



2011 LIFEGUARD APPLICATION PACKET

Milford Recreation Department

70 West River Street
Milford, CT 06460

Dear Applicant,

First I would like to say thank you for showing interest in employment with the Milford Recreation Department. This packet contains all of the necessary paperwork that you will need to apply for a LIFEGUARD. Please take time to read, complete and return ALL of the forms and return them to the Recreation Department **BEFORE March 31st, 2011.** Applications received after March 31st will be kept on file for any positions open after the initial hiring process.

To become a LIFEGUARD, you must first meet the following criteria:

- Applicants must be 16 years of age.
- Possess a CURRENT Lifeguard Training Certification (those currently enrolled in a class can apply)
- Possess a CURRENT CPR for the Professional Rescuer Certification (those currently enrolled in a class can apply)
- Possess the physical ability to perform all duties and skills of a Lifeguard
- Complete and return **ALL** paperwork contained in this packet to the Recreation Department as soon as possible.
 - a. Employment Application
 - b. Copies of the following (must be legible):
 1. State Issued Photo Identification (Driver's License, Identification Card, Passport, etc.)
 2. Certification cards (LGT, CPR, etc.).
 3. Any other pertinent certifications, licenses, etc.
 - c. Statement of Physical Examination. Exam must have taken place within 12 months of the tentative date of employment (June, 2011). A copy of a recent High School or College physical is acceptable.

You will receive notification of the employment process by either phone or mail by April 8th. If you do not receive notice by then, please contact my office immediately.

The employment process consists of the following:

1. A **Practical Exam** will be given to assess the current physical ability and knowledge of skills:
 - a. A 500yd swim
 - b. A 50yd and 100yd swim (sprint)
 - c. Rescue Scenarios, which can include but not limited to:
 - Active Victim
 - Passive Victim
 - Submerged Victim
 - Multiple Victim
 - Spinal management
 - Brick Recovery and Swim
 - Victim Removal
 - Equipment Based Rescue
2. An **Interview/Written Test** will be given to assess knowledge of Lifeguard Training, First Aid and CPR skills.

Applicant's scores will be totaled. A second interview will be given to prospective Lifeguard Candidates that scored the highest on their combined scores. Once the positions are filled, applications and scores will remain on file (for the remainder of the year) for future staff openings.

If you have any questions or concerns, please contact my office by email [mjacobson@ci.milford.ct.us](mailto:mjacobsen@ci.milford.ct.us) or by phone (203) 783-3387.

Good Luck,

Michael Jacobsen
Recreation Supervisor

MILFORD RECREATION DEPARTMENT EMPLOYMENT APPLICATION

NAME (Last, First, MI)	DATE OF BIRTH	AGE	APPLICATION DATE
ADDRESS (Street, City, State, ZIP)			SOCIAL SECURITY #
EMAIL (please print neatly)	HOME PHONE	CELL PHONE	
EMERGENCY CONTACT (Name)	EMERGENCY CONTACT (Relation)	EMERGENCY CONTACT (Phone)	

POSITION APPLYING FOR: (Check all that apply)	CURRENT CERTIFICATIONS:		
	Expiration Date	Certification Agency	Location
Lifeguard - Pool <input type="checkbox"/>	Lifeguard Training	_____	_____
Lifeguard - Beach <input type="checkbox"/>	CPR / FPR	_____	_____
Water Safety Aide <input type="checkbox"/>	W.S.I.	_____	_____
Water Safety Instructor <input type="checkbox"/>	Safe Boating or PWC	_____	_____
Parking Attendant <input type="checkbox"/>	SCUBA	_____	_____
Pool Attendant <input type="checkbox"/>	_____	_____	_____
Other (Please Specify) <input type="checkbox"/>	_____	_____	_____

EMPLOYMENT RECORD (List Three / List Latest Employer First):

