



2019 INTERNSHIP APPLICATION



NAME _____
FIRST MIDDLE LAST

CHURCH & CITY _____

AGE REQUIREMENTS:

Applicant must be a High School graduate.

BEFORE SENDING APPLICATION TO THE MSM OFFICE, BE SURE YOU:

- Signed in all locations needed
- Complete All Information and Questions
- Staple a Photo of Yourself
- Obtain Personal and Pastoral References Including a Pastoral Signature (Not Signed by Applicant)
- Put the date of last background check and background check cannot be older than 2 years. (ONLY if applicant is 18 years or older)

JUST A REMINDER:

- Deadline for Internship Application - Postmarked by **April 5th, 2019**.
- You will be expected to arrive at GBC on Wed. June 26 and you will be released from your summer internship on Sunday July 28.

Print clearly - form must be completed and signed by all parties, otherwise applications will not be processed and be sent back.

CONTACT INFORMATION:

Please print clearly, ALL fields are required.

Name _____
First Middle Last

Gender at Birth _____ Age _____ Birthdate (MM/DD/YY) _____

Mailing Address (No PO Box) _____ City _____ State _____ Zip _____

Cell Phone Number _____ Email Address _____

FOR OFFICE USE ONLY	
Postmark _____	Approved _____
Letter Sent (Pastoral) _____	Background Check _____

2019 INTERNSHIP APPLICATION

NAME _____

INTERSHIP PREPARATION:

Have you previously served at camp? Yes No
If so, how many years? _____

Background Check Date Completed (if 18 or older):

PERSONAL INFORMATION:

Church Now Attending _____ City _____

- Yes No I have been born again and know my salvation is real. Salvation Date: _____
- Yes No I fully and completely agree with, believe in, and adhere to the tenets of faith of the AG.
- Yes No Do you currently use tobacco?
- Yes No Do you drink alcoholic beverages?
- Yes No Do you use illegal drugs?
- Yes No Have you been found guilty of a crime?
- Yes No Have you ever been the subject of an investigation for child abuse, neglect or endangerment?

If yes, please explain. _____

- Yes No Do you have trouble with anxiety or anxiety related issues?

If yes, please explain. _____

EMERGENCY CONTACT INFORMATION:

Emergency Contact _____ Daytime Phone: _____

Relationship to Participant _____ Cell Phone: _____

By signing below, I understand, agree with, and am willing to abide by the Glacier Bible Camp Guidelines and Camp rules. Lack of cooperation, unnecessary roughness, lack of respect for property, unlawful activity or an unwholesome attitude on the part of any Participant will result in expulsion from camp.

X

applicant signature

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CHURCH HISTORY:

List names and addresses of other churches you have attended regularly during the past five years:

List all previous church work involving children: (List church's name and address, type of work, and dates)

List all previous non-church work involving children: (List each organization's name and address, type of work, and dates)

PASTORAL REFERENCE CERTIFICATION: *The senior pastor or other pastoral staff MUST complete this portion.*

NAME OF STAFF APPLICANT _____

In evaluating the fitness and suitability of each staff applicant, MMN places great reliance on the opinion of those who know the applicant best. Therefore, we are asking the applicant's senior pastor, or other pastoral staff member (choose the one who knows the applicant best) to certify below that there are no facts or allegations that raise any question concerning the applicant's fitness and suitability for working with minors. We also are requesting that the senior pastor, or other pastoral staff member, certify that a background check was performed on the applicant by the applicant's church, if this is the case.

DO NOT USE SOMEONE WHO IS RELATED TO YOU. (Check all that apply)

- I am personally acquainted with the applicant, and in my opinion, he or she is competent and qualified to work with minors of any age.
- I know of no facts or allegations that raise any questions concerning his or her suitability for working with minors in any activity.
- Our church performed a background check on the applicant that included references and a criminal records check. There was no information suggesting that the applicant poses a risk of harm to minors.
- I prefer to discuss my response by telephone. I can be reached at the following telephone number during the day:
Phone Number: _____

Pastor's Signature _____

Type or Print Name _____

I am: (Please check one) the Senior Pastor other Pastoral Staff: _____

Church Phone Number _____ - _____ - _____

Cell Phone Number _____ - _____ - _____

PASTORAL REFERENCE CERTIFICATION

PLEASE PRINT

PARTICIPANT'S LAST NAME: _____ FIRST NAME: _____

AGREEMENT FOR RELEASE AND ASSUMPTION OF RISK; AND PHOTOGRAPH & VIDEO RELEASE

I understand that I am being asked to read the following agreements carefully. I understand that if I wish to discuss any of the terms contained in this agreement, I may contact the Network Office, 406-652-2417.

