CONFIDENTIAL MEDICAL HISTORY AND MEDICAL AUTHORIZATION

Applicant and guardian must read and sign **both sides** of this form. This completed and signed form must be on file for the camper to participate in activities with **Discovery Ministries, HCR 3 Box 32, Eminence, MO 65466, (573) 226-3213**.

Please Print

Group/Trip Name____ Beginning date of retreat/trip ___/___/___

Applicant Name (last)_____________________(first)________________ Birth Date ___/___/___ Sex ___ Age ___

Address ____ _______ Height__' ___" Weight____lbs

City _____________________________________ State _____ ZIP _____________Phone (_______)__________

Person to notify in emergency _______________________________________ Relationship _______________

Address ____ City _________________ State _____ ZIP _____

Home Phone (______)_______________ Business Phone (______) ___________________________________

Physician's Name ____________________________________ Phone (______)___________________________

Address ____ City _________________ State _____ ZIP _____

Do you regularly have, or have you had any of the following conditions or symptoms?

	Yes	No		Yes	No		Yes	No
1. High Blood Pressure	___	___	20. Knee/Ankle Problems	___	___	37. Medical Equip./Devices	___	___
2. Heart Disease	___	___	21. Neck/Back Problems	___	___	38. Stomach Ulcers	___	___
3. Heart Murmur	___	___	22. Leg/Foot Problems	___	___	39. Intestinal Problems	___	___
4. Irregular Heartbeat	___	___	23. Headaches	___	___	40. Active Bedwetting	___	___
5. Tuberculosis	___	___	24. Head Injury w/Neurological Impairment	___	___	41. Chest Pain/Pressure at rest	___	___
6. Active/History Hepatitis	___	___	25. Jaundice	___	___	42. Heart Palpitations	___	___
7. Seizure disorder	___	___	26. Heatstroke or Heat Intolerance	___	___	43. Unexplained Sweating	___	___
8. Bleeding Disorder	___	___	27. Bladder/Kidney Problem	___	___	44. Frequent Shortness of Breath	___	___
9. Blood Disorder/Anemia	___	___	28. Thyroid Problems	___	___	45. Frequent Dizziness/ Fainting	___	___
10. Asthma	___	___	29. Endocrine Problems	___	___	46. Heartburn	___	___
11. Diabetes	___	___	30. Hearing Impairment	___	___	47. Muscle Cramps	___	___
12. Hypoglycemia	___	___	31. Vision Impairment	___	___	48. PMS or Menstrual Problems	___	___
13. Anorexia/Bulemia	___	___	32. Motion Sickness	___	___	49. Other _____________ __________________ __________________	___	___
14. Cancer	___	___	33. Sleep Walking	___	___			
15. Skin Problem	___	___	34. Currently Pregnant	___	___			
16. Frostbite/Cold Intolerance	___	___	35. Special Diet	___	___			
17. Circulation Problems	___	___	36. Learning disability	___	___			
18. Broken Bones	___	___						
19. Arm/Shoulder Problems	___	___						

If you have answered "yes" to any of the above items, please explain below. Include the following:

- *What specific symptoms are occurring
- *How long symptom/conditions lasts
- *How often symptom/condition occurs
- *How you care for symptom/condition
- *How symptom/condition restricts your activity in any way, including your ability to run, lift and climb
- *Date of last occurrence

Item No. **Detailed Description (including restrictions if any)**

___________ ____

___________ ____

___________ ____

___________ ____

Please use separate sheet of paper for additional information

102506

Be Sure To Complete Side Two

Hospitalizations/Emergencies--Please list any hospital or emergency department visits in the last two years.
Dates Reason Length of stay

__________ ____

__________ ____

Medications--List any medications you are using, including psychiatric and over-the-counter medication.
Medication Condition Dosage (size & freq.) Side Effects/Contra-indications

__________ ____

__________ ____

Allergies--List all allergies (drugs, foods, insect bites, poison ivy, etc.)
Allergy Reaction Medication Required

__________ ____

__________ ____

Required Immunization--Tetanus Date ____/____/____

When it comes to swimming I (circle one): (sink like a rock) (am uncomfortable in 10 ft. of water, but can swim a little) (play comfortably in 10 ft. of water) (comfortably stay in 10 ft. of water for 15 minutes) (can swim 500 m. nonstop).

Personal History--Circle Yes or No

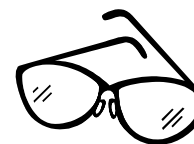
1. Have you been in counseling with a psychiatrist, psychologist, or other counselor within the past two years? Yes No
2. Are you currently in counseling/treatment? Yes No
3. Reason for counseling? ____
4. If you are currently under treatment of psychiatrist/counselor, give name, address and phone number
   ____

Describe any chemical or drug usage problems

____

Do you use alcohol or tobacco? (if so, how much)

____



Carefully Read and Sign this Medical Authorization

I hereby consent and authorize Discovery Ministries, its designees and agents to authorize any medical treatment deemed necessary in the event of any injury I should have while participating in an activity should I be mentally or physically incapable of making such a decision. If the participant named below is less than 18 years of age, I hereby authorize Discovery Ministries, its designees and agents to consent to appropriate medical care and treatment (in loco parentis) should I be unavailable to render such consent for my minor child ______________________(their name).

I covenant and promise to pay for all medical and liability expenses for any bodily injury, rescue, or property damage I may incur while participating in Discovery Ministries activities and for any bodily injury, rescue, or property damage caused to a third party as a result of my participation in Discovery Ministries activities.

Insurance Company and Policy #:____

My signature below indicates that I have read this entire document, understand it completely, agree to be bound by its terms, and declare the information I put on this form is true.

Signature of participant: ____________________________ Print name: ________________________

Date:_____/____/______

If under 18 signature of
parent or guardian: ________________________________ Print name: _______________________

Date:_____/____/______

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