COLORADO CHAPTER
NATIONAL HEMOPHILIA FOUNDATION

The Colorado Chapter of the National Hemophilia Foundation
Mile High Camp
Counselor in Training Application

Thank you for your interest in applying to the CIT program at Mile High Camp. Developing a cohesive and engaged staff to set the tone of camp and create a positive environment is paramount. Please read the following Camp Mission and Counselor in Training (CIT) Program Objectives below and apply if you want to be an integral contributor to life-long memories for campers and staff alike. A phone interview, after your application has been received, is required prior to acceptance into the program.

CIT Program Mission:
Mile High Summer Camp's Counselor-In-Training (CIT) Program seeks to develop former campers into the future counselors and leaders of Mile High Summer Camp and the bleeding disorders community, with an emphasis on developing leadership style, maturity and accountability.

CIT Program Objectives:
Graduated leadership campers, ages 19-21 may apply for the CIT program. CITs must possess maturity, flexibility, a strong work ethic and the ability to have fun. CITs will have the chance to shadow actual counselors, help facilitate activities and participate in nearly every camp activity. Service work and involvement in the improvement of camp is a crucial part of this program. CIT's will have the opportunity to grown in their conflict resolution, group moderating and teambuilding skills as well developing an understanding of the technical aspects of running a summer camp.

The CIT program is an educational program with a curriculum designed to develop the people and technical skills necessary to be an effective camp counselor. CITs will be subject to the same code of behavior and policies as regular staff and will participate in all aspects of camp life.

CIT Core Values

Accountability
Learning
Responsibility
Resilience
Timeliness
Professionalism
Positivity
Adaptability
Patience
Respect

This application must be completed by the potential CIT. Applications completed by a parent will not be considered.

Please return the following to NHF Colorado by May 1st, 2018 to sjeffrey@hemophilia.org or mail to the address below:

1. Completed application
2. One letter of recommendation from a non-family member (i.e. employer, coach, teacher, etc.)
3. One personal reference, preferably someone who has witnessed you working with children, different from the individual who wrote your letter of recommendation (HTC staff is not recommended).
4. An email address (for a background check).
5. Copy of your insurance card and bleeding disorder card.
6. Copy of any certifications relevant to camp (i.e. CPR, first-aid, lifesaving, etc.)

Colorado Chapter, National Hemophilia Foundation
Attn: Sean Jeffrey
1385 S. Colorado Blvd., Denver, CO 80222
(720) 545-0755 – sjeffrey@hemophilia.org

Please contact Sean for any questions or difficulties completing the application.
The Mile High Camp Director will follow up with a phone interview as soon as we receive your application.

Camp Dates:

Staff Orientation: Thursday, July 12th from 1pm-5pm (for all CITs and staff)
Camp: Friday, July 13th through Friday, July 20th

Are you available for the entire program? ☐Yes ☐No
If no, please indicate your conflict. (Not being available for the entire program may exclude your from being considered) _____

Personal Information

Name: _____

Address: _____
(street)

_____
(city) (state) (zip)

Phone: _____ _____
(home) (cell)

Email address: _____ T-Shirt Size: _____

Permanent address: _____
(if different from above) (street)

_____
(city) (state) (zip)

May your contact information be included on a list to be distributed to others? ☐Yes ☐No

Do you have any special dietary needs? ☐ Yes ☐ No
If yes, please explain so we may do our best to accommodate your needs:

_____

Personal Reference:
Name:_____Contact Phone #: _____

Relationship to you: _____

Educational Background:

High School: _____

Year Graduated:_____or highest grade completed: _____

Education after high school: _____

Field of Study:_____Year Graduated: _____

Work Experience: (please list in order of most current, or attach a resume)

1) Employer: _____

Position: _____ Years worked: _____

Responsibilities: _____

2) Employer:_____

Position: _____ Years worked: _____

Responsibilities: _____

3) Employer:_____

Position: _____ Years worked: _____

Responsibilities: _____

Camp Experience:

