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, 17043 State Route E, 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			41.	Chest Pain/Pressure		
6.	Active/History Hepatitis	___	___		Impairment	___	___		at rest	___	___
7.	Seizure disorder	___	___	25.	Jaundice	___	___	42.	Heart Palpitations	___	___
8.	Bleeding Disorder	___	___	26.	Heatstroke or Heat			43.	Unexplained Sweating	___	___
9.	Blood Disorder/Anemia	___	___		Intolerance	___	___	44.	Frequent Shortness		
10.	Asthma	___	___	27.	Bladder/Kidney Problem	___	___		of Breath	___	___
11.	Diabetes	___	___	28.	Thyroid Problems	___	___	45.	Frequent Dizziness/		
12.	Hypoglycemia	___	___	29.	Endocrine Problems	___	___		Fainting	___	___
13.	Anorexia/Bulimia	___	___	30.	Hearing Impairment	___	___	46.	Heartburn	___	___
14.	Cancer	___	___	31.	Vision Impairment	___	___	47.	Muscle Cramps	___	___
15.	Skin Problem	___	___	32.	Motion Sickness	___	___	48.	PMS or Menstrual		
16.	Frostbite/Cold Intolerance	___	___	33.	Sleep Walking	___	___		Problems	___	___
17.	Circulation Problems	___	___	34.	Currently Pregnant	___	___	49.	Other _____		
18.	Broken Bones	___	___	35.	Special Diet	___	___		_____		
19.	Arm/Shoulder Problems	___	___	36.	Learning disability	___	___		_____	___	___

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:_____/____/_____