



# 2022 Staff Application Form

UNITED YOUTH CAMPS PHILIPPINES

Sponsored by: United Church of God, an International Association

## General Information

The United Youth Camps is a Christian camp organized by the United Church of God, an International Association, to provide youths with an environment that will demonstrate that God's way works as they develop towards maturity in all aspects of life. The United Youth Camps (Philippines) is open to youths who subscribe to the Church's fundamental beliefs and practices and are between 13 and 18 years old. Please see below for the camp schedule and site this year, or contact the Camp Director for confirmation.

Volunteer staff positions are needed to carry out the United Youth Camps program of activities. UYC provides free board and lodging to staff volunteers. It is essential, however, that you are of legal age, fully subscribe to the Church's fundamental beliefs and practices, be a model Christian, and that you fill out this application form to help us determine your actual qualifications to help in this program. Thank you for your interest. We look forward to the possibility of you being accepted and working with us and our youths. Please notify the Camp Director ahead of time for any change in your plans: **Mobile Number(s): 0917 718 1775 · Email: rey\_evasco@ucg.org**

Mailing Address: UNITED CHURCH OF GOD AIA PILIPINAS  
Commercial B, Visard Building,  
#21 Sen. Gil Puyat Avenue, Makati City

Camp Site: **Eden Nature Park, Davao City**  
Camp Setup & Training: **Thursday July 15-17, 2022**  
Camp Proper: **July 18 – 23, 2022**

### For office use only:

Date Received: \_\_\_\_\_  
Deposit: \_\_\_\_\_  
Payment: \_\_\_\_\_  
Med. Consent Form: \_\_\_\_\_  
Letter Sent? \_\_\_\_\_  
Acceptance Status: \_\_\_\_\_  
Remarks: \_\_\_\_\_

- Instructions:**
1. Fill up this form including the attached *Health History and Examination Form* clearly and completely.
  2. Attach a recent photograph of yourself (or click to insert your picture) in the shaded box below.
  3. Submit the completed form to your Church Pastor on or before **May 14, 2022** and wait for approval.

Applicant's Full Name: (Last)		(First)		(Middle)	
Complete Mailing Address					
Cell./Phone Number	Birth Date	Age	Gender <input type="checkbox"/> Male <input type="checkbox"/> Female	Height	Weight
Civil Status or Name of Spouse, if Married			No. of Children	Ages of Children	
No. of times you attended summer camps _____ as camper _____ as staff		Church Area/Pastor*		Date of Baptism	

**IMPORTANT**

Please attach a recent photo of yourself here.

(Size: 2 x 2 in.)

\* If not attending a UCG congregation, please indicate your

UCG contact's name: \_\_\_\_\_

Present church affiliation: \_\_\_\_\_

Adult T-shirt size:  S  M  L  XL

Please rank which activity you can serve in, or fill in the blanks what other activities you may wish to serve in: ➔

Outdoor/Sports	Workshops	Services
<input type="checkbox"/> Dance	<input type="checkbox"/> Song Leading	<input type="checkbox"/> Counselor/Asst.
<input type="checkbox"/> Basketball	<input type="checkbox"/> Basic Sewing	<input type="checkbox"/> First Aid
<input type="checkbox"/> Volleyball	<input type="checkbox"/> Flower Arranging	<input type="checkbox"/> Kitchen/Dining
<input type="checkbox"/> Softball	<input type="checkbox"/> Cooking & Baking	<input type="checkbox"/> Laundry
<input type="checkbox"/> Team Building	<input type="checkbox"/> Basic Carpentry	<input type="checkbox"/> Property
<input type="checkbox"/> _____	<input type="checkbox"/> Computer	<input type="checkbox"/> Setup/Maintenance
<input type="checkbox"/> _____	<input type="checkbox"/> _____	<input type="checkbox"/> Transportation

**Why would you like to serve in the United Youth Camps?**

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Educational Background:**

Years Attended	Course/Degree	Institution	Distinctions & Awards

**Employment Record:**

Period of Employment	Position	Company/Employer	Reason for Leaving

**Summer Camp Experience:**

Location of Camp	Year	Position & Responsibilities	Distinctions & Awards

**Special Skills, Training, and Other Awards:**


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**Law Record**

Have you ever been convicted of adult or child abuse, child molestation, child neglect, sexual assault, rape, or any other sex offences; or have you ever been convicted of any other crime?  Yes  No *If you checked 'Yes,' please explain below:*

**Health & Fitness Record**

The United Youth Camps Program requires staff volunteers to engage in a wide range of rigorous and physically challenging activities. Good health and fitness are essential. Does the applicant have any physical or mental handicap which would prevent vigorous physical activity? Has the applicant had any nervous disorder, such as hysteria, fainting spells; allergies; or recent contagious illness/es; etc.?