FROM Month/Year	TO Month/Year	EMPLOYER Name / Address / Phone	Type of Occupation	Reason Terminated	Rate of Pay

Have you ever been employed by the City of Milford? YES / NO
 What department, dates of employment and reason for leaving. _____

Do you have any relatives employed by the City of Milford? YES / NO
 Please give Name, Relationship and Department. _____

Do you have any friends employed by the Recreation Department? YES / NO
 Please give Name(s) _____

Valid Drivers License? YES / NO License # _____ Your own transportation? YES / NO

Have you ever been convicted of a crime? YES / NO If so, give details _____

APPLICANTS NAME (LAST, FIRST) _____

EDUCATION	NAME OF SCHOOL Address	HIGHEST GRADE COMPLETED	DID YOU GRADUATE Degree
High School			
College (Major)			
Other			

EXTRACURRICULAR ACTIVITIES (Clubs, Organizations, Sports, Hobbies):

EXPERIENCE IN THE POSITION YOU ARE APPLYING FOR (Skills, Talents, Etc):

PERSONAL REFERENCES (List Three - No Relatives):

NAME	ADDRESS	TELEPHONE

I certify that the facts set forth on this application are true and complete. I understand that false statements may be considered sufficient cause for rejection or termination if hired.

APPLICANTS SIGNATURE

DATE

DO NOT WRITE BELOW THIS LINE (For Office Use Only)

_____ PRACTICAL _____ / 60	<input type="checkbox"/> W-4	<input type="checkbox"/> LGT	_____
_____ INTERVIEW _____ / 40	<input type="checkbox"/> CT-W4	<input type="checkbox"/> CPR / FPR	_____
TOTAL SCORE _____ / 100	<input type="checkbox"/> I-9	<input type="checkbox"/> WSI	_____
	<input type="checkbox"/> HAR	<input type="checkbox"/> DEP SBC	<input type="checkbox"/> DEP PWO

HIRED ? **YES / NO**

PAY RATE _____

DATE OF HIRE _____

PAYROLL ID # _____

START DATE _____

REMARKS _____

RECREATION SUPERVISOR

DATE
2011 Employment Application - Aquatics



State of Connecticut Department of Education Health Assessment Record



To Parent or Guardian:

In order to provide the best educational experience, school personnel must understand your child's health needs. This form requests information from you (Part I) which will also be helpful to the health care provider when he or she completes the medical evaluation (Part II).

State law requires complete primary immunizations and a health assessment by a legally qualified practitioner of medicine, an advanced practice registered nurse or registered nurse, a physician assistant or the school medical advisor prior to school entrance in Connecticut (C.G.S. Secs. 10-204a and 10-206). An immunization update and additional health assessments are required in the 6th or 7th grade and in the 9th or 10th grade. Specific grade level will be determined by the local board of education. This form may also be used for health assessments required every year for students participating on sports teams.

Please print

Student Name (Last, First, Middle)	Birth Date	<input type="checkbox"/> Male <input type="checkbox"/> Female
Address (Street, Town and ZIP code)		
Parent/Guardian Name (Last, First, Middle)	Home Phone	Cell Phone
School/Grade	Race/Ethnicity	<input type="checkbox"/> Black, not of Hispanic origin
Primary Care Provider	<input type="checkbox"/> American Indian/ Alaskan Native	<input type="checkbox"/> White, not of Hispanic origin
	<input type="checkbox"/> Hispanic/Latino	<input type="checkbox"/> Asian/Pacific Islander
		<input type="checkbox"/> Other
Health Insurance Company/Number* or Medicaid/Number*		
Does your child have health insurance?	Y N	If your child does not have health insurance, call 1-877-CT-HUSKY
Does your child have dental insurance?	Y N	

* If applicable

Part I — To be completed by parent/guardian.

Please answer these health history questions about your child before the physical examination.

Please circle **Y** if "yes" or **N** if "no." Explain all "yes" answers in the space provided below.