Have you ever attended a camp program as a camper? ☐ Yes ☐ No

Have you attended a camp program as staff either volunteer or paid? ☐ Yes ☐ No

If the answer to either of the previous questions was yes, please complete the information below:

1) Camp Name/Organization: _____

Location:_____ Years attended: _____

Camp Director/Contact Name: _____ Contact Phone #: _____

2) Camp Name/Organization:_____

Location:_____ Years attended: _____

Camp Director/Contact Name: _____ Contact Phone #: _____

3) Camp Name/Organization:_____

Location: _____ Years attended: _____

Camp Director/Contact Name: _____ Contact Phone #: _____

In your opinion, what are the most important character traits of a Counselor/CIT?

If you worked at a circus, who would you be and why?

Who do you look up to the most, and what are the qualities you respect about them?

Please list current certifications and expiration dates. Please also include copies of any certificates or proof of certification or training: (i.e. CPR, First Aid, AED, etc.)

Conflict of Interest and Commitment Statement

As staff of Mile High Camp, I have an obligation to the camp and campers I serve and to maintain the highest standards of ethical conduct. I will not commit acts contrary to these standards, nor will I condone the commission of such acts by others within the camp. Some examples of unethical conduct are:

1. Using campers' personal and/or medical information for your own use
2. Discussing medical information including factor product selection or homecare/pharmacy selection outside of the presence of health center staff
3. Influencing campers and peers with my personal opinions of religion, politics, or sexual orientation
4. Using intoxicants of any kind

CONFIDENTIALITY

The undersigned, as a condition to attending or participating in the NHF Colorado summer camp program, and in consideration of such participation, agrees that he or she will not use any information obtained as a result of his or her participation for any purposes other than participation in Mile High Camp. Without limiting the foregoing, the undersigned agrees that, while participating in Mile High Camp, he or she shall not solicit addresses of those affected by a bleeding disorder and related complications, including HIV infection or hepatitis, nor shall he or she use any information obtained as a result of participation in Mile High Camp for any financial or commercial gain. The undersigned also agrees that this agreement is reasonable, that he or she intends to be bound by this agreement and in the event of any violation of this agreement; he or she agrees that this agreement may be enforced by injunctive relief.

CONFLICT OF INTEREST

I have a responsibility to avoid any direct or indirect, actual or apparent, conflicts of interest. I will advise the Camp Directors of any potential conflicts. I will refrain from engaging in any activity that would prejudice my ability or the ability of others to carry out duties ethically.

LEGAL ASSURANCE

I have the responsibility to report any future allegations of criminal activities, investigations, arrests, and/or convictions involving myself, to NHF Colorado as long as I am on staff with Camp Mile High Camp.

INTEGRITY

I have a responsibility to refrain from either actively or passively subverting the attainment of the NHF Colorado's legitimate and ethical objectives. I will refrain from engaging in or supporting any activity that would discredit NHF Colorado. I will perform my duties in accordance with relevant laws, regulations and camp policies and standards. I will represent the interests of all people served by this camp and will not favor special interests inside or outside NHF Colorado.

Do you or a member of your family work for a factor provider or factor manufacturer? ☐ Yes ☐ No
If yes, please identify the entity for which you or your family member work:

_____

I understand the concepts of ethics and conflicts of interest. I represent that I have not been party to an unethical or conflicting action that has not been previously disclosed. I also agree to report any future conflicts of interest or observed unethical activity. I do not currently have any criminal proceedings pending against me, nor have I been placed under arrest or been convicted of a criminal offense within the past year.

_____ _____

Signature of CIT Applicant **Date**

I hereby affirm the information provided in this application is true and correct to the best of my knowledge and I understand that any falsification of the information contained herein may serve as the basis for rejection of said application and/or termination of appointment. In addition I fully understand that my participation with Mile High Camp is contingent upon compliance with any conditions, rules, or regulations required by the Colorado Chapter of the National Hemophilia Foundation. I understand that prior experience and education attainment as of this date as listed in this application is complete and accurate, and no additional claims will be made following appointment. I hereby authorize educational institutions, employers, law enforcement authorities, organizations and individuals having relevant information concerning me to release all information from their files and other sources pertaining to any personal background including, but not limited to academic and athletic sources pertaining to my personal history, disciplinary action, police, or other records to the Colorado Chapter of the National Hemophilia Foundation for their official use. I hereby release all persons, institutions, and organizations, individually and collectively, from any and all liability for damages of whatever kind, which may at any time result from NHFCO's actions, my heirs, family, or associated because of compliance with this authorization and request to release information, or any attempt to comply with it. Should there be any questions as to the validity of the release, you may contact NHFCO.

