Name _____ (Last, First)
Acct # P00 _____
☐ Reviewed _____

General Information (COMPLETE IN BLACK/BLUE INK ONLY—**NOT PENCIL**)

Name:_____ Date of Birth:____ / ____ / _____ Gender: Male ___ Female ___

Address:_____

City:_____ State:_____ Zip:_____

Emergency Phone Numbers: MANDATORY

Mother's name: _____ Email: _____

Mother: *(hm)* ( ) _____ - _____ *(wk)* ( ) _____ - _____ *(cell)* ( ) _____ - _____

Father's name: _____ Email: _____

Father: *(hm)* ( ) _____ - _____ *(wk)* ( ) _____ - _____ *(cell)* ( ) _____ - _____

Emergency contact person if parents cannot be reached: _____

Relationship to the participant: _____ Email: _____

Phone: *(hm)* ( ) _____ - _____ *(wk)* ( ) _____ - _____ *(cell)* ( ) _____ - _____

Family Doctor/Clinic: _____ Phone: ( ) _____ - _____
(contact info for medical records in case of emergency)

Health History To Be Completed By a Parent/Legal Guardian if Participant **is Under 18.**

CIRCLE Yes or No ****Please explain anything circled yes on the lines below.***

1. Chicken Pox	Yes No	14. Prone to Bronchitis	Yes No	27. Sleep Disorders	Yes No
2. Birth Defects	Yes No	15. Frequent Sinus Problems	Yes No	28. Bone/Joint Problems	Yes No
3. Diabetes	Yes No	16. Ear/Hearing Problems	Yes No	29. Convulsions/Seizures	Yes No
4. Frequent Headaches	Yes No	17. Ear Infections	Yes No	30. Speech Problems	Yes No
5. Migraine Headaches	Yes No	18. Frequent Nosebleeds	Yes No	31. Eye/Vision Problems	Yes No
6. Drug Allergies	Yes No	19. Frequent Constipation	Yes No	32. Contacts/Glasses	Yes No
7. Hay Fever	Yes No	20. Frequent Diarrhea	Yes No	33. Previous Surgeries *(when and for what?)*	Yes No
8. Food Allergies	Yes No	21. Bladder Control Difficulties	Yes No		
9. Allergies to Insect Bites	Yes No	22. Blood Disorders	Yes No	34. Previous Hospitalizations Including Psychiatric Care (when and for what?)	Yes No
10. Other Allergies	Yes No	23. Infections of any kind	Yes No		
11. Toothaches/Wisdom Teeth Problems	Yes No	24. Ulcers	Yes No	35. Physical Handicaps	Yes No
12. Frequent Colds and Flu	Yes No	25. Frequent Upset Stomach	Yes No	36. Asthma	Yes No
13. Frequent Sore Throat or Strep	Yes No	26. Heart Problems	Yes No	37. Other	Yes No

_____

_____

If you have severe allergic reactions, YOU MUST BRING 2 EMERGENCY TREATMENT KITS.

38. Family history of drug allergies or severe food allergies _____

39. Do you have any special food requirements or food restrictions? _____ If yes, what? Is this a _____medical allergy or _____health preference? If allergy, what allergic reaction do you have? **Please contact Kairos to discuss if we are able to accommodate any food restrictions you have.*

40. Do you have any activity restrictions? _____ If yes, what? and why?

41. Have you ever seen a counselor or had psychiatric care? _____ If yes, explain.

42. Do you, or have you ever struggled with any of the following? __ Eating disorder __ Depression __ ADD/ADHD __ Learning Disability If yes, explain.

43. If you have asthma, when was your last attack? _____ Under what conditions do you have problems with asthma?

You MUST attach a prescription for any medication needed for your asthma, and BRING TWO INHALERS if you use them at all.

44. Are you currently taking a prescription medication? _____ If yes, what? And why?

45. Have you taken any prescription medication in the last three years? _____ What?_____
When? _____ Why? _____

HEALTH FORM
Due August 15th

46. Do you have any medication that needs to be refrigerated? _____ If yes, explain.

47. **Girls Only:** How often do you get your period? _____ Is your flow: light ___ medium ___ heavy ___
Do you have cramping? _____ If yes, ___ light ___ medium ___ heavy
Do you take any medication for this? _____ If yes, what?
Are you prone to yeast infections? _____ ***If yes, please bring one treatment of medication with you.***

48. Is there any other information that we need to know about the participant in regards to health?

*** Please contact Kairos if there are any significant changes in your medical health.**

Medical Permission & Insurance

Required for ALL Participants *(Note: **guardians of minors required to initial all 3 statements**, those over 18 required to initial 1st statement only. Forms filled out incorrectly will need to be returned to be corrected.*

PERMISSION

I verify that this form has been truthfully completed to the best of my knowledge. I hereby give my permission to the physician or dentist selected by Reign Ministries' personnel to hospitalize, secure proper treatment and/or order an injection, anesthesia, or surgery, and disclose protected health information for _____ *(name of participant)* to Reign Ministries' personnel for the purpose of treating the health and well being of the aforementioned person. I understand that the information used or disclosed may be subject to re-disclosure by Reign Ministries' personnel receiving it and would then no longer be protected by federal privacy regulations. I may revoke this authorization by notifying Reign Ministries in writing of my desire to revoke it. However, I understand that any action already taken in reliance on this authorization cannot be reversed, and my revocation will not affect those actions. This authorization begins on arrival and expires on August 31, 2019 OR upon the completion of Kairos Discipleship School's program.

_____ I give permission for the above named participant or for myself (if 18 or over) to receive medication according to the prescription or parental request for Over the Counter (OTC) drugs, and any special instructions. I understand the information is confidential and only Reign Ministries' personnel, needing to know, have access to this information. I agree to coordinate and work with Reign Ministries and the prescriber if questions arise *(initials required for guardians of minors or participants over 18).*

_____ I give permission for the nurse or designated Reign Ministries' personnel to administer any OTC non-prescription drug according to the manufacturer's directions *(initials required for guardians of minors only).*

_____ I give permission for my son/daughter to self-administer medication, if the nurse or designated Reign Ministries' personnel determines it is safe and appropriate *(initials required for guardians of minors only).*

Parent/Legal Guardian Signature: _____ Date: ____ / ____ / _____
(required if participant is under 18 years old)

Participant Signature: _____ Date: ____ / ____ / _____
(required for all participants)

INSURANCE

Medical insurance is required. Please record your complete medical insurance information below.
Note: If you do not have medical insurance at this time, you may send the information separately. The insurance information must be sent in and be active prior to the start of Kairos.

Parent/Legal Guardian Signature: _____ Date: ____ / ____ / _____
(required if participant is under 18 years old)

Participant Signature: _____ Date: ____ / ____ / _____
(required for all participants)

MEDICAL INSURANCE AND DENTAL INSURANCE INFORMATION
Medical insurance is required. *Dental insurance is not required.*

Medical Insurance Company: _____

Policy #: _____ Co-Pay? _____

Name of Insured: _____ Birthdate: ____/____/_____

Dental Insurance Company: _____
Policy #: _____ Co-Pay? _____

** Make a photocopy of this form for yourself, and send the original to Kairos upon completion.
** Kairos must have this original, signed form.