Any health concerns	Y	N	Hospitalization or Emergency Room visit	Y	N	Concussion	Y	N
Allergies to food or bee stings	Y	N	Any broken bones or dislocations	Y	N	Fainting or blacking out	Y	N
Allergies to medication	Y	N	Any muscle or joint injuries	Y	N	Chest pain	Y	N
Any other allergies	Y	N	Any neck or back injuries	Y	N	Heart problems	Y	N
Any daily medications	Y	N	Problems running	Y	N	High blood pressure	Y	N
Any problems with vision	Y	N	"Mono" (past 1 year)	Y	N	Bleeding more than expected	Y	N
Uses contacts or glasses	Y	N	Has only 1 kidney or testicle	Y	N	Problems breathing or coughing	Y	N
Any problems hearing	Y	N	Excessive weight gain/loss	Y	N	Any smoking	Y	N
Any problems with speech	Y	N	Dental braces, caps, or bridges	Y	N	Asthma treatment (past 3 years)	Y	N
Family History						Seizure treatment (past 2 years)	Y	N
Any relative ever have a sudden unexplained death (less than 50 years old)						Diabetes	Y	N
Any immediate family members have high cholesterol						ADHD/ADD	Y	N

Please explain all "yes" answers here. For illnesses/injuries/etc., include the year and/or your child's age at the time.

Is there anything you want to discuss with the school nurse? Y N If yes, explain:

Please list any **medications** your child will need to take **in** school:

*All medications taken in school require a separate **Medication Authorization Form** signed by a health care provider and parent/guardian.*

I give permission for release and exchange of information on this form between the school nurse and health care provider for confidential use in meeting my child's health and educational needs in school.

Signature of Parent/Guardian

Date

Part II — Medical Evaluation

Health Care Provider must complete and sign the medical evaluation and physical examination

Student Name _____ Birth Date _____ Date of Exam _____

I have reviewed the health history information provided in Part I of this form

Physical Exam

Note: *Mandated Screening/Test to be completed by provider under Connecticut State Law

*Height _____ in. / _____% *Weight _____ lbs. / _____% BMI _____ / _____% Pulse _____ *Blood Pressure _____ / _____

	Normal	Describe Abnormal	Ortho	Normal	Describe Abnormal
Neurologic			Neck		
HEENT			Shoulders		
*Gross Dental			Arms/Hands		
Lymphatic			Hips		
Heart			Knees		
Lungs			Feet/Ankles		
Abdomen			*Postural <input type="checkbox"/> No spinal abnormality <input type="checkbox"/> Spine abnormality: <input type="checkbox"/> Mild <input type="checkbox"/> Moderate <input type="checkbox"/> Marked <input type="checkbox"/> Referral made		
Genitalia/ hernia					
Skin					

Screenings

*Vision Screening			*Auditory Screening			Lead:	Date
Type:	<u>Right</u>	<u>Left</u>	Type:	<u>Right</u>	<u>Left</u>		
With glasses	20/	20/	<input type="checkbox"/> Pass	<input type="checkbox"/> Pass	<input type="checkbox"/> Fail	<input type="checkbox"/> Fail	
Without glasses	20/	20/	<input type="checkbox"/> Referral made				
<input type="checkbox"/> Referral made			<input type="checkbox"/> Referral made			*HCT/HGB:	
						Other:	

TB: High-risk group? No Yes PPD date read: _____ Results: _____ Treatment: _____

***IMMUNIZATIONS**

Up to Date or Catch-up Schedule: **MUST HAVE IMMUNIZATION RECORD ATTACHED**

***Chronic Disease Assessment:**

Asthma No Yes: Intermittent Mild Persistent Moderate Persistent Severe Persistent Exercise induced
If yes, please provide a copy of the Asthma Action Plan to School

Anaphylaxis No Yes: Food Insects Latex Unknown source

Allergies *If yes, please provide a copy of the Emergency Allergy Plan to School*