Photo/Video Release:
I understand that my photograph and video may be taken at camp. I grant permission for any photographs and/or videos taken of me made available for use in the promotional, educational, informational, or media related materials/activities which are approved by the Colorado Chapter of the National Hemophilia Foundation.

☐ **Yes** ☐ **No**

NHF COLORADO SUMMER CAMP PROGRAM IS AN ALCOHOL, DRUG, AND SMOKE FREE ENVIRONMENT
(prescription drugs are stored and administered by Camp Medical Staff)

I hereby understand and agree to comply with the above policies while at Mile High Camp.

_____ _____

Signature of CIT Applicant **Date**

Fill this form out COMPLETELY. If any changes prior to camp, please contact the NHFCO to update the information.

COUNSELOR IN TRAINING INFORMATION:

CIT's Full Name: _____ T-Shirt Size: _____

Age: _____ Date of Birth:____/ __/____ Gender: M F Grade in School (in the fall) _____

Address: _____

City: _____ State: _____ Zip: _____

Who does the CIT live with: _____

If the CIT does not live with both parents, who has legal custody? _____

CONTACT INFORMATION:

Mother/Guardian Name: _____ Employer Name: _____

Address (If different from child's): _____

Home Phone #:_____ Work Phone #: _____

Cell Phone #: _____ E-Mail: _____

Father/Guardian Name: _____ Employer Name: _____

Address (If different from child's): _____

Home Phone #: _____ Work Phone #: _____

Cell Phone #: _____ E-Mail: _____

EMERGENCY CONTACT INFORMATION:
If parents cannot be reached, who should we call?

First Contact: Name: _____ Relationship to child: _____

Home Phone #: _____ Work Phone #: _____ Cell Phone #: _____

Second Contact: Name: _____ Relationship to child: _____

Home Phone #: _____ Work Phone #: _____ Cell Phone #: _____

INSURANCE INFORMATION:

Insurance Co.:_____ Policy #: _____

Name of Policy Holder: _____ Group #: _____

HEALTH CARE PROVIDER INFORMATION:

Primary Care Physician Name: _____ Phone #: _____

Date of Counselor in Training's Last Examination: _____

CURRENT OR RECURRING MEDICAL CONDITIONS:

This information is so medical staff can better care for you while at camp. Please check all that apply:

_____ADHD	_____Cancer	_____Seizure Disorder
_____Diabetes (attach diet)	_____Liver Disease	_____Heart Problems
_____Kidney Disease	_____Sleep walking	_____Chronic diarrhea
_____Bedwetting	_____Bowel/Bladder Problems	_____Other Infectious Diseases
_____Emotional/behavioral or learning	_____Hay Fever	
_____Asthma or other breathing problems*	_____Allergies to bee or wasp stings*	

Please provide more specific information about health conditions checked above including treatment needed while at camp:

_____

_____

_____

_____

Food or drug allergies: _____

_____

List any target or problem joints, any bone or muscle problems: _____

_____

_____

Serious illness or surgeries within past year: _____

_____

_____

Dietary Restrictions: _____

_____

SELF TREATMENT CONSENT:

As a Counselor in Training, I understand that I am responsible for the storage, schedule and administration of my clotting factor infusions, other general medicines and any allergy medication that I need during camp. I understand that the HTC and camp clinical staff will be available for emergency situations, but will rely on each CIT for regular infusions.

