

**Application for Use of Camp Asaayi Facilities**

Form NCA - 001

Group Name: \_\_\_\_\_ Group Sponsor: \_\_\_\_\_

Address: \_\_\_\_\_ Phone #: (\_\_\_\_) \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Group Affiliation: \_\_\_\_\_ Total Participants: \_\_\_\_\_

Do you have Liability Insurance Policy for your group? Yes / No if so, please include a photo copy of your Insurance Certificate with this application.

Requested Date (s): From: \_\_\_\_\_ To: \_\_\_\_\_

From: \_\_\_\_\_ To: \_\_\_\_\_

Purpose of Use:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

NOTE: If approved for encampment, I agree to read and comply with all campground rules and regulations as set forth in the CAMP ASAAYI POLICIES AND PROCEDURES HANDBOOK. The camp is the property of the Navajo Nation and my group shall obey all the laws of the Navajo Nation. The Navajo nation and/or Camp Asaayi Tribal Park will not be responsible for the loss of money, food items or valuables of any kind.

Group Sponsor Signature: \_\_\_\_\_ Date: \_\_\_\_\_

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**TO BE COMPLETED BY CAMP SUPERINTENDENT ONLY**

Date application received: \_\_\_\_\_

Is camp available at requested date? \_\_\_\_\_ Amount Deposited (25%): \_\_\_\_\_

If not, alternate date available: From: \_\_\_\_\_ To: \_\_\_\_\_

Group above: \_\_\_\_\_ Approved / Disapproved for encampment.

Reasons/Conditions: \_\_\_\_\_  
\_\_\_\_\_

Camp Superintendent Signature: \_\_\_\_\_ Date: \_\_\_\_\_

# MEDICAL HISTORY

NCA - 002

THE COLLECTION OF DATA IS SOLELY TO SAGEGUARD THE HEALTH, SAFETY, AND WELFARE OF USERS AT CAMP ASAAYI. THE DATA MAY BE PROVIDED TO A PHYSICIAN IN THE EVENT MEDICAL TREATMENT IS NECESSRY. THEREFORE, TO COMPLY WITH CAMP ASAAYI POLICIES, PLEASE COMPLETE TEH INFORMATION BELOW.

## 1. IDENTIFICATION

NAME: \_\_\_\_\_ GENDER: Male \_\_\_ Female \_\_\_ AGE: \_\_\_ DOB: \_\_\_\_\_  
          LNAME                  FNAME                  MI  
ADDRESS: \_\_\_\_\_ TELEPHONE #: \_\_\_\_\_  
                  BOX/STREET                  CITY                  STATE                  ZIP

Health and Medical Insurance: Yes \_\_\_ No \_\_\_. If so, Insured by: \_\_\_\_\_

\_\_\_\_\_  
Address                                  City                                  State                                  Zip

The health and medical data is a validation of participation for groups and orgainzaions using Camp Asaayi. The validation expires one (1) year after date of physician's consent of fitness.

The followinng data is subject to review for Camp use and may be required for special events. Please complete the followiing information below.

## 2. EMERGENCY MEDICAL INFORMATION

Any allergies to medication, food, plant, animal, or insect toxin? Yes \_\_\_ No \_\_\_

If yes, please explain: \_\_\_\_\_

Do you have any type of medical condition that may require special care, medication, or diet: Yes \_\_\_ No \_\_\_

If yes, please explain: \_\_\_\_\_

Have you or are having any of the following health problems?

<input type="checkbox"/> Asthma	<input type="checkbox"/> Bleeding Disorder	<input type="checkbox"/> Fainting Spells	<input type="checkbox"/> Mumps
<input type="checkbox"/> Diabetes	<input type="checkbox"/> Hay Fever	<input type="checkbox"/> Poison Ivy/Oak	<input type="checkbox"/> Measle
<input type="checkbox"/> Convulsions	<input type="checkbox"/> Insect Sting/Bites	<input type="checkbox"/> Skin Conditions	<input type="checkbox"/> Whooping Cough
<input type="checkbox"/> Heart Complications	<input type="checkbox"/> Ears/Nose/Throat	<input type="checkbox"/> Lungs	<input type="checkbox"/> Chicken Pox
<input type="checkbox"/> Digestion Problems	<input type="checkbox"/> Menstrual Problems		

Please explain: \_\_\_\_\_

## 3. IMMUNIZATION

Do you have the following immunizations: If yes, show date of original series and date of boosters, if none (Tetanus shot is desired), unless you have recieved on (or booster) within last five (5) years.

Thypoid Vaccine: Yes \_\_\_ No \_\_\_ Date of Original Series: \_\_\_\_\_ Date of Booster: \_\_\_\_\_

Tetanus Toxide: Yes \_\_\_ No \_\_\_ Date of Original Series: \_\_\_\_\_ Date of Booster: \_\_\_\_\_

Polio: Yes \_\_\_ No \_\_\_ Date of Original Series: \_\_\_\_\_ Date of Booster: \_\_\_\_\_

## TO SIGNED BY PARENTS OF THOSE UNDER 18 YEARS OF AGE:

To my knowledge, I (have \_\_\_) (have not \_\_\_) been exposed to any contagious or infectious disease in the past (3) three weeks. I am in a state of health that will allow me to participate in my affiliated group/organization at Camp Asaayi.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

OVER\_

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**TO BE COMPLETED BY PARENTS OR GUARDIAN OF THE APPLICANT:**

This shall certify that I am familiar with my particular group, organization, program and give my consent for \_\_\_\_\_, my Son/Daughter to participate with and in all activities as a member of the \_\_\_\_\_.  
Goup/Organization/Program

**Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

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