Dear Counselor/Volunteer Applicants,

Camp Wonder Hands is a unique summer camp for hard-of-hearing and deaf children. This camp originated over 20 years ago as an idea of Marolyn W. Amick, a Child Life Specialist at Prisma Health Children’s Hospital–Midlands. Mrs. Amick, who herself is hard-of-hearing and has a child who is deaf, felt the need to provide an atmosphere where deaf children would be able to identify with others and learn that they are not alone in their experience.

This year Camp Wonder Hands will be held **Sunday, June 21 to Friday, June 26, 2020**, at Camp Kinard in the Batesburg-Leesville community. **There is a mandatory training on Friday, June 19 and Saturday, June 20.** There will be swimming, games, crafts, community presenters, and lots of fun. We need your assistance to make this year’s camp a continued success!

Sign language skills are optional, but strongly encouraged. We are in need of individuals who communicate with the use of sign language who would be interested in serving as an overnight camp counselor. There is a need for full-day and half-day counselors. You may also volunteer to coordinate a particular activity or just be an extra pair of hands to help with a worthy and rewarding cause.

If you are interested in having a wonderful time and becoming involved with the deaf and hard-of-hearing community, please contact us. Please complete all forms of the enclosed application and return the packet to the return address provided or by email as an Adobe PDF attachment. **Counselor application return deadline is Monday, March 16, 2020.** Should you have any questions, feel free to contact E.T. Taylor, Director at CampWonderHands@PrismaHealth.org or call (803) 296-KIDS (5437). We will get back to you as soon as possible.

You will be notified of your acceptance as a Counselor/Volunteer no later than **Monday, April 6, 2020**

Thanks again for your time. We look forward to meeting and working with you. Please feel free to make copies of this packet and pass it on to family, friends, church, etc.

Sincerely,

E.T. Taylor, RN, BSN, Director,
Camp Wonder Hands
Prisma Health Children’s Hospital–Midlands

Marolyn Amick, Founder-Emeritus
Camp Wonder Hands
Prisma Health Children’s Hospital–Midlands

**Disclaimer:** Please be advised as you complete this year’s Camp Wonder Hands application, please do not alter the format of this form. Either print the application and complete it handwritten or type the requested information. Any application submitted in an alternative format will not be accepted. Thank you.
Counselor/Volunteer Application  
For Camping Session Sunday – Friday, June 19-28, 2020

ALL COUNSELORS/VOLUNTEERS MUST BE 18 YEARS OF AGE.

Name:  
Age________________________ Race: ________________________
Date of Birth__________________________________________
Home Address:__________________________________________
County:________________________________________________
Home Phone:___________________________________________
Email Address:__________________________________________
Work/School Address:____________________________________
Work/School Phone:______________________________________
Emergency Contact Name:________________________________
Relationship to Applicant:________________________________
Emergency Contact Phone Numbers:________________________

ANY APPLICANT WHO HAS NOT PREVIOUSLY WORKED WITH C.W.H. MUST PARTICIPATE IN A TELEPHONE INTERVIEW & PROVIDE TWO LETTERS OF REFERENCE PRIOR TO ACCEPTANCE.

References (no immediate family- these references must write letters of recommendation to the interviewers using enclosed form.)

1. ___________________________________________ 2. ___________________________________________

Age Group Preferred  
☐ 7-9 year olds ☐ 10-12 year olds ☐ 13-15 year olds

Certificates Held (example, CPR, First Aid, WSI, ASL): ____________________________

How did you learn about Camp Wonder Hands?: ____________________________
Why do you want to be a Camp Wonder Hands Counselor?  
(In a brief paragraph, explain what qualities and/or special training you have that would make you a good counselor at Camp Wonder Hands. Use additional paper if needed.)

Check all areas in which you have experience:
☐ Arts/Crafts  ☐ Swimming
☐ Song leader  ☐ Campfire programs
☐ Musical instruments  ☐ Signing experience
☐ Ropes Courses  ☐ Sports Games (please describe your level of skill)
☐ Other (specify) Click or tap here to enter text.

If you are not applying as a full-time counselor, what days and times would you be available to help?: _________________________________

T-Shirt Size:
☐ Small  ☐ Medium
☐ Large  ☐ Extra Large
Please attach a recent photograph.