History of Anaphylaxis No Yes Epi Pen required No Yes

Diabetes No Yes: Type I Type II

Other Chronic Disease:

Seizures No Yes, type: _____

This student has a developmental, emotional, behavioral or psychiatric condition that may affect his or her educational experience.
Explain: _____

Daily Medications (*specify*): _____

This student may: participate fully in the school program
 participate in the school program with the following restriction/adaptation: _____

This student may: participate fully in athletic activities and competitive sports
 participate in athletic activities and competitive sports with the following restriction/adaptation: _____

Yes No Based on this comprehensive health history and physical examination, this student has maintained his/her level of wellness.
Is this the student's medical home? Yes No I would like to discuss information in this report with the school nurse.

Signature of health care provider MD / DO / APRN / PA	Date Signed	Printed/Stamped Provider Name and Phone Number
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Immunization Record

To the Health Care Provider: Please complete and initial below.

Vaccine (Month/Day/Year) Note: *Minimum requirements prior to school enrollment. At subsequent exams, note booster shots only.

	Dose 1	Dose 2	Dose 3	Dose 4	Dose 5	Dose 6
DTP/DTaP	*	*	*	*		
DT/Td						
Tdap						
IPV/OPV	*	*	*			
MMR						
Measles	*	*				
Mumps	*					
Rubella	*					
HIB	*				Students under age 5	
Hep A						
Hep B	*	*	*			
Varicella	*					
PCV					Pneumococcal conjugate vaccine	
Meningococcal						
HPV						
Flu						
Other						

Disease Hx _____
of above (Specify) (Date) (Confirmed by)

Exemption

Religious _____ **Medical: Permanent** _____ **Temporary** _____ **Date** _____
 Recertify Date _____ Recertify Date _____ Recertify Date _____

Immunization Requirements for Newly Enrolled Students at Connecticut Schools

KINDERGARTEN DTaP: At least 4 doses. The last dose must be given on or after 4th birthday
 Polio: At least 3 doses. The last dose must be given on or after 4th birthday
 MMR: 1 dose on or after the 1st birthday
Measles: Second dose of measles vaccine (or MMR), given at least 4 weeks after the first dose
 Hib: Children less than 5 yrs of age need 1 dose at 12 months or older Children 5 and older do not need proof of Hib vaccination
 Hep B: 3 doses
 Varicella: 1 dose on or after the 1st birthday or verification of disease

GRADES 1-6 DTaP /Td/Tdap: At least 4 doses. The last dose must be given on or after 4th birthday
 Students who start the series at age 7 or older only need a total of 3 doses
 Polio: At least 3 doses. The last dose must be given on or after 4th birthday
 MMR: 1 dose on or after the 1st birthday
Measles: Second dose of measles vaccine (or MMR), given at least 4 weeks after the first dose
 Hep B: 3 doses
 Varicella: 1 dose on or after the 1st birthday or verification of disease

GRADES 7-12 Td/Tdap: At least 3 doses. The last dose must be given on or after 4th birthday. Students who start the series at age 7 or older only need a total of 3 doses
 Polio: At least 3 doses. The last dose must be given on or after 4th birthday
 MMR: 1 dose on or after the 1st birthday
Measles: Second dose of measles vaccine (or MMR), given at least 4 weeks after the first dose
 Hep B: 3 doses
 Varicella: 1 dose on or after first birthday or verification of disease:
VARICELLA VACCINE: For students <13 years of age, 1 dose given on or after the 1st birthday. For students 13 years of age or older, 2 doses given at least 4 weeks apart
VERIFICATION OF DISEASE: Confirmation in writing by a MD, PA, or APRN that the child has a previous history of disease, based on family or medical history

_____ Initial/Signature of health care provider MD / DO / APRN / PA	_____ Date Signed	_____ Printed/Stamped Provider Name and Phone Number
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