

VOLUNTEER HISTORY:

Please list your last three volunteer activities, beginning with the most recent.

PERSONAL REFERENCES:

Please list the name, address and telephone number of three individuals who are sufficiently familiar with you to describe your character.

(Name) (Address) (Phone Number)

Name) (Address) (Phone Number)

Name) (Address) (Phone Number)

Signature of Applicant Data

Return the completed form to:
Ray Bosenbecker
1920 Lanchester Ct.
Chesterfield, MO 63017

ULSTER PROJECT – ST. LOUIS COUNSLEOR HEALTH FORM

Understanding the specific needs of the Ulster Project teens helps us ensure they have a more successful and safe summer. **We ensure that all the following information will be kept strictly confidential and is not for dissemination. At no time during the application process will anyone be discriminated due the to information given below.**

NAME: _____

HEIGHT: _____ WEIGHT: _____

HEALTH HISTORY - PLEASE Mark Yes or No

	YES	NO
Asthma	_____	_____
Hearing Loss	_____	_____
Attention Deficit Disorder	_____	_____
Diabetes	_____	_____
Hepatitis A, B or C	_____	_____
Scoliosis	_____	_____
Tuberculosis	_____	_____
Special Diet/Vegetarian	_____	_____
Anxiety Disorder	_____	_____
Seizures	_____	_____
Attention Deficit Hyperactivity	_____	_____
Heart Problems	_____	_____
Human Immunodeficiency	_____	_____
Allergies	_____	_____
Eye Vision Problems	_____	_____
Blood Disorders	_____	_____
Daily Medication	_____	_____

If you have answered yes to any of the above, please explain below: