

HEALTH FORM For King s Kids Camp Counselors and Staff

Counselor s Name _____ Home Phone (____) _____

Address _____ City _____ State _____ Zip _____

Date of Birth _____ Social Security Number _____

Emergency Contacts

Name _____ Relationship _____ Phone (____) _____

Name _____ Relationship _____ Phone(____) _____

Family Physician _____ Phone (____) _____ Exchange(____) _____

Medical/Hospital Insurance: Carrier _____ Policy/Group # _____

**** PLEASE INCLUDE A COPY OF INSURANCE CARDS WITH HEALTH FORM ****

HEALTH HISTORY: (Please answer Yes or No; if answer is Yes, give approximate dated.)

ALLERGIES

<input type="checkbox"/> Frequent Ear Infections	<input type="checkbox"/> Hypertension	<input type="checkbox"/> Chicken Pox	<input type="checkbox"/> Hay Fever	<input type="checkbox"/> Asthma
<input type="checkbox"/> Heart Defect/Disease	<input type="checkbox"/> Mononucleosis	<input type="checkbox"/> Measles	<input type="checkbox"/> Poison Ivy/Oak	<input type="checkbox"/> Insect Stings
<input type="checkbox"/> Epilepsy/Convulsions	<input type="checkbox"/> Diabetes	<input type="checkbox"/> German Measles	<input type="checkbox"/> Penicillin	<input type="checkbox"/> Bee Stings
<input type="checkbox"/> Psychiatric Treatment	<input type="checkbox"/> Fainting/Dizzy Spells	(Rubella)	<input type="checkbox"/> Other Drugs (Specify) _____	
<input type="checkbox"/> Bleeding/Clotting Disorders	<input type="checkbox"/> Sleep Disorders	<input type="checkbox"/> Mumps	<input type="checkbox"/> Other (specify) _____	

Other Diseases or Details of Above _____

Food Allergies/Dietary Modifications _____

Operations, Major Injuries or Hospitalization (include dates) _____

Disability or Chronic or Recurring Illness _____

Date of Last Tetanus Booster _____

PERMISSION TO PROVIDE NECESSARY TREATMENT OR EMERGENCY CARE: I hereby give permission to the medical personnel selected by the camp administration to order X-rays, routine tests, treatment; to release any records necessary for insurance purposes; and to provide or arrange necessary related transportation for me. I hereby give permission to the physician selected by the camp administration to secure and administer treatment, including hospitalization, for myself in the event of an emergency. This completed form may be photocopied for trips out of camp.

SIGNATURE _____ **Date** _____

WITNESS _____ **Date** _____
