

**HEALTH HISTORY FORM/RELEASE FROM ALL CLAIMS**

Kentucky Woman's Missionary Union

Mission Adventure Camp

Church Name \_\_\_\_\_

Camp Date \_\_\_\_\_

Church Contact Person \_\_\_\_\_ Home phone \_\_\_\_\_ Cell phone \_\_\_\_\_

attach  
current  
photo

**THIS FORM SHOULD BE COMPLETED BY PARENT OR GUARDIAN.  
BRING SIGNED AND NOTARIZED FORM TO CAMP.**

Participant's Name \_\_\_\_\_ Birthdate \_\_\_\_\_ Age \_\_\_\_\_ Grade \_\_\_\_\_ Gender \_\_\_\_\_  
First Middle Last

Social Security # (required in case of medical emergency) \_\_\_\_\_

Parent/Guardian or Spouse \_\_\_\_\_ Home Phone \_\_\_\_\_

Cell Phone \_\_\_\_\_

Address \_\_\_\_\_ Mailing address City State Zip Work Phone \_\_\_\_\_

In Emergency Notify \_\_\_\_\_ Address \_\_\_\_\_ Day Phone \_\_\_\_\_

Evening Phone \_\_\_\_\_

**HEALTH HISTORY** Check all that apply and give approximate date beside each item checked.

**\*Please give full details on separate sheet.**

Disease

- \*Mononucleosis
- \*Frequent Colds/Sore Throats
- \*Sinusitis/Bronchitis
- \*Frequent Ear Infections
- \*Heart Defect/Disease
- \*Epilepsy/Seizures
- \*Bleeding/Clotting Disorders
- \*Diabetes
- \*Asthma
- Strep Throat

- Chickenpox
- Measles
- Mumps
- German Measles
- Whooping Cough
- Tuberculosis
- Polio
- Hypertension
- Stomach Problems
- Back or joint pain

\*Allergies

- Hay Fever, Etc.
- Poison Ivy/Oak/Sumac
- Insect Stings
- Penicillin
- Aspirin
- Other \_\_\_\_\_
- Food \_\_\_\_\_
- SUBJECT TO  Sleep Walking
- Bedwetting  Fainting
- Constipation Other \_\_\_\_\_

Recent Exposure to Contagious Disease \_\_\_\_\_

Operations or Serious Injuries (describe & give dates) \_\_\_\_\_

Are Immunizations up to date? \_\_\_\_\_ If no, explain \_\_\_\_\_

Date of Last Tetanus Shot \_\_\_\_\_ Date of Last TB Skin Test \_\_\_\_\_

Any Swimming or other Activity Limitations? \_\_\_\_\_

Any Special Medical or Dietary Regime to be continued? \_\_\_\_\_

Any Specific Activities to be encouraged? \_\_\_\_\_ Restricted? \_\_\_\_\_

Name of Family Physician \_\_\_\_\_ Address & Phone \_\_\_\_\_

Suggestions for Camp Personnel \_\_\_\_\_

**List ALL MEDICATIONS on the attached sheet.**

**MEDICAL INSURANCE**

Insurance issued in the name of (cardholder): \_\_\_\_\_ Birthdate of cardholder: \_\_\_\_\_

Employer of cardholder \_\_\_\_\_ Cardholder SS # \_\_\_\_\_

Address of insured: \_\_\_\_\_ Street or Box City State Zip

Is this coverage for a dependent? \_\_\_ If so, give name of dependent: \_\_\_\_\_ Relationship \_\_\_\_\_

Name of Insurance Company: \_\_\_\_\_

Address of Insurance Company: \_\_\_\_\_ Street or Box City State Zip

Telephone Number: \_\_\_\_\_ Policy number: \_\_\_\_\_

Group number: \_\_\_\_\_

**CUSTODIAL PARENT OR GUARDIAN MUST SIGN THE BACK OF THE FORM**

Updated: 4/7/2010