READ THIS DOCUMENT ("AGREEMENT") CAREFULLY BEFORE SIGNING

Participation Agreement

IN CONSIDERATION of my acceptance as camp staff at Montana Ministry Network- Glacier Bible Camp or/and EMBC for the activities land risk located in #2 below and other considerations the sufficiency of which is acknowledged, represent and agree that:

1. Status. I attest and certify that I am physically fit and have no medical conditions that would prevent me from participating in the below-referenced activities.
2. Risks of activity. I am aware of the hazards and risks to my person associated with participating in this Camp. Participant named above (the "Participant"), does hereby consent to the participation of the Participant in the activities of the 2019 Montana District Council. Activities include, but not limited to outdoor activities in which participants may be subject to hazardous plants and bites from insects, ticks, mosquitos, spiders, and snakes. Other activities include swimming which may involve water and mud, team games such as basketball, volleyball, soccer, and others, recreational games (relay race style, tug-of-war, etc.) Participant represents that Participant is in good health and in proper physical condition to participate in the above-referenced activities. Further, Participant certifies that Participant is physically able and adequately trained to participate in such events, specifically swimming. Participant hereby understand and acknowledge the physical rigors associated with the above-referenced activities and/or use of such equipment and understand that participation involves risks and dangers which include, without limitation, serious bodily injury, permanent disability, disease, strains, fractures, partial and/or total paralysis, eye injury, blindness, heat stroke, heart attack or death, inaccessibility of medical care, dangers arising from adverse weather conditions, inadequate safety measures, participants of varying skill levels, situations beyond the immediate control of Montana District Council, other undefined harm or damage which may not be readily foreseeable, and other presently unknown risks and dangers (collectively the "Risks"). Participant understands these Risks may be caused in whole or in part by Participant's own actions or inactions, the actions or inactions of others participating in the activities. I have made my own investigation of these risks, understand these risks, and assume them knowingly and willingly.

I understand and agree that if, during my participation in the above-described activities, if I have suffered an injury, or am otherwise in a situation that raises significant health and safety concerns, then a representative of the Montana District Council may contact the person whose name I have provided as my "emergency contact". I understand that the Montana District Council ordinarily will not initiate such contact without first having a discussion with me.

3. GENERAL RELEASE AND ASSUMPTION OF RISK:

KNOWING THE RISKS DESCRIBED ABOVE, I AGREE, ON BEHALF OF MY FAMILY, HEIRS, AND PERSONAL REPRESENTATIVES, TO ASSUME ALL THE RISKS AND RESPONSIBILITIES SURROUNDING MY PARTICIPATION IN THE ABOVE-DESCRIBED ACTIVITIES, BOTH KNOWN AND UNKNOWN. TO THE MAXIMUM EXTENT ALLOWED BY LAW, I RELEASE, HOLD HARMLESS, AND AGREE TO INDEMNIFY MONTANA DISTRICT COUNCIL AND THEIR OFFICERS, DIRECTORS, EMPLOYEES, VOLUNTEERS, AND AGENTS, FROM AND AGAINST ANY PRESENT OR FUTURE CLAIMS, LOSSES, LIABILITIES, COSTS AND EXPENSES FOR INJURY TO PERSON OR PROPERTY, OR FOR ANY OTHER DAMAGE, WHICH I MAY SUFFER, OR FOR WHICH I MAY BE LIABLE TO ANY OTHER PERSON, RELATED TO MY PARTICIPATING IN SAID ACVITITIES (INCLUDING PERIODS IN TRANSIT TO OR FROM MY DESTINATIONS), RESULTING FROM ANY CAUSE, INCLUDING BUT NOT LIMITED TO NEGLIGENCE ON MY PART OR ON THE PART OF ANY OF THE RELEASED PARTIES; PROVIDED THAT THIS RELEASE OF LIABILITY SHALL NOT APPLY TO GROSS NEGLIGENCE OR WILLFUL OR WANTON MISCONDUCT.

4. I expressly waive any defense to the enforcement of any provision of this commitment arising from a claim of lack of consideration and warrant that this commitment constitutes a legal, valid, and binding obligation upon me enforceable against me in accordance with its terms.
5. Invalidation of any one or more of the provisions of this Agreement shall in no way affect any of the other provisions hereof, which shall remain in full force and effect.
6. I expressly agree that this assumption of risk, release, and indemnity agreement is intended to be as broad and inclusive as permitted by law. I further state that I HAVE CAREFULLY READ THIS AGREEMENT AND UNDERSTAND ITS CONTENTS, AND I VOLUNTARILY SIGN THIS AGREEMENT AS MY OWN FREE ACT.

I certify that I am age 18 or older. I understand and agree that no oral or written representations can or will alter the contents of this document. This Agreement shall be governed and construed in accordance with the laws of the State of Montana, excluding its choice of law rules, and all claims relating to or arising out of this Agreement, including claims for injuries or wrongful death in any way related to the above-described activities, shall likewise be governed by the laws of the State of Montana, excluding its choice of law rules.

Signature _____ Date: _____
(Participant)

INTERN HEALTH HISTORY FORM AND AUTHORIZATION:

PLEASE PRINT

PARTICIPANT'S LAST NAME _____ FIRST NAME _____ BIRTHDATE _____ GENDER _____

MOTHER/GUARDIAN NAME _____ FATHER/GUARDIAN NAME _____

EMERGENCY CONTACT PHONE NUMBER _____

FAMILY PHYSICIAN

NAME _____

PHONE _____

INSURANCE Yes No Is participant covered by insurance?