Please return references and application by **Monday, March 16, 2020.**

Camp Wonder Hands  
Attn: E.T. Taylor, Camp Director  
Prisma Health Children’s Hospital–Midlands  
7 Richland Medical Park Drive  
First Floor Admin Suite  
Columbia, S.C. 29203  
CampWonderHands@PrismaHealth.org

If accepted as a full-time counselor, I agree to attend Camp Wonder Hands from Sunday, June 21 through Friday, June 26th. (June 19 and June 20 are mandatory planning/orientation days for all counselors, interpreters, volunteers and staff.)

Signature: ____________________________________________________________

Date: _________________________________

Thank you for your interest in Camp Wonder Hands!
Counselor/Volunteer Health Information Form
For Camping Session June 19-26, 2020

Please note: The following information that you are required to submit will be kept in the strictest confidence in keeping with all healthcare privacy regulations including the Health Insurance Portability and Accountability Act (HIPAA). This information will only be shared with the Co-Directors of the camp representing Camp Wonder Hands and Children’s Hospital–Midlands Administration.

HEALTH HISTORY
Are you in Good Health? ☐ Yes ☐ No

Check any Diagnosis that applies:
☐ Heart Defect/Disease ☐ Asthma
☐ Convulsions/Seizures ☐ Cancer
☐ Diabetes ☐ ADHD/ADD
☐ High Blood Pressure ☐ HIV/AIDS
☐ Kidney Disease ☐ Other Diagnosis

Please explain in detail any Diagnosis checked above:
________________________________________________________________________
________________________________________________________________________

List any physical restrictions or limitations:
________________________________________________________________________
________________________________________________________________________

Describe any recent injuries or surgeries:
________________________________________________________________________

Other medical problems or disabilities:
________________________________________________________________________
________________________________________________________________________

Have you had chickenpox? ☐ Yes ☐ No
Mumps? ☐ Yes ☐ No

Primary Physician:
________________________________________________________________________

Address & Phone #: __________________________________________________________

Primary Dentist:
________________________________________________________________________

Address & Phone #: __________________________________________________________
MEDICATIONS

Are you currently taking any medications?  □ Yes  □ No

If yes, list the drugs: ______________________________________________________

Will this medication be needed during Camp?  □ Yes  □ No

(If medications are needed during camp, please ensure that the Camp Medical Staff is provided with correct medications in the correct amount to cover the time you will be with us.)

ALLERGIES

□ Hay Fever  □ Poison Ivy/Oak
□ Insect Stings  □ Drugs (Penicillin, etc.)
□ Food  □ Others (Specify)  Click or tap here to enter text.

Please explain in detail any allergies checked above: ____________________________________________

IMMUNIZATIONS

Are Immunizations up to date?  □ Yes  □ No

Have you had a Tetanus shot?  □ Yes  □ No

If not in the last 10 years, then you must receive a Tetanus Shot and provide documentation to that effect prior to Camp.

Please indicate any further information about your medical needs or medical history that would be helpful.

__________________________________________________________________________

__________________________________________________________________________

__________________________________________________________________________

__________________________________________________________________________
COMMUNICATION/SOCIALIZATION

How do you communicate?
☐ Sign Language
☐ Lip Reading
☐ Speech
☐ All of the Above

Are you Deaf? ☐ Yes ☐ No
Are you Hard-of-Hearing? ☐ Yes ☐ No
Do you wear a HEARING AID/S? ☐ Yes ☐ No
Do you wear a Cochlear Implant? ☐ Yes ☐ No
Do you use ASL Sign Language? ☐ Yes ☐ No
Do you use another form of Sign Language? ☐ Yes ☐ No
Do you have any other disabilities? ☐ Yes ☐ No

If yes, please explain what disability you are currently managing. ____________________________
________________________________________
________________________________________

SWIMMING

Can you swim? ☐ Yes ☐ No

If yes, how well?: ____________________________
________________________________________

Do you have any limitation that would prevent you from participating in any activities? ☐ Yes ☐ No

If yes, please explain: ____________________________
________________________________________
________________________________________
Full Name: ________________________________________________________________

