



Dear Potential Camp Erin Volunteer:

Thank you for your interest in being a part of Camp Erin Orange County! Camp Erin is a special camp for children and teens ages 6-17 that have lost someone close to them, combining traditional camp activities with grief counseling and emotional support. The camp is made possible through a partnership between The Spencer Hospice Foundation and The Moyer Foundation. The Spencer Hospice Foundation is an Orange County based non-profit dedicated to enhancing the quality of life for terminally ill patients and their families. The Moyer Foundation is a non-profit organization founded by World Series champion, All-Star MLB pitcher Jamie Moyer and his wife, Karen with a mission of helping children in distress.

Camp Erin Orange County is one of 8 new camps opening in 2010, thanks to The Moyer Foundation's *Campaign for Kids*, a nationwide fundraising effort to help establish and fund as many as 60 new camps by 2012 – including one camp in every Major League Baseball city. Through the support of individuals, corporate sponsors and partner organizations nationwide, Camp Erin has become the largest network of bereavement camps in the country, with 36 camps in 23 states and one in Canada.

Camp Erin Orange County will be held August 13-15th, 2010 at the Irvine Ranch Outdoor Education Center in the city of Orange.

Things You Should Know:

- We will process applications as they are received, so you are encouraged to return your application as soon as possible
- We will conduct a background check on each volunteer applicant
- We do maintain a waiting list for all applicants who are declined
- We will conduct a mandatory volunteer training session for all accepted applicants
- Please feel free to contact Michelle Wulfestieg at (888) 469-1581 or email her at mwulfestieg@spencer-foundation.org if you have questions or need assistance completing the application

Application Checklist:

- I am at least 21 years old
- I **do not** have a family member who is attending camp as a camper this summer
- Keep a copy of your completed application for your records
- Return your completed application **by fax to (714) 597- 8275** or mail it to the

Spencer Hospice Foundation
3401 W. Sunflower Ave, Ste. 125
Santa Ana, CA 92704

Sincerely,

The Spencer Hospice Foundation



VOLUNTEER INFORMATION

NAME: _____ Nick-name (if preferred): _____

Mailing Address: _____

City/Zip Code: _____

Home Phone Number: _____ Cell Phone Number: _____

Date of Birth: _____ Gender: M F Email: _____

Contact person and phone number in case of an emergency (Name, Number, & Relationship):

Bilingual: Yes No If yes, what languages: _____

Employed by: _____ Job: _____

Highest level of education earned: _____ Year completed: _____

Counseling Background: Degree: _____ License #: _____

Describe experience working with children: _____

Camp Experience: Yes No - If yes, describe _____

Have you ever been convicted of a criminal offense? Yes No - If yes, describe:

What is your T-Shirt size? Adult: S M L XL XXL

How did you learn about this program?

Hospice Co-worker Flyer Friend Newspaper Other _____



MEDICAL INFORMATION

Volunteer Name: _____

Address: _____

Phone _____ Date of Birth: _____

Does you have any of the following:	Yes	No
Physical Limitations	<input type="checkbox"/>	<input type="checkbox"/>
Asthma	<input type="checkbox"/>	<input type="checkbox"/>
Dietary Restrictions (i.e. physician recommended, religious etc.)	<input type="checkbox"/>	<input type="checkbox"/>
Convulsions / Seizures	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>
Ear Infections	<input type="checkbox"/>	<input type="checkbox"/>
Hearing Impairment	<input type="checkbox"/>	<input type="checkbox"/>
Motion Sickness	<input type="checkbox"/>	<input type="checkbox"/>
Nosebleeds	<input type="checkbox"/>	<input type="checkbox"/>
Wears Glasses / Contacts	<input type="checkbox"/>	<input type="checkbox"/>
Recurring headaches or stomach aches	<input type="checkbox"/>	<input type="checkbox"/>
Other: (please specify)	<input type="checkbox"/>	<input type="checkbox"/>
Are you currently under the care of a physician?	<input type="checkbox"/>	<input type="checkbox"/>
If yes , Physician's Name _____ Phone # _____	<input type="checkbox"/>	<input type="checkbox"/>
Do you have any allergies? (i.e. food, medicine, or other)	<input type="checkbox"/>	<input type="checkbox"/>
If yes , please explain _____	<input type="checkbox"/>	<input type="checkbox"/>
Any history of operations or serious illnesses?	<input type="checkbox"/>	<input type="checkbox"/>
Will you be taking medications at camp?	<input type="checkbox"/>	<input type="checkbox"/>
If yes , what are the medications treating? _____	<input type="checkbox"/>	<input type="checkbox"/>
What is the date of your latest Tetanus shot?	<input type="checkbox"/>	<input type="checkbox"/>

REQUIRED INFORMATION:

EMERGENCY CONTACT NAME: _____ PHONE: _____

Is there a hospital that your insurance mandates? _____

HOSPITAL OF CHOICE: _____

Name of Preferred doctor: _____ Phone Number: _____

Health Insurance Provider: _____ Name of Policy Holder: _____

Identification # _____ Group: _____



BEREAVEMENT HISTORY

Volunteer Name: _____

Please indicate the losses you have experienced in your life:

Relation to the person who died (i.e. mother, brother, friend)	Date of Death	Cause of Death

Use this space to explain any further explain any responses or to add information that you feel would be useful in processing your application.



SKILLS & PREFERENCES

NAME: _____ Nick-name (if preferred): _____

Phone Number: _____ Email: _____

Are many volunteer opportunities available! Please select the opportunities that best suit you and your talents by placing #1 next to your first choice, a #2 next to your second choice, and a #3 next to your third choice.

- | | | |
|---|--|---|
| <input type="checkbox"/> Facility set-up & clean-up | <input type="checkbox"/> Playing an instrument | <input type="checkbox"/> Cabin Big Buddy |
| <input type="checkbox"/> Camper registration | <input type="checkbox"/> Expressive Arts | <input type="checkbox"/> Grief Activity Facilitator |
| <input type="checkbox"/> Fundraising | <input type="checkbox"/> Singer | <input type="checkbox"/> Camp Photographer |
| <input type="checkbox"/> Comfort gifts | <input type="checkbox"/> Entertainer | <input type="checkbox"/> Certified Life Guard |
| <input type="checkbox"/> Community outreach | <input type="checkbox"/> Massage Therapy | <input type="checkbox"/> Greeter or Goodbyer |
| <input type="checkbox"/> Games & skits | <input type="checkbox"/> Yoga Instructor | <input type="checkbox"/> Arts & Crafts |
| <input type="checkbox"/> Logistics | <input type="checkbox"/> Writer | <input type="checkbox"/> Painter |

Age group preference: 6-8 9-11 12-14 15-17

REFERENCES

We must receive **three** completed references. Your references should include at least one professional. **NO FAMILY MEMBERS.**

Please provide the name, address, phone number and relationship for each of your three references.

Name	Address	Phone	Relationship
1.			
2.			
3.			