CAMP ZANIKA LACHE CAMP FIRE USA
NCW COUNCIL MEDICAL INFORMATION FORM

PERSONAL INFORMATION

Camper's Name: _____ Birth date: _____ Sex: _____ Age: _____

Parent/Guardian/Spouse: _____

Home Address: _____ City: _____ State: _____ Zip: _____

Phone(s) - Day: _____ Evening: _____

Emergency Contact: _____ Relationship: _____ Phone: _____

Camper's Doctor/Clinic: _____ Phone: _____

Address: _____ City: _____ State: _____ Zip: _____

Do you carry medical insurance? Circle: Yes No Policy #: _____ Carrier: _____

PARTICIPANT'S HEALTH HISTORY: PLEASE CHECK

Asthma	☐ YES	☐ NO	ADD/ADHD	☐ YES	☐ NO	Headaches	☐ YES	☐ NO
Heart Defect/ Disease	☐ YES	☐ NO	Head Lice (past 6 months)	☐ YES	☐ NO	Tuberculosis	☐ YES	☐ NO
Seizures	☐ YES	☐ NO	Bed Wetting	☐ YES	☐ NO	Ear Infections	☐ YES	☐ NO
Diabetes	☐ YES	☐ NO	Sleep Walking	☐ YES	☐ NO	Allergies	☐ YES	☐ NO
Recent Hospitalization	☐ YES	☐ NO	Fainting	☐ YES	☐ NO	Other (explain Below)	☐ YES	☐ NO

PLEASE GIVE THE DATE OF THE FOLLOWING IMMUNIZATIONS OR ILLNESSES:

	Immunization	Illness		Immunization	Illness
DPT, TD or Tetanus	_____	_____	Rubella (German/3-day measles)	_____	_____
Sabin (oral polio)	_____	_____	Chicken Pox	_____	_____
Measles	_____	_____	Other: _____	_____	_____
Mumps	_____	_____			

List all food and drug allergies: _____

_____

List recent illnesses (past two months): _____

_____

List current medications and dispensing instructions: _____

_____

Is there any special medical or dietary care needed? _____

Are there any restrictions in any of the physical programs (swimming, hiking, games, etc.?) _____

_____

_____

Use this space to provide any additional information about the participant's behavior and physical, emotional or mental health about which the camp should be aware._____

_____

CAMPER NAME: _____

CAMP NAME: _____

Staff Agreement

I have completed the above information (with my parents, if a minor) and will assume the responsibility for restricting any activities agreed upon and listed above. I will exercise good judgement in regard to my own health, safety and well-being at Camp Zanika.

STAFF SIGNATURE_____**DATE**_____

FOR OFFICIAL USE ONLY	
How are you feeling?	Health House Screening
	Hair ☐
Any changes since you sent in your form?	Hands ☐
	Feet ☐
Have you been exposed to any communicable diseases?	Toes ☐
	Comments:
Do you have any prescription or over the counter medications?