

2010 ADULT MEDICAL FORM

▶ Please attach a copy - front and back - of insurance or medical card to this form.▶

PLEASE PRINT WITH DARK INK, COMPLETE ALL SECTIONS & MAIL TO: KIRKMONT CENTER, PO BOX 128, ZANESFIELD, OH 43360

Last Name _____ First Name _____ Male or Female? DOB: |__|_|_| Age: _____

EMERGENCY CONTACT INFORMATION

Name _____ Relationship _____
Home Address _____
City _____ State ___ Zip _____ Home Phone (____) _____
Work Phone (____) _____ Cell (____) _____

I GIVE MY PERMISSION to administer emergency medical treatment. In the event that all reasonable attempts to contact the person listed above have been unsuccessful, or in the event that immediate action is considered necessary to preserve life, I hereby give my consent to administration of emergency treatment by a licensed physician and to transfer me to any reasonably accessible hospital facility. This authorization DOES NOT include major surgery unless the medical opinions of two other licensed physicians are obtained prior to surgery. *Signature* _____ *Date* _____

1. ACTIVITY RESTRICTIONS Circle: Diving Hiking Swimming Other _____

2. ALLERGIES	Yes	No	If yes, what treatment has been given?	Need more space? Continue on back.▶
Asthma	___	___	_____	_____
Hay Fever	___	___	_____	_____
Insect Stings	___	___	_____	_____
Penicillin	___	___	_____	_____
Poison Ivy	___	___	_____	_____
Poison Oak	___	___	_____	_____
Poison Sumac	___	___	_____	_____
Other Drugs	___	___	_____	_____
Other Allergies	___	___	_____	_____

3. CHRONIC OR RECURRING ILLNESS OR MEDICAL CONDITION _____

Other Diseases _____

4. DIETARY RESTRICTIONS _____

5. FAMILY DENTIST/ORTHODONTIST _____ Phone (____) _____

6. FAMILY PHYSICIAN _____ Phone (____) _____
_____ Phone (____) _____
_____ Phone (____) _____
_____ Phone (____) _____

7. HEALTH HISTORY Circle: Diabetes Epilepsy Heart Disease
Other _____

Date of Last Physical Exam _____ Anything special that we should know? _____

8. IMMUNIZATIONS & DATES Hepatitis B _____ Tetanus _____
Other _____

9. MEDICATIONS (All medications must be brought to camp in the original prescription container(s) with the pharmacy label attached. For adults accompanying children to Kids Kamp, all medications must be given to the camp nurse at registration check-in time.)

Current Medications _____

10. OPERATIONS OR SERIOUS INJURIES (Please provide approximate dates. Need more space?

Continue on back. ▶
