

Worker Application

Church City		Church Name	
First Name	Middle Name	Gender (Circle One) Male Female	
Last Name		Maiden Last Name	
Home Address	Circle One: Monitor / MIT / Dean / Coordinator / Support Staff Tractor Driver / Kitchen Help		
City	State	Zip	
Birthdate (mm/dd/yy) / /	Age	Home Phone () -	
E-mail Address	Married/Single	Shirt Size (Circle One) Youth S M L Adult S M L XL 2X 3X 4X	
Social Security Number - -	Driver's License Number	State	
Emergency Contact	Day Phone () -	Evening Phone () -	

BACKGROUND CHECK INFORMATION: If you were screened last year, it is still applicable to this year's application. It is also important to make sure your proof of background has been checked in the following areas: National Criminal Search, Social Security Verification, and Sex Offender's Database. We will contact you if there is any interference in your acceptance due to the background check. Please check the appropriate box below that describes your situation:

My background check is on file with the district from my 2007 Kid's or Youth Camp application. If my background check is not current (within 2 years), I authorize NTDC to process one for an additional \$5 fee.

I do not have a background check and request NTDC to process one for an additional \$5 fee.

I have enclosed proof of my background check (which has been screened in the above mentioned areas) with this application. ****Must be enclosed with application.**

Is there any information we should have concerning your welfare (handicaps, restrictions, diets, allergies, etc.)? _____

Have you ever been convicted of (or pled guilty to) child abuse or a crime involving actual or attempted sexual molestation of a minor or adult? Yes No If yes, explain. _____

Have you ever been convicted of (or pled guilty to) any other crimes? ? Yes No If yes, explain. _____

Do you currently use alcohol, tobacco, or any illegal drugs? Yes No

Are you a member and regular attendee of your church?
How long have you been saved?
How long have you been spirit filled?
Areas of church involvement:

Pages 1 and 2, and the Pastoral Reference Form MUST be completed in entirety for workers to be accepted.

Worker Application

Church City	Church Name
First and Middle Name	Last Name

Chronic/Recurring Conditions: Please check all conditions that apply.

<input type="checkbox"/> Asthma/Respiratory	<input type="checkbox"/> Hearing Impairment
<input type="checkbox"/> Bleeding/Clotting Disorder	<input type="checkbox"/> Heart Disease
<input type="checkbox"/> Constipation	<input type="checkbox"/> Hypertension
<input type="checkbox"/> Diabetes	<input type="checkbox"/> Kidney disease/bed wetting
<input type="checkbox"/> Ear Infection	<input type="checkbox"/> Musculoskeletal disorder
<input type="checkbox"/> Emotional Disturbances	<input type="checkbox"/> Nosebleed
<input type="checkbox"/> Epilepsy	<input type="checkbox"/> Seizures
<input type="checkbox"/> Fainting	<input type="checkbox"/> Sickle Cell Trait or Disease
<input type="checkbox"/> Headaches	<input type="checkbox"/> Special Dietary Regimen
<input type="checkbox"/> Other _____	

Please list date of most recent immunization.		
Polio	MMR	DTP
/ /	/ /	/ /
TB Skin Test (not required)		* Please do not send a copy of the shot record.
Date	Result	
/ /		

Immunization dates are required for minors only.

Date of last examination: _____

Are Activities Restricted? Yes No If yes, Explain.

Name of Physician _____ Phone (____)____-_____

Medical/Hospital Insurance Carrier _____

Policy Number _____ Group Number _____

Allergies: Please check all that apply, and list treatment required.

<input type="checkbox"/> Animals _____	<input type="checkbox"/> Plants _____
<input type="checkbox"/> Food _____	<input type="checkbox"/> Pollen _____
<input type="checkbox"/> Insect Bites _____	<input type="checkbox"/> Hayfever _____
<input type="checkbox"/> Medicines/Drugs _____	<input type="checkbox"/> Other _____

May you be given the following:	Yes	No
Tylenol		
Benadryl		
Ibuprofen		
May you be given over-the-counter, non-prescription medications or applications, not to exceed recommended dosage for stomach discomfort, burns, cuts, insect bites, rash, or scrapes?		
List Exceptions:		
Circle if you wear: contact lenses glasses dental appliances		

I do hereby state that while I am a registered staff member at any North Texas A/G summer camp, I hereby authorize any director, nurse, dean, lifeguard, or other responsible person of said Camp to consent to any x-ray, examination, anesthetic, medical or surgical treatment, and hospital care, to be rendered under the general or special supervision and on the advice of any physician or surgeon licensed to practice in the United States, when such medical or surgical treatment is necessary. I also hereby authorize this document to be released to first responders and emergency personnel.

Worker Signature _____ Date _____

Parent Signature (if worker is under 18) _____ Date _____

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