Yes  No *If you checked 'Yes,' please explain below:*

**AGREEMENT AND RELEASE**

All United Camps maintain a high standard of conduct and dress code based on Godly principles. These standards and rules include but are not limited to: No possession or use of alcohol, tobacco, or illegal drugs; no sexual misconduct, disorderly conduct, profanity; no theft, destruction of property; or refusal to cooperate fully with camp and program personnel. Jewelry for body piercing (other than a pair of earrings for girls), short shorts, midriffs, halter tops, or wearing inappropriate apparel (or the lack thereof) will not be allowed. Except for pocketknives—firearms and other deadly weapons, even though they might be legally possessed, are not allowed within the camp or in any of its activities. Campers and staff who do not comply with these rules and standards, or whose conduct or attitude undermines the positive environment and objectives of the camp, are subject to disciplinary action and dismissal. Under such cases (if any) the individual concerned will be sent home at his or her own expense, apart from being accountable for moral and legal liabilities if any. Dismissal is very rare, and we hope this notice will prove to be totally unnecessary.

**Certification:** I certify that the answers given by me herein are complete, true, and accurate to the best of my knowledge and ability. If necessary, I hereby authorize the companies, schools, or persons named herein to give information related to the statements entered herein. I hereby release said entities from liability or damage arising from releasing said information. I also understand that information obtained will be treated with confidentiality.

**Quitclaim:** *This quitclaim must be completed in order for you to serve in the UYC program.*

I/We, the undersigned, whose name (and picture) appear on this application, and who is voluntarily participating in the United Youth Camps being sponsored by the United Church of God; hereby consent to release the Council of Elders, Board of Trustees, its officers, agents, employees, assistants, and other entities hereinafter collectively called the "Church", from all actions, claims or demands which I/we may hereafter have, arising from unfortunate incidents not covered by insurance. I/We agree not to sue, and to indemnify and hold harmless, the Church from any loss or expense that may be incurred. I/We execute this quitclaim for any and all legal purposes it may serve. In the event only one person signs, the plural pronouns shall be deemed as singular.

Applicant's Signature	Date	Spouse's Signature (if applicable)	Date
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**UCG Pastor/Elder's Evaluation:**

*Highly Recommended*       *Recommended*       *Satisfactory*       *Not Recommended*

Comment: \_\_\_\_\_

<b>Name</b> _____ <small>(For camp use)</small>	<b>Staff / Camper</b> <small>(Circle one)</small>	<b>Dorm</b> _____ <small>(For camp use)</small>	<b>Year</b> _____ <small>(For camp use)</small>
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## Health History and Examination Form for *United Youth Camps*

Sponsored by:  
**United Church of God, an *International Association***

This form must be completed (all 4 pages) by each person attending camp, or in the case of minors, by their parents or guardians. Please PRINT clearly.

### Personal Information

Applicant's Name: \_\_\_\_\_  Male  Female Birth Date: \_\_\_\_/\_\_\_\_/\_\_\_\_  

First
Middle
Last
Gender

Address: \_\_\_\_\_ Phone: (\_\_\_\_) \_\_\_\_\_

Parent/Guardian or Emergency Contact: \_\_\_\_\_ Relationship: \_\_\_\_\_

Telephone: (\_\_\_\_) \_\_\_\_\_ (\_\_\_\_) \_\_\_\_\_ (\_\_\_\_) \_\_\_\_\_  

Home
Work
Other

Second Parent/Guardian/Emergency Contact: \_\_\_\_\_ Relationship: \_\_\_\_\_

Telephone: (\_\_\_\_) \_\_\_\_\_ (\_\_\_\_) \_\_\_\_\_ (\_\_\_\_) \_\_\_\_\_  

Home
Work
Other

### Insurance Information

The Church's no-fault accident insurance is optional, or if current, is limited and secondary to any other collectible insurance. Please furnish the following medical and insurance coverage information:

Insurance Company: \_\_\_\_\_ Policy or Group # \_\_\_\_\_

SSS Number of Policyholder or Insurance ID Number: \_\_\_\_\_

Insurance Phone # (\_\_\_\_) \_\_\_\_\_ Address: \_\_\_\_\_

Family Physician: \_\_\_\_\_ Phone: (\_\_\_\_) \_\_\_\_\_

Address: \_\_\_\_\_

Family Dentist/Orthodontist: \_\_\_\_\_ Phone: (\_\_\_\_) \_\_\_\_\_

Address: \_\_\_\_\_

### Medical History

Many activities such as sports and challenge courses require participating in physical exercises that are physically demanding. Do you have health problems or disabilities that might hinder you from participating fully in camp activities?  Yes  No

