Volunteer Application 2016

Instructions: Complete the application and email it to Stacey Mortenson at smortenson@lungs.org.

Checklist: Please attach a copy of your Medical License and CPR card.

Volunteer's Name (Last) _____ (First) _____

Other Last Name/*Maiden _____

SSN # _____ Date of Birth _____

Mailing Address _____

City _____ State _____ Zip Code _____

Phone: Home _____ Work _____ Cell _____

Other _____ Email Address: _____

Gender Male Female T-shirt size: S M L XL 2XL 3XL

Medical License: MD DO PA RN NP RRT CRT PharmD Paramedic

Other: _____

Occupation/Position _____ Employer _____

Employer's Address _____

Number of Years in Profession: _____

1. Do you have experience working in asthma? Yes No
   If yes, please explain

2. Please select any certifications you currently hold: CPR ACLS First Aid PALS

PLEASE SUBMIT A COPY OF YOUR MEDICAL LICENSE AND CPR CARD WITH THIS APPLICATION IN ORDER FOR IT TO BE PROCESSED

3. What days are you interested in volunteering?
   (We must ask for a minimum commitment of 3 ½ days to ensure continuity of care for the children.)
   ☐ May 28 – June 3, 2016 (Full Week)
   ☐ May 28 - May 31, 2016 (Saturday – Tuesday)
   ☐ May 31 – June 3, 2016 (Tuesday – Friday)

4. Would you be interested in riding the bus with the children to and from camp? Yes No
5. Have you ever been convicted of a criminal offense? Yes No
   If yes, please explain:

6. Do you use illegal drugs? Yes No
7. Have you ever been convicted of child neglect or abuse? Yes No
8. Other than the above, is there any fact or circumstance involving you or your background that would call into question your being entrusted with the supervision, guidance, and care of young people? Yes No
   If yes, please explain:

9. What gender and age group would you prefer to work with? _____ _____
10. Would you be interested in precepting a student? Yes No
11. Would you be interested in receiving an asthma overview prior to camp? Yes No

*** PLEASE NOTE: In order to attend camp, all volunteers will be asked to attend Volunteer Orientation*** Information about the time and locations of these orientation meetings will be sent to you with additional details that you will need regarding Camp Not-A-Wheeze 2016. Please call Stacey Mortenson at 602-258-7507 if you have questions regarding this requirement. Thanks!

CONSENT:

If I am accepted as a volunteer at Camp Not-A-Wheeze, I understand that my room/board and participation in all activities is included as a volunteer. I further understand that no monetary or material compensation will be made for my time.

I understand that I will be asked to either teach or assist in teaching daily asthma education sessions. I further understand that the asthma education curriculum will be provided for me by the ***American Lung Association in Arizona****.*

I hereby acknowledge the risk involved in a camp environment and I release Friendly Pines Camp, the American Lung Association of Arizona and all camp sponsors, their incorporators, board members, officers, employees, agents, independent contractors and volunteer/contract workers from any liability for injuries, emergencies, or other problems occurring during camp.

I consent to be photographed or videotaped for the purpose of recording the camp experience. I understand that these photographs or tapes may be used for publicity, fundraising or other purposes by the sponsoring organizations and I do not expect monetary or material compensation for their use.

***Background checks will be conducted on all volunteers.** Information obtained will be kept confidential.

_____ _____

Print Name Date

EMERGENCY CONTACT(S)

Name _____ Relationship _____

Phone: Home _____ Work _____ Cell _____

Address _____

City _____ State _____ Zip Code _____

Place of Employment _____ Work Hours _____

Name _____ Relationship _____

Phone: Home _____ Work _____ Cell _____

Address _____

City _____ State _____ Zip Code _____

Place of Employment _____ Work Hours _____

HEALTHCARE INFORMATION

Name of Medical Insurance Company _____

Policy Number _____

Physician's Name _____

Physician's Address _____

Physician's Phone _____

GENERAL MEDICAL HISTORY

Please list any special medication problems

Please list any allergies (bees, food, etc.)

Please list any drug allergies

Immunizations – Please include dates:

Tetanus _____ HIB _____ TB _____

Please list any medications

MEDICATION	DOSAGE	DOSING SCHEDULE	COMMENTS

You Can Also Mail or Fax Your Completed Application:

American Lung Association in Arizona

Attn: Stacey Mortenson

102 W McDowell Road

Phoenix, AZ 85003

Fax: (877) 276-2108

Please call 602-258-7505 with any questions