

## **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 \_\_\_/\_\_\_/\_\_\_  
 Participant 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/Bulimia	___	___	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**

**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 indications	Condition	Dosage (size & freq.)	Side Effects/Contra-
_____	_____	_____	_____
_____	_____	_____	_____

**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: \_\_\_\_/\_\_\_\_/\_\_\_\_