If yes, please describe in detail (attach note if necessary): \_\_\_\_\_

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Do you have any severe allergies (including food allergies) or any other condition or limitation that could affect your camp experience?  Yes  No If yes, please explain (attach note if necessary): \_\_\_\_\_

Are you allergic or sensitive to any medicine or other substances?  Yes  No If yes, please list and describe the reaction and its management: \_\_\_\_\_

**Medications Being Taken**

Are you taking any medications (including over the counter or other non-prescription drugs) routinely?  Yes  No

If yes, please list all medications (including over the counter or other non-prescription drugs) taken routinely. Be sure to bring your medication with you in the original packaging that will identify the doctor, the dosage and the frequency of administration:

Medication	Dosage	Frequency	Reason for Taking

**Health History** (Explain any 'yes' answers below)

<i>Has/does the participant:</i>	Yes	No		Yes	No
1. Had any recent injury, illness or infectious disease?	<input type="checkbox"/>	<input type="checkbox"/>	13. Have an orthodontic appliance being brought to camp?	<input type="checkbox"/>	<input type="checkbox"/>
2. Have chronic or recurring illness/condition?	<input type="checkbox"/>	<input type="checkbox"/>	14. Have any skin problems (e.g., itching, rash, acne)?	<input type="checkbox"/>	<input type="checkbox"/>
3. Have frequent headaches?	<input type="checkbox"/>	<input type="checkbox"/>	15. Have diabetes?	<input type="checkbox"/>	<input type="checkbox"/>
4. Wear glasses, contacts or protective eye wear?	<input type="checkbox"/>	<input type="checkbox"/>	16. Have asthma?	<input type="checkbox"/>	<input type="checkbox"/>
5. Ever had frequent ear infections?	<input type="checkbox"/>	<input type="checkbox"/>	17. Had mononucleosis in the past 12 months?	<input type="checkbox"/>	<input type="checkbox"/>
6. Ever passed out during or after exercise?	<input type="checkbox"/>	<input type="checkbox"/>	18. Have problems with sleepwalking?	<input type="checkbox"/>	<input type="checkbox"/>
7. Ever been dizzy during or after exercise?	<input type="checkbox"/>	<input type="checkbox"/>	19. Have a current history of bed-wetting?	<input type="checkbox"/>	<input type="checkbox"/>
8. Ever had seizures?	<input type="checkbox"/>	<input type="checkbox"/>	20. Have an eating disorder?	<input type="checkbox"/>	<input type="checkbox"/>
9. Ever had chest pain during or after exercise?	<input type="checkbox"/>	<input type="checkbox"/>	21. Ever had emotional or mental difficulties for which professional help was sought?	<input type="checkbox"/>	<input type="checkbox"/>
10. Ever had high blood pressure?	<input type="checkbox"/>	<input type="checkbox"/>			
11. Ever been diagnosed with a heart murmur?	<input type="checkbox"/>	<input type="checkbox"/>			
12. Ever had back problems?	<input type="checkbox"/>	<input type="checkbox"/>			

If you checked 'yes' to any of the above, please write the question number and explain:

Which of the following has the applicant had? (Check each one that applies)

- Measles     
  Chickenpox     
  German measles     
  Mumps     
  Rheumatic Fever  
 Hepatitis A     
  Hepatitis B     
  Hepatitis C     
  TB Test (Date: \_\_\_\_\_ Pos or Neg? \_\_\_\_\_)

**Immunizations** (Fill in the dates for any of the following immunizations applicant has had)

Immunization	Date Last Received	Immunization	Date Last Received
DPT		Mumps	
TD (tetanus/diphtheria)		Rubella	
Tetanus		Gamma Globulin (Hepatitis)	
Polio		Chickenpox	
German Measles		Smallpox	

**Note:** A record of immunizations is for informational purposes. Immunizations are not a required prerequisite for acceptance to or attendance at camp. If a camper has not been immunized, however, and one of the above-named communicable or contagious diseases is found in camp, he or she will be subject to the regular quarantine or isolation procedures of the camp and of the community for children who are not immune.

**ADULT APPLICANT:** I certify that to the best of my knowledge this health history is correct and complete, that I am in good health and able to participate in this event/assignment.

**Adult application signature** \_\_\_\_\_ **Date** \_\_\_\_\_

**PARENT/GUARDIAN AUTHORIZATION:**

This health history is correct and complete as far as I know, and the person herein described has permission to engage in all camp activities except as noted. I understand that if any statement in this Health History is false, misleading or incorrect; or the Church is unable, in its sole judgment, to properly care for or protect my child (due to his/her medical condition), he or she may be sent home at my expense.

