HEALTH FORM

Please Complete: Program Location: _____

Program Dates: _____

Participant Information:

Name: _____

Date of Birth: _____

Address: _____

Town/State/Zip: _____

Guardian #1: _____

Guardian #1 Cell: _____

Guardian #2: _____

Guardian #2 Cell:_____

Health History:

Date of participant's last physical (must be within 13 months of the program start date):

_____

Both myself and the physician above deem that the participant is in good health and able to participate in all program activities:

YES ☐ NO ☐

Does the participant have any allergies, medical conditions or behavioural concerns we should know about (diabetes, seizures, injuries, asthma, etc)?

_____

_____

_____

Is the participant currently taking any medication?

YES ☐ NO ☐

Please list:

_____

_____

_____

_____

_____

Has the participant had a concussion in the last 18 months?

YES ☐ NO ☐

What was the date?

_____

Contact Information:

Emergency Contact #1 _____

Emergency Phone #1 _____

Emergency Contact #2 _____

Emergency Phone #2 _____

Physician's Name _____

Physician's Phone _____

Immunizations:

I certify that the participant is up to date with all immunizations required by the state to attend school:

YES ☐ NO ☐

I hereby request exemption of the participant from the immunization requirements for program entry because all or some immunizations are contrary to my beliefs:

YES ☐ NO ☐

Additional Questions:

I authorize Steel Sports to supply sunscreen to my child. I understand the staff will not apply sunscreen to my child.

YES ☐ NO ☐

I authorize Steel Sports to supply hand sanitizer with at least 60% alcohol to my child (state minimum). I understand the staff will encourage my child to use hand sanitizer throughout the day.

YES ☐ NO ☐

I authorize Steel Sports to supply bug spray to my child. I understand the staff will not apply bug spray to my child.

YES ☐ NO ☐

I authorize Steel Sports to screen my child for COVID-related symptoms. This includes, but is not limited to, taking my child's temperature, asking if my child is feeling well, observing my child and his/her symptoms throughout the day. I understand certain staff trained by the camp's Health Care Consultant will conduct these screenings. These screenings will take place in an area that allows for privacy, confidentiality and social distancing.

YES ☐ NO ☐

For overnight campers only: I authorize Steel Sports to conduct routine or medically indicated COVID testing while at camp, if necessary.

YES ☐ NO ☐

Confirmation:

In case of emergency, I understand that every effort will be made to contact me. In the event I cannot be reached, I hereby give permission to the physician selected by the program director to secure and administer treatment, including, but not limited to, transport to emergency care, hospitalization, and administration of medications for the person named above. I further understand that if I do not have medical insurance that covers all costs, I will be responsible for such medical costs.

Guardian Name: _____ **Date:** _____

Signature: _____