Permission Regarding Medical Care

Medical Information

This form must be filled out entirely.

Name of Participant: _____ Date of Birth: _____

Gender: M / F Phone Number: _____ Email: _____

Address: _____

HEALTH INSURANCE INFORMATION: (All Camp participants are required to have health insurance coverage during the Camp program. If you will not have active health insurance coverage, you will be required to purchase a short-term health plan for the week. If this is your position, please call 800-873-8957 for further instructions.)

Insurance Company: _____
Policy Holder: _____
Policy Number: _____ Group Number: _____

PARENT OR LEGAL GUARDIAN CONTACT INFORMATION:
Name: _____
Relationship to Student: _____
Address: _____
Home Phone: _____ Cell Phone: _____

CURRENT MEDICATIONS: (list all)

Medication	Dosage	How Often	Special Instructions

FORGE
Kingdom Building Ministries

IMMUNIZATION HISTORY: (List all immunizations you have received and the dates administered, or you can attach your immunization record to this form.)

_____ _____

_____ _____

_____ _____

PERSONAL PHYSICIAN CONTACT INFORMATION:

Physician: _____

Address: _____

Phone Number: _____

Date of your last physical examination: _____

MEDICAL CONDITIONS: (check any that apply)

___ Asthma ___ Convulsions/seizures ___ Bleeding Disorder ___ Heart trouble

___ Diabetes ___ Nervous condition ___ Fainting spells

___ Hernia ___ Menstrual problems ___ Stomach Issues

Explain any above checked items: _____

_____

_____

Other medical conditions not listed: _____

_____

_____

List any condition that may require special care, diet, medications: _____

_____

_____

List any allergies to medications, foods, plants, animals, or insect toxins (Include reaction):

_____

_____

ACKNOWLEDGEMENT:

I, _____, (participating student) acknowledge that all the information listed on this Medical Form is complete and accurate.

Signature of Participant: _____ Date: _____

Signature of Parent/Legal Guardian (if required):

_____ Date: _____