

# Division of Youth Weekends

Application for Staff, ages 21 and under

**You must be at least a rising 10<sup>th</sup> grader to staff a Junior High DOY Weekend. We must have your completed application in the diocesan office by October 16th.**

**Staff members must be present for the entire Junior High DOY Weekend (Oct. 31-Nov. 2, 2008). To help keep the cost of DOY weekends low, staff members must pay a fee of \$30, payable at registration.**

**Please mail your application to: The Rev. Patrick Sanders, P.O. Box 23107, Jackson, MS 39225  
Or Fax your application to the diocesan office (601-354-3401)  
If you have any questions please contact Patrick @ 662-695-1641 or  
patrick@stjamesgreenville.com**

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Name: \_\_\_\_\_ Name Called By: \_\_\_\_\_

Address: \_\_\_\_\_ City, State, Zip: \_\_\_\_\_

Email (*please print very clearly*): \_\_\_\_\_

Home Phone: \_\_\_\_\_ Birthdate: \_\_\_\_\_ Age: \_\_\_\_\_

Home Church: \_\_\_\_\_ City: \_\_\_\_\_ Priest: \_\_\_\_\_

Parent's Name: \_\_\_\_\_ Parent's Email: \_\_\_\_\_

Grade/Year in College Just Completed: \_\_\_\_\_

If in college, name of college attending: \_\_\_\_\_

If employed, place of employment: \_\_\_\_\_

Have you attended a DOY Weekend (circle one)? Y N List years: \_\_\_\_\_

Have you staffed a DOY Weekend (circle one)? Y N List years: \_\_\_\_\_

*Please answer the following questions in the space provided.*

How are you active in your church and/or in diocesan activities?

Why do you wish to serve as a staff member for a DOY Weekend?

**\*\*\*\*\*The Health Certificate on the back of this form MUST be completed for applicants to be considered for DOY staff.\*\*\*\*\***

**HEALTH CERTIFICATE**

**All ages must complete the following information. If you are a high school student (ages 18 or under), your parents must sign the health certificate where indicated.**

Have you had permanent immunization against tetanus (circle one)? Yes\_\_\_ No\_\_\_ Date of last booster:\_\_\_\_\_

Do you have any allergies, including but not limited to: medicines, food, insect bites or stings? Yes\_\_\_ No\_\_\_  
If yes, please list type of allergy, reaction, and treatment required:\_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

Do you require any regular or occasional medicines? Yes\_\_\_ No\_\_\_  
If yes, please list medications with instructions and be prepared to hand them over to the medical staff at registration:\_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

Is there any other information of a medical nature of which the DOY coordinator and medical staff should be aware (asthma, epilepsy, etc.)?\_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

Parent or person(s) to notify in case of emergency:\_\_\_\_\_

Home Phone:\_\_\_\_\_ Work Phone:\_\_\_\_\_ Cell Phone:\_\_\_\_\_

**In case of emergency, I give my permission to the physician selected by the DOY coordinators and/or medical staff to hospitalize and/or secure proper treatment for my child as deemed necessary.**

\_\_\_\_\_  
**Applicant's Signature**

\_\_\_\_\_  
**Date**

**If applicant is in high school (18 or under), parent MUST sign also.**

\_\_\_\_\_  
**Parent's or Guardian's Name (please print)**

\_\_\_\_\_  
**Parent's or Guardian's Signature**

**Insurance Carrier and Policy Number:**\_\_\_\_\_

**\*\*\*\*\*Please attach a front and back copy of your insurance card.\*\*\*\*\***