**Parent signature** \_\_\_\_\_ **Printed Name** \_\_\_\_\_ **Date** \_\_\_\_\_

**PARENTAL NOTIFICATION POLICY:**

United Youth Camps policy is that parents will be contacted: 1) anytime the nurse or a physician deems necessary; 2) anytime a camper is taken to see a physician, dentist or emergency personnel for an accident or illness; 3) when an illness lasts longer than 24 hours.

**Important - These boxes must be completed for attendance**

**Permission to Provide Necessary Treatment or Emergency Care:**

I hereby give permission to the available medical personnel at the camp to administer prescribed medications and provide routine or alternative health care. In the event of an accident/illness, I consent to the administration of emergency on-site first aid by trained personnel. If I cannot be reached in an emergency, I hereby give permission to the camp medical personnel to secure and administer treatment, including hospitalization, for the person named above. This authorization includes consent to any medical, emergency, dental, surgical, naturopathic, or hospital diagnosis, treatment or care to be rendered to or for me/ or my child under the general or specific supervision of a qualified physician, surgeon, naturopathic doctor or dentist. It also includes permission to release any records necessary for supervision, treatment, referral, billing or insurance purposes and to provide or arrange necessary related transportation. I understand and agree that all the foregoing will be at my expense. (This consent shall terminate without further notice on the date when a minor reaches 18 years of age at which time such individual assumes his adult responsibilities.) This completed form may be photocopied for trips out of camp.

**Parent/guardian (or adult camper/staff) signature** \_\_\_\_\_

**Printed Name** \_\_\_\_\_ **Date** \_\_\_\_\_

➤ **If medication for life-threatening conditions is brought to camp (epi pen, inhaler, etc.) I hereby request that said medication remain with:**  **UYC Personnel**  **My Child** *(Please check one)*

I understand that accommodating some medical conditions or disabilities may not be ideal and may differ depending on the activity. Therefore, if I am accepted, I agree to abide by any restrictions which may be placed on my camp activities that the camp staff feels are necessary for my comfort or safety or that of my fellow campers or staff.

**Camper/Staff signature** \_\_\_\_\_ **Date** \_\_\_\_\_

**Special note about medication:**

Please note that if your camper will be bringing **ANY** medication to camp, including all prescription, over the counter, and herbal remedies, the following rules will need to be followed:

- 1) All medications must be in their original packages. i.e., prescriptions in the prescription bottle, Tylenol in the Tylenol bottle, herbs in the bottle that they were originally bought in.
- 2) All medications must be accompanied by written and signed instructions for administration (the prescription on the bottle will be fine unless doses or times have changed).
- 3) Any nonprescription bottles must have the camper's name written on them (prescription bottles must be for that camper).

PLEASE help us to take good care of the precious and wonderful campers that you have entrusted to us! —UYC Nursing Staff

**MEDICAL EXAM / RECOMMENDATION AND RESTRICTIONS** (Exam to be done within 2 months of arrival at camp)

**Applicant's Name:** \_\_\_\_\_ **Birth Date:** \_\_\_\_/\_\_\_\_/\_\_\_\_

I have examined the above-named participant on \_\_\_\_/\_\_\_\_/\_\_\_\_ (date). BP \_\_\_\_\_ Weight \_\_\_\_\_ Height \_\_\_\_\_

In my opinion, the above applicant:  is  is not able to participate in an active camp program.

The applicant is under the care of a physician for the following conditions \_\_\_\_\_

\_\_\_\_\_

Current treatment at the time of this report includes \_\_\_\_\_

\_\_\_\_\_

**Recommendations and Restrictions at Camp**

Treatment to be continued at camp \_\_\_\_\_

\_\_\_\_\_

Medications to be administered at camp (name, dosage, frequency) \_\_\_\_\_

\_\_\_\_\_

Any medically prescribed meal plan or dietary restrictions \_\_\_\_\_

\_\_\_\_\_

Known allergies \_\_\_\_\_

\_\_\_\_\_

Description of any limitation or restriction on camp activities \_\_\_\_\_

\_\_\_\_\_

Additional information for health care staff at camp \_\_\_\_\_

\_\_\_\_\_

**Signature of Licensed Medical Personnel** \_\_\_\_\_  
Printed Name \_\_\_\_\_ Title \_\_\_\_\_  
Address \_\_\_\_\_  
Phone \_\_\_\_\_ Date \_\_\_\_\_ Lic # \_\_\_\_\_

**Screening Record (for camp use only)**  
Date screened \_\_\_\_\_ Time \_\_\_\_\_ Meds received \_\_\_\_\_  
Updates/additions to health history noted?  Yes  No  None required  
Current health needs identified \_\_\_\_\_  
Observational notes \_\_\_\_\_  
Screened by \_\_\_\_\_