Volunteer Registration for The Great Gluten Escape Camp

June 14 – 19, 2009

Please return completed form to The Great Gluten Escape Camp, 1019 Rockefeller Lane, Allen, TX 75002.
For more information, contact Diana Webb, GGE Registrar at registrar@greatglutenescape.org or 972-727-4654.

Volunteer Information:

Name: _____ Age:_____ DOB:_____ Gender:____
Last First Middle I.

Address: _____ _____
Street City State Zip Driver License # State

Phone: (____) _____ (____) _____ _____
Home Cell/Other Email

*Diagnosed Celiac: ○ Yes ○ No | Gluten Intolerant: ○ Yes ○ No | Dairy/ Casein Free Diet: ○ Yes ○ No (If checked yes, you will be required to eat DFCF at camp)

The camp will serve gluten-free food and accommodate dairy/casein free and nut free diets. Effective in 2009, we will not accommodate any other special dietary restrictions. There will be no exceptions to this policy. We cannot guarantee that all food products used at camp have been manufactured in gluten-free and/or nut-free facilities.

T-Shirt Size: Adult: ○ S ○ M ○ L ○ XL

*Ethnicity: ○ Black ○ Hispanic ○ Asian/Pacific Islander ○ Native American ○ Caucasian

EMERGENCY NOTIFICATION:

_____ (____) _____ (____) _____ _____
Name Phone Other Phone Relationship to Counselor

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HEALTH HISTORY:

Allergies: *(Check all that apply and explain)*

○ Animals _____ ○ Soy _____ ○ Nuts _____
○ Food _____ ○ Plants/Pollen_____ ○ Medicines/Drugs _____
○ Insect Bites/Stings_____ ○ Peanuts _____ ○ Other _____

If severe allergic reaction occurs, is an epi pen necessary? ○ Yes ○ No If, yes, include epi pen with medications.

Check if you wear: ○ Contacts ○ Glasses ○ Dental Appliance ○ Other _____

Chronic /Recurring Conditions: *(Check all that apply)*

○ Asthma / Respiratory Problems	○ Diabetes	○ Emotional Disturbances	○ Headaches	○ Bleeding / Clotting Disorder	○ Hearing Impairment
○ Kidney Disease	○ Ear Infection	○ Sickle Cell Trait or Disease	○ Fainting	○ Hypertension	○ Musculoskeletal Disorders
○ Heart Disease	○ Seizures	○ Epilepsy	○ Nosebleeds	○ Constipation	○ Other_____

May be Given: *(Check all that apply)*
All medications are gluten-free

○ Acetaminophen	○ Insect Repellent	○ Benadryl	○ Antiseptic Ointment
○ Ibuprofen	○Sunscreen	○ Calamine	○ Claritin

How did you hear about us: _____

VOLUNTEER QUESTIONNAIRE:

Which age level would you prefer? Please mark 1st, 2nd, 3rd choice. (We cannot guarantee choice.) ___age 7-9 ___age 10-12 ___age 13-15

What experiences have you had with kids other than your own? _____

_____

What are your outdoor experiences? (camping, outdoor cooking, etc.) _____

_____

REFERENCES (CANNOT be related)-- Please list name, email, phone number, and address (we use email when possible).

1_____ _____ _____ _____
Name Email Phone Address

2_____ _____ _____ _____
Name Email Phone Address

3_____ _____ _____ _____
Name Email Phone Address

*Information collected for statistics for grant writing purposes.