

Dear Counselor-In-Training Applicant:

Attached to this letter is an application for volunteering as a Counselor-In-Training for the Malta Summer Recreation Program. You must be 15 years old by July 1, 2026 to apply for this program.

The camp begins on Tuesday, July 7, 2026 and continues until Friday, August 14, 2026. The basic hours are from 9:00am-12:45pm. Orientation will be held on Monday, July 6, 2026 at the Malta Community Center.

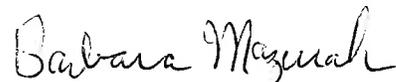
Please complete the attached forms and return to me at the

David R. Meager Malta Community Center
Attention: Barbara Mazurak
One Bayberry Drive
Malta, New York 12020

When I receive the application, I will contact you to confirm your participation as a Counselor-In-Training in the Malta Summer Recreation Program for 2026.

In this letter there will be more details about the orientation. Please remember to include a letter of reference with your application and a copy of your immunization record from your doctor.

Sincerely yours,



Barbara Mazurak

Malta Youth Director



Town of Malta

Counselor-In-Training

2026 CIT Application

Department of Parks, Recreation & Human Services
One Bayberry Drive
Malta, NY 12020 518-899-4411

Name _____ Home Phone _____

Cell Phone _____

Street Address _____ E-Mail _____

City/Zip _____ Grade (as of Fall 2026) _____

Check the Summer Camp You Prefer: Malta Community Park _____ Shenantaha Creek Park _____

The Counselor in Training (CIT) program is a unique leadership opportunity designed to teach motivated young adults to work with children. It is a volunteer position meant to guide children into leadership positions. Select candidates will assist counselors with crafts and activities. Duties may vary from day to day. **To be considered to be a Counselor-In-Training, you must be 15 years of age by July 1, 2026.** Your application must be completely filled out and include current immunization forms. If a CIT is required on a trip, the trip fees are waived. There are no registration fees for this program. **For more information, please call 518-899-4411 ext. 304.**

One written letter of reference must be attached with your paperwork.

Why are you interested in becoming a Counselor in Training?

What experience do you have working with children?

What do you hope to gain by participating in the Counselor in training program?

Return with— _____ all pages completed with required signatures

_____ current immunization forms

_____ one letter of reference

MEDICATION AUTHORIZATION FOR THE USE OF EPI-PENS &/OR INHALERS

This form is to be filled out **ONLY** if your child needs to carry an epi-pen or an inhaler and must be completed by your child's physician.

The Town of Malta Summer Recreation Program is a day camp and Malta staff is not allowed to dispense medication. The Department of Health regulations prohibit the administration of medicine, including but not limited to Benadryl, Tylenol, aspirin, Advil, or Motrin by an unlicensed individual. The two exceptions are asthma inhalers and epi-pens which camp personnel are permitted to assist in administering. This form is for permission to carry **ONLY** epi-pens and/or inhalers. No other medication can be brought to camp.

*** It is important that your child is educated about the signs and treatment of anaphylaxis as this knowledge will significantly improve the safety of your child. You are required to bring your child into the Department of Parks, Recreation and Human Services office to demonstrate that they can self-administer the epi-pen and/or inhaler and they can tell people around them about their allergy and what they can do in the event of an emergency (for example, notify a counselor of an exposure, any trouble breathing, etc.). This is required before camp starts or your child may not be allowed to attend camp.**

THE FOLLOWING SECTION IS TO BE COMPLETED AND SIGNED BY PARENT/GUARDIAN

Physicians Information	Name	Address	Phone
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My child has permission to:

carry his/her epi-pen and/or inhaler to camp

to have an epi-pen and/or inhaler available at camp (parent/guardian must deliver and bring medicine home daily)

my child has been trained to self-administer his/her epi-pen and/or inhaler

Parent/Guardian Signature Date Home Phone # Emergency Phone #

Witness Date

THE FOLLOWING IS TO BE COMPLETED BY THE PHYSICIAN

Diagnosis for which epi-pen and / or inhaler is given: _____

Name of Medication _____

Form _____ Dose _____

If epi-pen and / or inhaler is to be given "WHEN NEEDED" describe indications _____

How soon can medication be repeated? _____ Has child been trained to self-administer? _____

List significant side effects _____

Other Information _____

Date Physician's Signature

EXPIRATION DATE OF MEDICATION _____