Camp Zanika
Required Camper Forms

Every camper attending Camp Zanika must have a copy of the required forms. Forms can be found on our website, emailed, or mailed. All forms need to be returned to the Camp Fire Office 2 weeks before your child attends camp. If you do not receive confirmation that we have received your forms within a week, please contact us. Having paperwork in on time helps us keep things running smoothly and reduces any waiting in line time at Check In/Drop Off.

Forms can be turned in my mail or email. Email forms to: campzanikalache@gmail.com . Mail forms to: Camp Zanika P.O Box 1734, Wenatchee WA 98807. If you would prefer to fax the forms, please contact us for further directions.

Required Forms Check List:

- Camper Medical Form – 3 Pages
  - Copy of insurance card
  - Parent/Guardian signature
  - Date & Year of Immunizations Required

- Camper Release & Dismissal Information Form – 1 page
  - Camper Release must have names of parents/guardians picking child up
  - Parent/Guardian signature for both Release & Dismissal
  - Camper Signature for Dismissal
- Special Form – 2 Pages
  - List any special dietary needs or concerns on Special Needs portion
  - Parent Guardian signature on Permission to Administer, Waiver, and Special Needs

Add-On Activity Forms:

- Horseback Riding Form – 2 Pages
  - Required for any camper signed up for horseback riding
  - Parent/Guardian Initials by every letter & signature on back
  - Camper initials by every letter & signature on back
  - Siblings can use the same horseback form
  - Helmets are required
- River Rafting Form – 1 Page
  - Required for any camper signed up for river rafting
  - Parent/Guardian signature
  - Camper signature

Camper's Name: Session Attending:

Permission to Administer Over the Counter Medications

I (Parent/Guardian) of _____, hereby give permission for Camp Zanika to administer the following over the counter medications if the nurse deems it necessary. Dosage will be administered according to directions on the bottle unless a physician directs otherwise.

Headaches - *Tylenol/Advil*
Upset Stomach - *Nausea Medicine*
Diarrhea – *Imodium AD*
Menstrual Cramps - *Ibuprophen*
Poison Ivy – *Calamine Lotion or Benadryl Lotion*
Allergies - *Benadryl*
Mosquito Bites – *Bug Spray, Calamine Lotion, Benadryl*

Parent/Guardian Signature:_____ Date: _____

Photo Permission/Participant Waiver/ Off Camp Trips

I give permission for my child's picture to be used by Camp Fire USA. Use of such pictures may include, but is not limited to, brochures, videos and internet websites promoting or reporting on the camp and the American Camp Association. I waive any claims which may arise from my child's participation in Camp Fire activities. I understand that in order to provide a safe cooperative group experience, a child may be dismissed from the program for reason including behavior, illness/injury, or homesickness. My child has permission to participate in all camping activities, including hiking out of camp, and be transported by camp for any camp activities away from camp property

Parent/Guardian Signature:_____ Date: _____

Special Needs/Dietary Needs

Camper's Name: Session Attending:

My Child has:	☐ No Special Requirements
	☐ Vegetarian Diet
	☐ A Diet related to religious practice. **Please explain below**
	☐ A Diet related to allergies and medical conditions. **Please explain below**
At Camp Zanika we do our best to accommodate the dietary needs of all our campers. If your child has a strict dietary need, odd dietary need, or one that you are not sure we can accommodate please contact us for further information.	

My Child's Counselor should know:

Our goal is to provide a complete camping experience for all of our campers. To aid us in accomplishing this goal, we ask camper guardians to inform us of any special needs, issue or other concerns that you may have.
(i.e sleep walking, not a strong swimmer, behavioral problems, night terrors, etc.)

If your child has any issues that you feel need to be further addressed please contact the Camp Fire Office, 509.663.1609 or campzanikalache@gmail.com

Parent/Guardian Signature:_____ Date: _____

FOR CAMP OFFICE USE ONLY
Session #:_____
Cabin: _____
Alert: _____

CAMPER PICK-UP & RELEASE FORM

IMPORTANT

Person(s) authorized to pick-up your child *must* be listed below… *don't forget to include yourself*. ONLY one camper per form.