Date of Birth: ____________________________________________________________

Insurance Company: _______________________________________________________

Effective Date: ____________________________________________________________

If coverage is Medicaid, please give Medicaid number: __________________________

Hospital Preauthorization Needed? ☐ Yes ☐ No

Company Insurance Form Needed? ☐ Yes ☐ No

Telephone number for Pre-Authorizations: ________________________________

Emergency admissions need to be called in within how many working days?: _______

Primary Care Physician’s Name and Phone Number: __________________________

Name of Insured: _________________________________________________________

Date of Birth: ___________________________________________________________

Policy Number: __________________________________________________________

Group Number: __________________________________________________________

Telephone Number for Claim Information: _________________________________

Mailing address for claims: _______________________________________________

(Please send a copy of the front & back of your Insurance Card or Medicaid Card.)
Consent for Photography
Prisma Health Children’s Hospital–Midlands
Camp Wonder Hands
June 19-26, 2020

I, ___________________________________________________________ hereby consent to and authorize the taking of photographs, motion pictures, and/or television pictures while I participate as a Staff Member/Counselor at Camp Wonder Hands. I also consent to the use of any or all such photographs, motion pictures, and/or television pictures by Camp Wonder Hands’ officials, their representatives, or the publication media.

I hereby give permission to Camp Wonder Hands’ officials and/or the publication media to identify me by name in association with the publication of photographs, motion pictures, and/or television pictures taken while I participate as a Staff Member/Counselor at Camp Wonder Hands.

☐ Yes  ☐ No

__________________________________
Print Full Name

__________________________________
Signature

__________________________________
Witness

__________________________________
Date
Consent for Medical Treatment/Hospitalization
Prisma Health Richland Hospital
Camp Wonder Hands
June 19-26, 2020

I, ____________________________ hereby give my consent for Camp Wonder Hands’ officials, its nurses, or other personnel to render and/or obtain medical treatment for me while I participate as a Staff Member/Counselor at Camp Wonder Hands.

Additionally, I hereby authorize Camp Wonder Hands’ officials, its nurses or other personnel to admit the above-named Staff Member/Interpreter to Prisma Health Richland Hospital if it is determined that hospitalization is necessary.

I know and understand that I am financially responsible for the medical care and treatment rendered to me if there is a charge for the medical services provided.

_____________________________________
Print Full Name

_____________________________________
Signature

_____________________________________
Witness

_____________________________________
Date
Counselor/Volunteer Letter of Recommendation

Applicant’s Name:__________________________________________________________

How long have you known the applicant?_______________________________________

In what relationship/capacity did you come to know the applicant?____________________

What qualities does the applicant possess that will make him/her a good counselor at Camp Wonder Hands?

__________________________________________________________________________

__________________________________________________________________________

__________________________________________________________________________

__________________________________________________________________________

__________________________________________________________________________

__________________________________________________________________________

__________________________________________________________________________

Signature

__________________________________________________________________________

Address

__________________________________________________________________________

Home Number

__________________________________________________________________________

Date
Dear Camp Counselor/Volunteer:

In an effort to provide the parents of our campers the assurance that Camp Wonder Hands is a safe environment for their children, Prisma Health Children’s Hospital–Midlands and the Camp Wonder Hands Executive Committee requires each Staff Member, Interpreter, Counselor-in-Leadership-Training and Volunteer to complete a **Staff/Volunteer Security Clearance & Background Check Application. (Required for Non-Prisma Health Employees Only.)**

In order to obtain the required information, we must have the enclosed **Prisma Health Authorization of Release for Processing of Background Screening** completed and returned with your application. You may print the Release Form, completed it and mail it or you may complete and sign it electronically and then email it back to us via our camp email address.

If you have any questions regarding this policy please contact E.T. Taylor, Camp Director at CampWonderHands@PrismaHealth.org or call Children’s Hospital at 803-296-KIDS (5437).

Thank you for your help in making Camp Wonder Hands a secure environment for the campers.

Sincerely Yours,

**Camp Wonder Hands**  
**Executive Committee**  
**Prisma Health Children’s Hospital-Midlands**
Camp Wonder Hands 2020

This year’s theme is:

Camp Wonder Hands Discovers Treasure Island!

Staff/Interpreter/Campers get your thinking caps on, so you can come up with great ideas for skits, cabin themes, fun games, or anything else that will make camp a true blast!!!

See ya’ Soon!

E.T. and the C.W.H. Planning Committee