2025 Volunteer Application

Many adult volunteers are needed to help our summer youth camps be effective and successful. Please pray about this opportunity for service. Please select the area(s) below in which you would like to volunteer, and then complete the rest of the application. When you are finished, please return the application to the address listed at the end.

Name _____

Address _____

City _____ State _____ Zip _____

Phone _____ Email _____

Church _____

Skills Classes ___Arts/Crafts ___Nature ___Archery ___Survival Skills ___Slingshots
___Photography ___Other_____

General ___Bus Driver ___Kitchen ___Canteen ___Registration ___Nurse
___Pastor ___Bathroom Cleaning ___Other_____

Check camp (s) you are willing to serve:

___June 16-21 / Adventure Camp I (7^{th}-8^{th} grade)
___June 16-21 / Summit Camp I (9^{th}-12^{th} grade)
___July 07-12 / Summit Camp II (9^{th}-12^{th} grade)
___June 30-July 2 / Base Camp (1^{st}-3^{rd}grade)
___July 07-12 / Adventure Camp II (7^{th}-8^{th} grade)
___June 09-14 / Explorer Camp I (4^{th}-6^{th} grade)
___June 23-28 / Explorer Camp II (4^{th}-6^{th} grade)

Camp T-shirt size:

(Regular cut) ___Small ___ Med ___Large ___XL ___XXL ___XXXL ___ XXXXL

(V-Neck (unisex)) ___Small ___ Med ___Large ___XL ___XXL ___XXXL ___ XXXXL

All volunteers are required to undergo a background check. Please fill out the following Information.

Full Name_____

Date of Birth_____

By signing below, you are agreeing for WPC&RC to conduct the background check

_____

Signature Date

Thank you for your willingness to serve. I look forward to working with you this summer! If you have any questions, please feel free to contact me.

Please Mail to:
Wabash Park Camp & Retreat Center
Attention: Deana Hayes
Scott Lefler
304 E. CR 650 S
Clay City, IN 47841

Email: Deana@wabashparkcamp.org

Heath Form ~ 2025

Please print

Name_____ Date of Birth _____ /____/_____

Age _____ Gender: M___ F___

Home Address _____ City_____State_____Zip_____

Home Phone ( )_____ Cell Phone ( ) _____

Emergency Contact Name _____

Work Phone ( ) _____ Cell Phone ( ) _____

Family Physician _____ Physicians Phone ( ) _____

Do you currently take prescription or non-prescription medication on a regular basis? _____ yes _____ no

Do you have:
Allergies? _____yes _____no
Please specify:
_____
Asthma? _____yes _____no
Diabetes? _____yes _____no
Other? _____

Tetanus Immunization Date: _____

Other information that would be helpful to the camp nurse while you are at camp?

_____

Our family insurance coverage is _____ Policy # _____

Policy Holder's Name _____

*Please attach a photo static copy of your health insurance card.

AUTHORIZATION I herewith authorize any representative of Wabash Park Camp & Re- treat Center to request and consent in writing or otherwise as requested by Union Hospital, Inc. (Terre Haute, IN.), or any other licensed hospital, to any and all examinations, medical treatment and/or procedures to or for the above named minor, either on or off the premises of Union Hospital, as may be deemed advisable or appropriate by any physician or surgeon licensed to practice medicine in the state of Indiana. This authorization constitutes a Power of Attorney appointing the named staff as Attorney-In-Fact to sign said requests and consents as fully as though I myself did so. This consent is effective from 6/1/25 - 7/31/25. I hereby release the Wabash Conference of the Free Methodist Church, Camp Wildwood as well as WPC&RC and/or its personnel from responsibility in case of sickness and/or accident while he/she attends camp. I acknowledge that I understand the potential risk and the activities involved in youth camping.

Signed:_____Date:_____

(Note: This document must be signed and dated to be accepted)