Camper's Name: _____

Person(s) Camp Zanika may release camper to:

_____
_____
_____
_____

If applicable, please list any person(s) your child MAY NOT be released to:

_____
_____
_____
_____

Your signature below confirms you are the effective parent/guardian at the time your child is at camp.

_____ _____
Signature Date

FOR PICK UP DAY USE ONLY – Must show a valid photo ID.

_____ _____
Parent/Guardian Signature Date

Dismissal Information

A camper may be dismissed from Camp Zanika due to disruptive behavior, illness, or homesickness.

Children are entitled to a pleasant and harmonious environment at camp. The program cannot serve children who display chronically or severe disruptive behavior. Chronically disruptive behavior is defined as verbal or physical activity, which may include but is not limited to such behavior that:

- requires constant one-on-one attention from staff
- inflicts physical or emotional harm on children or staff
- displays disruptive behavior
- continually ignores or disobeys camp safety rules
- Includes use or possession of illegal drugs, alcohol, weapons, and/or explosives

Reasonable efforts will be made to assist children in adjusting to the program setting. If the child cannot adjust to the program setting and behave appropriately, then the child may be dismissed. Dismissal due to illness/injury will be at the discretion of the Camp Director and the health care staff. This may include but is not limited to contagious diseases and extended illness.

Dismissal due to homesickness will be at the discretion of the Camp Director in consultation with the parent.

In the event it is deemed necessary for a child to be dismissed, parents/legal guardians or a designated emergency contact will be responsible for transportation of the child upon notification of dismissal. Failure to comply may result in notification and involvement of child protection or other legal authorities.

_____ _____
Parent/Guardian Signature Date

_____ _____
Camper Signature Date

CAMPER HEALTH HISTORY FORM1

Developed and reviewed by: American Camp Association, American Academy of Pediatrics Council on School Health, & Association of Camp Nurses

american CAMP association®

Mail this form to the address below by_____(date)

Dates will attend camp: from_____ to_____
Month/Day/Year Month/Day/Year

Camper Name: _____
First Middle Last

O Male O Female Birth Date_____ Age on arrival at camp: _____
Month/Day/Year

To Parent(s)/Guardian(s): Please follow the instructions below. Attach additional information if needed.

1) ***Complete pages 1, 2 and 3 of this form (FORM 1) and make a copy.***
2) ***Send the original, signed FORM 1 to camp by the requested date.***
3) ***Complete the top of FORM 2 (CAMPER HEALTH-CARE RECOMMENDATIONS) and provide the copy of FORM 1 with FORM 2 to your child's health-care provider for review and completion.***
4) ***After it has been completed and signed by your child's health-care provider, return FORM 2 to camp by the requested date.***

Camper Home Address: _____
Street Address City State Zip Code

Parent/guardian with legal custody to be contacted in case of illness or injury:

Name:_____ Relationship to Camper:_____ Preferred Phones: (_____)_____(_____)_____

Email: _____

Home Address: _____
(If different from above) Street Address City State Zip Code

Second parent/guardian or other emergency contact:

Name:_____ Relationship to Camper:_____ Preferred Phones: (_____)_____(_____)_____

Email: _____

Additional contact in event parent(s)/guardian(s) can not be reached:

Name:_____ Relationship to Camper:_____ Preferred Phones: (_____)_____(_____)_____

Allergies: O No known allergies. O This camper is allergic to: O Food O Medicine O The environment (insect stings, hay fever, etc.) O Other
(Please describe below what the camper is allergic to and the reaction seen.)

Diet, Nutrition: O This camper eats a regular diet. O This camper eats a regular vegetarian diet. O This camper is lactose intolerant. O This camper is gluten intolerant. O Other, ***please explain in space.***

Restrictions:
O I have reviewed the program and activities of the camp and feel the camper can participate without restrictions.
O I have reviewed the program and activities of the camp and feel the camper can participate with the following restrictions or adaptations. ***(Please describe below.)***

Medical Insurance Information:

This camper is covered by family medical/hospital insurance O Yes O No

Include a copy of your insurance card if appropriate; copy both sides of the card so information is readable.