Camp insurance is accident-only coverage and is secondary to personal insurance.

INSURANCE CO. _____

GROUP # _____ SUBSCRIBER # _____

HEALTH HISTORY

Please check YES or NO to the following lead questions—if the response is YES you will have below to add more detail.

Does Participant have **CHRONIC HEALTH ISSUES** Yes No

Is Participant taking any form of **MEDICATION** for any reason? Yes No

Does Participant have **DIET RESTRICTIONS** Yes No

Does Participant have **ACTIVITY RESTRICTIONS** Yes No

Date of Last Tetanus _____

Are Participant's immunizations current? Yes No

Does the Participant sleep walk? Yes No

Can the Participant swim? Yes No

Is the Participant presently being treated for an injury or sickness or taking any form of medication for any reason? Yes No If yes, please explain: _____

Please list any and all diseases, serious illness, injuries and surgeries the Participant has or has had: _____

Does the Participant have any physical condition or illness which would prevent him/her from participating in rigorous activity? Yes No

If yes, please explain: _____

Does Participant have any of the health conditions on the chart below? Check all that apply.

	CONDITION	YES	NO		CONDITION	YES	NO
1	Asthma			Inhaler? Yes No	7	Bleeding	
2	Diabetes			Insulin? Yes No	8	Bee Sting Allergy	Epi Pen? Yes No
3	Epilepsy/Seizures				9	Peanut/Nut Allergy	Epi Pen? Yes No
4	Heart Condition				10	Other Food Allergy	Epi Pen? Yes No
5	Orthopedic				11	Drug Allergy	Epi Pen? Yes No
6	Fainting				12	Anaphylaxis reaction	Epi Pen? Yes No

Please list medications, foods, diet restrictions or environmental allergens that Participant is allergic to and the allergy reaction if not mentioned above: _____

MEDICATIONS

Does the Participant require any medications to be administered? Yes No

If yes, please list below all medications with dosage, frequency/time and reason for dispensing.

***Any personal medications (prescription and/or over-the-counter, including pain meds such as ibuprofen, Tylenol, etc.) MUST be brought in the original bottle to the nurse station to be administered to Participant. All meds must be original container with pharmacy label including patient name, physician name, medication name, prescription number, date prescribed, and dosage.* This DOES NOT include over-the-counter daily vitamins.

Permission is given for the following over-the-counter medications to be given to Participant as directed per age/weight:

- | | |
|--|--|
| <input type="checkbox"/> Yes <input type="checkbox"/> No Acetaminophen | <input type="checkbox"/> Yes <input type="checkbox"/> No Pepto Bismal |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Ibuprofen | <input type="checkbox"/> Yes <input type="checkbox"/> No Calamine Lotion |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Benadryl | <input type="checkbox"/> Yes <input type="checkbox"/> No Antibiotic Ointment |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Robitussin DM | <input type="checkbox"/> Yes <input type="checkbox"/> No Antacid(Tums,etc.) |

MEDICATION	DOSAGE	FREQUENCY	REASON

MEDICAL TREATMENT AUTHORIZATION

We, THE PARENTS AND/OR GUARDIANS OF Participant ("Parents"), and Participant (if 18 or over) understand that the undersigned Parents will be notified in the case of a medical emergency involving the Participant. However, in the event that Parents, or either of us, cannot be reached, and/or if Participant 18 or over is unable to make decisions, we authorize the calling of a doctor and the providing of necessary medical services in the event the Participant is injured or becomes ill. We authorize any one or more of the following persons to make emergency medical care decisions on behalf of the Participant, if required by law or a health care provider: Camp director or their authorized designee.

Parents and Participant (if 18 or over) understand that Montana District Council or any of their agents, employees, or volunteers, shall not be responsible for medical expenses incurred on the basis of this authorization. We hereby agree to hold harmless, defend and indemnify Montana District Council, its parents, subsidiaries and affiliates, board members, officers, employees, agents and volunteers from all obligations, damages, losses, attorney's fees, defense costs, demands, investigations, actions, liabilities, claims, cross-actions, third-party actions, causes of action, of any kind or nature whatsoever, including the negligence or gross negligence of Montana District Council (collectively "claims") that may be asserted by anyone and that has any relation to the Participant to the fullest extent permitted by law. It is our express intention to defend, indemnify and hold harmless Montana District Council from all claims arising out of or resulting from or in any manner relating to the treatment, medical or otherwise, of Participant.

We agree to notify Montana District Council in the event of any health changes which would restrict the Participant's participation in any activities. We also understand that Montana District Council representative(s) reserve the right to restrict the Participant from any activity for any reason. **A photocopy or facsimile of this authorization shall be as valid as the original.**

Parent/Guardian Signature: _____

Date: _____

Parent/Guardian Signature: _____

Date: _____

Participant (if 18 or over) Signature: _____

Date: _____