most recent booster doses.

   COVID-19 _____
   DTP: _____, _____, _____, Booster_____
   Polio: _____, _____, _____, Booster_____
   MMR: _____, _____
   Tuberculin Test:_____
   Other: _____

Child #2

1. Name _____
2. Date of Birth_____ Present Age _____
3. Any chronic or recurring illness you want the nurse or medical facility to be aware of if the parent and child becomes unable to speak for themselves? _____
   If so, explain:_____
   Presently on Medication: _____
   Allergies: _____
4. Immunization History: Required immunizations must be determined locally. This is a record of basic immunization and most recent booster doses.

   COVID-19 _____
   DTP: _____, _____, _____, Booster_____
   Polio: _____, _____, _____, Booster_____
   MMR: _____, _____
   Tuberculin Test:_____
   Other: _____