Insurance Company_____ Policy Number_____

Subscriber_____ InsuranceCompany Phone Number (_____)_____

Parent/Guardian Authorization for Health Care:

This health history is correct and accurately reflects the health status of the camper to whom it pertains. The person described has permission to participate in all camp activities except as noted by me and/or an examining physician. I give permission to the physician selected by the camp to order x-rays, routine tests, and treatment related to the health of my child for both routine health care and in emergency situations. If I cannot be reached in an emergency, I give my permission to the physician to hospitalize, secure proper treatment for, and order injection, anesthesia, or surgery for this child. I understand the information on this form will be shared on a "need to know" basis with camp staff. I give permission to photocopy this form. In addition, the camp has permission to obtain a copy of my child's health record from providers who treat my child and these providers may talk with the program's staff about my child's health status.

Signature of Custodial Parent/Guardian_____ Date:_____ Relationship to Camper: _____

If for religious or other reasons you cannot sign this, contact the camp for a legal waiver which must be signed for attendance.

Camper Name First Middle Last

(For Camp Use) Cabin or Group_____ (For Camp Use) Session Code(s):_____

CAMPER HEALTH HISTORY FORM 1

Developed and reviewed by: *American Camp Association, American Academy of Pediatrics Council on School Health, & Association of Camp Nurses*

Camper Name: _____
First Middle Last

Birth Date: _____
Month/Day/Year

Immunization History: Provide the month and year for each immunization. Starred (↑) immunizations must include date to meet ACA Standard. Copies of immunization forms from health-care providers or state or local government are acceptable; please attach to this form.

Immunization	Dose 1 Month/Year	Dose 2 Month/Year	Dose 3 Month/Year	Dose 4 Month/Year	Dose 5 Month/Year	Most Recent Dose Month/Year
Diptheria, tetanus, pertussis (DTaP) or (TdaP)						
Tetanus booster↑ (dT) or (TdaP)						
Mumps, measles, rubella (MMR)						
Polio (IPV)						
Haemophilus influenzae type B (HIB)						
Pneumococcal (PCV)						
Hepatitis B						
Hepatitis A						
Varicella (chicken pox) ○ Had chicken pox Date:						
Meningococcal meningitis (MCV4)						

Tuberculosis (TB) test	Date:	○ Negative ○ Positive

If your camper has not been fully immunized, please sign the following statement: I understand and accept the risks to my child from not being fully immunized.

Signature of Custodial Parent/Guardian: _____ Date: _____ Relationship to Camper: _____

Medication:
○ This camper will not take any daily medications while attending camp.
○ This camper will take the following daily medication(s) while at camp:

"Medication" is any substance a person takes to maintain and/or improve their health. This includes vitamins & natural remedies. ***Please review camp instructions about required packaging/containers. Many states require original pharmacy containers with labels which show the camper's name and how the medication should be given. Provide enough of each medication to last the entire time the camper will be at camp.***

Name of medication	Date started	Reason for taking it	When it is given	Amount or dose given	How it is given
			○ Breakfast ○ Lunch ○ Dinner ○ Bedtime ○ Other time: _____		
			○ Breakfast ○ Lunch ○ Dinner ○ Bedtime ○ Other time: _____		
			○ Breakfast ○ Lunch ○ Dinner ○ Bedtime ○ Other time: _____		
			○ Breakfast ○ Lunch ○ Dinner ○ Bedtime ○ Other time: _____		

The following non-prescription medications may be stocked in the camp Health Center and are used on an as needed basis to manage illness and injury. ***Cross out those the camper should not be given.***

Acetaminophen (Tylenol)
Phenylephrine decongestant (Sudafed PE)
Antihistamine/allergy medicine
Diphenhydramine antihistamine/allergy medicine (Benadryl)
Sore throat spray
Lice shampoo or cream (Nix or Elimite)
Calamine lotion
Laxatives for constipation (Ex-Lax)
Ibuprofen (Advil, Motrin)
Pseudoephedrine decongestant (Sudafed)
Guaifenesin cough syrup (Robitussin)
Dextromethorphan cough syrup (Robitussin DM)
Generic cough drops
Antibiotic cream
Aloe
Bismuth subsalicylate for diarrhea (Kaopectate, Pepto-Bismol)

