CONFIDENTIAL HEALTH FORM

Please complete this form and email to summersteps@stepafrika.org by **July 28, 2017**.
This form is required for any camper to participate in ***Summer Steps with Step Afrika!***

SECTION I – CAMPER CONTACT INFORMATION

Name_____

Birth Date_____/_____/_____ Age _____ Gender Male Female

Home Address_____ _____
STREET CITY STATE ZIP

Home Phone_____

Parent/Guardian #1 Name_____ Relationship:_____

Day Phone_____ Day Phone is Home Work Cell

Parent/Guardian #2 Name_____ Relationship:_____

Day Phone_____ Day Phone is Home Work Cell

Additional Emergency Contact_____Relationship_____ (In case we can't reach YOU)

Day Phone_____ Day Phone is Home Work Cell

Family Physician Name_____ Phone_____

SECTION II – INSURANCE INFORMATION

Is the camper covered by family medical/hospital insurance? Yes No

If yes, indicate Insurance Carrier_____ Group #_____

Policy #_____ Policy Holder's Name_____

SECTION III – MEDICATIONS

Will the camper be taking medications during camp hours? Yes No
(Medications include prescription, over-the-counter drugs, inhalers, etc.)

The medication or medical device will be administered under the supervision of Step Afrika! staff. A limited amount of medication for life threatening conditions should be carried by the camper.

Medication_____ Dosage_____ Take at what times_____

Reason for Taking_____

Prescribing Physician_____ Phone_____

Medication_____ Dosage_____ Take at what times_____

Reason for Taking_____

Prescribing Physician_____ Phone_____

SECTION IV – ALLERGIES

☐ Camper does not have any Allergies

Camper is allergic to ☐Hay Fever ☐ Poison Ivy/Oak ☐ Insect Stings ☐ Food ☐ Penicillin ☐ Drugs
☐ Other: _____

Describe allergy, reaction, and treatment:

_____

_____

_____

_____

SECTION VI – HEALTH HISTORY

Please know that we value your privacy. Health History information is available only to Step Afrika! staff. The more information you provide, the better we can take care of your child.

The camper has a history or is prone to any of the following (Please check all that apply).

☐ Recent injury, illness or infectious disease

☐ Chronic or recurring illness

☐ Asthma

☐ Seizure Disorder or Convulsions

☐ Diabetes

☐ Frequent headaches

☐Frequent Stomach aches

☐ Wears glasses/contacts

☐ Wears a Medic Alert ID

Please provide an explanation for any checked items:

_____

_____

_____

Date of Last Physical Exam (Recommended within 24 months of camp)_____

Physical Activities to be Limited or Restricted while at Camp:

_____

_____

_____

SECTION VII – AUTHORIZATION

The information provided on this form is accurate to the best of my knowledge. I have indicated any special health conditions, including required medication and activity limitations which should be known to Step Afrika! staff and medical personnel. I am aware of and accept the risk inherent in the program activity. I give consent in advance for medical treatment at an appropriate facility in case of illness or injury. I authorize camp staff to administer basic first aid and obtain emergency medical services as necessary.

Signature of Parent or Guardian _____ Date_____