2019 Diane Rauch Camp Nurse Jr. Application Guidelines

Requirements: Applicants must be entering either the 7th or 8th grade in the fall of 2019, and be interested in learning more about a nursing career. Applicants must have a cumulative middle school GPA of 2.75 or higher. Preference will be given to those children who have not attended this camp in the previous year.

Program cost: $60.00 camp fee will be **due as soon as the camper has been accepted into the program** (do not send money with the application). The $60.00 fee will be nonrefundable once the camper accepts his/her place in the camp. We accept either checks (made out to Clinical Education Services) or money orders.

Program Location: Camp Nurse Jr. will be held on the Mease Dunedin Campus, in the Clinical Education building at 818 Milwaukee Ave, Dunedin 34698.

Program dates/time: **Tuesday, July 23, 2019 to Thursday, July 25, 2019.** Camp is from **8:30 AM – 4:00 PM** (campers must not be dropped off before 8:15 AM, or leave after 4:15 PM). There will not be any adult supervision before or after these times.

Selection criteria: Selection will be based on letter(s) of recommendation, personal statement and number of qualified applicants. We will send an e-mail to all applicants advising them of the status of their acceptance no later than **June 14, 2019.** Please confirm by e-mail or phone that your camper plans to attend. Camp schedule and further instructions regarding clothing, meals and camp activities will be sent out via e-mail during the first week of July.

Application procedure:

1. Applications will be accepted beginning **Monday, April 22, 2019**. Applications will be considered on a first-come, first-serve basis, so don't wait to apply! Children of BayCare team members receive priority consideration. Only fully completed, signed, notarized applications will be considered for acceptance. **Final Application deadline: Thursday, June 6.**
   - **Please ensure that the e-mail address used on the application is a) legible and b) an account that is regularly checked. Specific information about the camp will be communicated via the e-mail address you provide.**

2. Completed application package must be sent together and include:
   - Original Diane Rauch Camp Nurse Jr application –please make sure it is legible, and includes an e-mail address
   - Medical authorization form ***this MUST be notarized***
   - Release of liability form
   - Media consent form
   - Copy of current middle school transcript. Since the school year will not have ended, a transcript for the first part of the school year only is acceptable.
   - Letter of recommendation from past or present math or science teacher on school letterhead.
   - One page, typed or neatly hand written, personal statement, which answers the following questions:
     - Why are you interested in nursing as a career?
     - What are your expectations of the camp?
     - What characteristics do you think are required to be a great nurse?

Completed applications should be mailed to:
Colleen Glass
Clinical Education Services
Mease Dunedin Hospital
600 Main St.
MS #430
Dunedin, FL 34698

You may also scan and e-mail applications to colleen.glass@baycare.org. However, we must have the original application forms by **Friday, June 28** if your camper has been selected. If we do not have originals by that date, we will select a camper from the waitlist.

Morton Plant Mease
BayCare Health System

2019 Diane Rauch Camp Nurse Jr. Application

Last Name________________________________ First Name____________________

Address____

City________________________________ State____________ Zip code_________

Parent/Guardian e-mail address:____

Parent/ Guardian Name(s):

_________________________ Work Phone ______________ Cell ______________

_________________________ Work Phone ______________ Cell ______________

Is the parent/guardian employed by BayCare Health Systems?
❑ Yes ❑ No
Did you attend Camp Nurse Jr. last summer? ❑ Yes ❑ No

Emergency Contact Name____________________________ Relationship____________

Emergency contact phone number(s)____

Grade during 2018-2019 academic school year (check one) _☐ 6th grade ☐ 7th grade

Date of birth:____________________ Gender ❑ Male ❑ Female

IMPORTANT* T shirt size: ❑ Adult Small ❑ Medium ❑ Large ❑ Extra-Large

List your extracurricular activities____

List your awards, honors and achievements_______________________________________

All information on this form is true and complete to the best of my knowledge.

Participant signature :____________________________________ Date :____________

Parent signature :____ Date :____________

CHECKLIST : Make sure to submit **all** the necessary forms for the application package. Incomplete applications will not be considered for acceptance. :

- ☐ Application Form. **Please include t-shirt size now, since we have to order early**
- ☐ Media Consent form (has to be witnessed)
- ☐ Medical Authorization form (has to be notarized)
- ☐ Current middle school transcript
- ☐ Release of Liability form
- ☐ Current middle school transcript. The transcript can be from just the first part of 2019.
- ☐ Letter of reference from a current or previous math/science teacher
- ☐ Personal statement, as described on the information sheet