CAMPER HEALTH HISTORY FORM 1

Developed and reviewed by: *American Camp Association, American Academy of Pediatrics Council on School Health, & Association of Camp Nurses*

Camper Name: _____
First Middle Last

Birth Date: _____
Month/Day/Year

General Health History: ***Check "Yes" or "No" for each statement. Explain "Yes" answers below.***

Has/does the camper:

1. Ever been hospitalized? ..... O Yes O No
2. Ever had surgery? ..... O Yes O No
3. Have recurrent/chronic illnesses? ..... O Yes O No
4. Had a recent infectious disease? ..... O Yes O No
5. Had a recent injury? ..... O Yes O No
6. Had asthma/wheezing/shortness of breath? ..... O Yes O No
7. Have diabetes? ..... O Yes O No
8. Had seizures? ..... O Yes O No
9. Had headaches? ..... O Yes O No
10. Wear glasses, contacts, or protective eyewear? O Yes O No
11. Had fainting or dizziness? ..... O Yes O No
12. Passed out/had chest pain during exercise? ..... O Yes O No
13. Had mononucleosis ("mono") during the past 12 months?. ..... O Yes O No
14. If female, have problems with periods/menstruation?. ..... O Yes O No
15. Have problems with falling asleep/sleepwalking? ..... O Yes O No
16. Ever had back/joint problems? ..... O Yes O No
17. Have a history of bedwetting? ..... O Yes O No
18. Have problems with diarrhea/constipation? ..... O Yes O No
19. Have any skin problems? ..... O Yes O No
20. Traveled outside the country in the past 9 months?. ..... O Yes O No

Please explain "Yes" answers in the space below, noting the number of the questions. For travel outside the country, please name countries visited and dates of travel.

Mental, Emotional, and Social Health: ***Check "Yes" or "No" for each statement.***

Has the camper:

1. Ever been treated for attention deficit disorder (ADD) or attention deficit/hyperactivity disorder (AD/HD)? ..... O Yes O No
2. Ever been treated for emotional or behavioral difficulties or an eating disorder? ..... O Yes O No
3. During the past 12 months, seen a professional to address mental/emotional health concerns? ..... O Yes O No
4. Had a significant life event that continues to affect the camper's life? ..... O Yes O No
   (History of abuse, death of a loved one, family change, adoption, foster care, new sibling, survived a disaster, others)

Please explain "Yes" answers in the space below, noting the number of the questions. The camp may contact you for additional information.

Health-Care Providers:

Name of camper's primary doctor(s): _____ Phone: (_____) _____

Name of dentist(s): _____ Phone: (_____) _____

Name of orthodontist(s): _____ Phone: (_____) _____

What Have We Forgotten to Ask? ***Please provide in the space below*** any additional information about the camper's health that you think important or that may affect the camper's ability to fully participate in the camp program. ***Attach additional information if needed***.

Parents/Guardians: STOP here. The rest of this is form is completed when the camper arrives at camp. Keep a copy for your records.

CAMPER HEALTH HISTORY FORM 1

Developed and reviewed by: *American Camp Association, American Academy of Pediatrics Council on School Health, & Association of Camp Nurses*

Camper Name: _____
First Middle Last

Birth Date: _____
Month/Day/Year

Individual Health Record (For Camp Use Only)

Initial Screening Date/Time:_____ Initials: _____

- Screening has been conducted according to camp protocol and significant findings noted as follows:

A. Any signs/symptoms of illness or injury upon arrival?. ..... No Yes as noted below

B. History of exposure to communicable disease?. ..... No Yes as noted below

C. Additions or corrections to information on this health history?. ..... No Yes as noted below

D. Medication given to health-care staff?. ..... No Yes as noted below

E. Any signs/symptoms of head lice?. ..... No Yes as noted below

Provider notes: (date/time/initial all entries) _____

Exit Note: Check one of the following:

- Left camp this day with no reported illness or injury symptoms.
- Left camp this day with the following problem/concern:

This person was told about the problem and instructed about follow-up as noted above: _____

Date/Time:_____ Initials: _____