X CIT Applicant Signature_____

Date: _____

BLEEDING DISORDER INFORMATION:

(Please fill the following page out or provide a bleeding card)

Type of Bleeding Disorder: _____Hemophilia A/factor VIII _____Hemophilia B/factor IX

_____Hemophilia Carrier with symptoms _____von Willebrand disease

_____Hemophilia Carrier with NO symptoms _____No bleeding disorder

_____Other Bleeding Disorder: _____

Hemophilia Severity: _____Severe _____Moderate _____Mild

Von Willebrand Type: _____Type 1 _____Type 2 _____Type 3 _____Unsure

Does your Counselor in Training have an inhibitor?__Yes _____No

Weight: _____ Height: _____ Factor Level:_____%

Treatment Product Name: _____

Is your Counselor in Training on a prophylaxis treatment regimen?_____Yes _____No

If yes, what is the dosing and weekly schedule? _____

Does your CIT self infuse?_____Yes_____No Does your CIT use numbing cream prior to infusing?_____Yes _____No

Is your CIT on home infusion?_____Yes _____No If yes, who does the infusion at home? _____

Does your CIT us Amicar?_____Yes _____No When? _____

Does your CIT have a central line?_____Yes _____No If yes, what type? _____

Additional comments about infusing your CIT: _____

_____

In case your CIT runs out of factor, who is your factor provider? _____

Contact person of pharmacy Phone #:

_____

*****PLEASE BRING ENOUGH FACTOR FOR SCHEDULED PROPHYLACTIC INFUSIONS AND EXTRA TRAUMA DOSES IN CASE OF BLEEDING. FOR COUNSELORS IN TRAINING WITH MODERATE OR MILD DIAGNOSES, FACTOR IS STILL NECESSARY TO HAVE ON HAND. CHECK EXPIRATION DATES PRIOR TO CAMP.*****

BRECKENRIDGE OUTDOOR EDUCATION CENTER
SHORT COURSE MEDICAL FORM

Parent/Guardian/ Participant: Please fill out this form and ensure that all information is correct**. Disclosure of the following medical information is required before participation in a BOEC program.** By law, the information you disclose is confidential. This information helps us screen applicants for medical issues that may pose a risk during programs and assists treatment in the event of an emergency.

Organization/School/Group Name:_____ Date:

Name & Title:_____

Age_____ Height_____ Weight_____ Sex M / F Date of Birth_____Disability/Diagnosis_____

Ethnic Origin: (This section is optional. We gather this information to gage our effectiveness in reaching a diverse clientele. Please check appropriate box.)
African American___ Hispanic___ Asian American___ Native American___ Caucasian___ Other___

Have you ever attended a BOEC program? ___no __yes

Work Telephone_____ Home Telephone_____

Work Address_____ Mailing Address_____

City_____ State____ Zip Code_____

Email: _____ Email: _____

Emergency Contact: _____ Phone:_____ Relationship:_____

If participant is a minor or please include the Names and phone numbers of Adult(s) allowed to pick-up student
_____
Please note: the above line applies to minors only!

All BOEC participants are responsible for personal medical fees or charges that are incurred during a program. We recommend that all BOEC participants be covered by personal medical insurance. If medical care is required during a BOEC program, for any reason, the participant or the participant's personal health insurance will be the primary insurance.

1. Are you aware of any physical, mental or sensory limitations that may affect your ability to participate? ___no __yes
If yes, please explain_____
_____
2. Are you currently taking medication (prescription or non-prescription)? no yes If yes, state what you are taking, and what condition(s) it is for:_____
_____
3. Have you had any recent injury or illness? no _yes If yes, please describe: _____
_____
4. Do you have any history of heart, lung, or cardiovascular problems? (e.g. heart attack, asthma, heart disease, etc.)
___no _yes If yes, please list and describe in detail any limitations:_____
_____
_____
5. Do you smoke? ___no ___yes
6. Do you exercise regularly? ___no ___yes If yes, please describe the type, frequency, and duration of your exercise program:_____
_____
7. Are you allergic to any medicines or do you have any other serious allergies? ___no ___yes If yes, please describe:
_____
_____
8. Do you have any food allergies or dietary restrictions?_no yes If yes, please describe:
_____