VOLUNTARY PARTICIPATION AND RELEASE AGREEMENT

NAME:____

ADDRESS:____

CITY:________________________________STATE:________________ZIP CODE:__________

HOME PHONE:__________________________WORK PHONE:______________________________

CELL PHONE:__________________________EMAIL ADDRESS:____________________________

IN CASE OF EMERGENCY CONTACT:____

RELATIONSHIP:___________________________ PHONE NUMBER:_______________________

ALTERNATE PHONE NUMBER:____

By my signature below, I hereby confirm that I, or my child or children, wish to attend, and participate in the activities associated with, the Camp Nurse Jr. (the "**Camp Nurse Jr.**"). By attending and participating in the Camp Nurse Jr., I, or on behalf of my child or children, hereby agree to forever release, indemnify, and hold harmless BayCare Health System, Inc., Morton Plant Mease Foundation, Inc., and any and all of their affiliates, subsidiaries, volunteers, employees, and other professional/administrative personnel (collectively, "**Camp Nurse Jr. Entities and Personnel**") from any and all liabilities, damages, claims, costs, and/or expenses arising from, or in any way related to, my attendance and participation in the Camp Nurse Jr., including, without limitation, all claims for bodily injury, death, and/or property damage. In other words, I will not make any legal claims against the Camp Nurse Jr. Entities and Personnel related in any way to attendance and participation in the Camp Nurse Jr.

I have had an opportunity to ask questions, and consult an independent physician, about attendance and participation in the Camp Nurse Jr. Any questions I have asked have been answered to my complete satisfaction. I subjectively understand the risks associated with attendance and participation in the Camp Nurse Jr., and knowing and appreciating these risks, I, on behalf of my child of children, voluntarily choose to attend and participate in the Camp Nurse Jr. I assume responsibility for immediately reporting any changes in physical condition that occurs at any point during the Camp Nurse Jr. I understand that emergency contact will be notified as soon as possible in the event of an emergency. In the event emergency contact cannot be reached, I hereby authorize the Camp Nurse Jr. to obtain any and all medical treatment.

This Voluntary Participation and Release Agreement is intended to be as broad as allowable under the laws of Florida.

I am aware this is a waiver and release of any and all liability associated with attendance and participation in the Camp Nurse Jr., and I agree to assume all risks associated with attendance and participation in the Camp Nurse Jr.

I have carefully read this Voluntary Participation and Release Agreement, and fully understand it and agree to be bound by all of its terms and conditions.

SIGNATURE OF PARENT OR GUARDIAN:

____ DATE:______________________

PRINT NAME:____

Photo and Recording Consent and Authorization

Recording Procedure: (Select all that apply)

o **Still Photographs** o **Videotapes, Moving Pictures, Television** o **Interview**

I, ______________________, hereby authorize the taking of photographs and/or video or audio recordings of myself or my minor child, ___________________ by Morton Plant Mease Health Care, its respective agents, contractors, employees, or representatives of the news media for the purposes of publishing the same.

I understand that the released information is no longer protected by Federal privacy regulations. I release Morton Plant Mease, its employees, personnel, agents, medical staff and the photographer or video photographer from any or all liability, royalties or cognizable claims that may be associated with the taking, reproduction and/or use of such photographs, videotapes, recordings or interviews. This authorization has no expiration date unless I notify Morton Plant Mease in writing, at a future date, that I have revoked this authorization.

I understand that I do not need to sign this authorization to ensure treatment and it will not affect the status of my account or billing, directly or indirectly.

Signature: ___________________________
o Patient o Parent or Legal Guardian

Date: ____________________________

Print Name, Address and Phone Number:

____
____
____

Witness: ____________________________
Date: ____________________________

MEDICAL AUTHORIZATION
FOR STUDENTS UNDER THE AGE OF 18

STUDENT'S NAME ____ AGE _________

MALE ___________ FEMALE ___________

STREET __________________________________ CITY ____________ STATE ___ ZIP ________

PARENT/GUARDIAN'S NAME ____

PARENT'S HOME PHONE _______________ CELL ______________ WORK PHONE _______________

EMERGENCY PHONE (IN CASE PARENT/GUARDIAN CAN'T BE REACHED) ________________________

TO WHOM IT MAY CONCERN:

I (Parent/Guardian) hereby give consent to any hospital and/or licensed doctor to administer necessary emergency treatment to my child, ____________________________________, in the event of any emergency, provided such treatment is imperative, and I cannot be contacted. I also give my consent for my child to be transported by ambulance if the situation warrants. This authorization is good for one year from the date above.

NAME OF FAMILY PHYSICIAN __________________________________ PHONE ________________

ALLERGIES OF CHILD ____

DATE OF LAST DPT OR TETANUS ____

NAME OF HEALTH INSURANCE COMPANY ____

POLICY NUMBER __________________________________ EXPIRATION DATE _______________

________________________ ____

DATE PARENT/GUARDIAN'S SIGNATURE

NOTARIZATION REQUIRED:

SATE OF FLORIDA COUNTY OF ______________

The foregoing was acknowledge before me this ___________ day of ___________, 2019 by

____.

- ☐ Personally known to me, or
- ☐ Produced identification: ___________________________
- ☐ DID take an oath.

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NOTARY PUBLIC, STATE OF FLORIDA