Medical Information

Please note that this information will be shared with the KOSMOS Ministries Team Leader(s) and/or medical personnel.

Name: ____
First Middle Initial Last

Address: ____
Street City State Zip

Gender: M F Age: ___________Phone: ___________________ Birth date: ______________
Parents' Names (if under 21) ____
Parent's Phone: _____________________________ Work: _____________________________

Health Information (To be completed by all participants)

Do you have: (If yes, please explain)

Yes No Drug allergies ____
Yes No Food allergies ____
Yes No Environmental allergies ____
Yes No Has any allergic reaction required emergency room care? ___________________
Yes No Heart condition? ____
Yes No Are you diabetic? Diet controlled Oral Medication Insulin
Yes No Do you have asthma? ____
Yes No Have you had any serious illnesses, surgery or hospitalizations within the past three years? If so, list with dates. ____
Yes No Are you current with vaccinations? _____________________________________

Are you subject to: (If yes, please explain)

Yes No Fainting? ____
Yes No Sleep walking? ____
Yes No Upset stomach? ____
Yes No Do you have any condition that would prevent you from participating in any activities whatsoever? ____

Describe your general health condition ____
Please indicate ANYTHING else that the leadership should know to help deal with any situation that may arise: ____

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LIST ALL CURRENT MEDICATIONS, DOSAGES, AND WHAT IT IS BEING TAKEN FOR:

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EMERGENCY INFORMATION: MUST BE INCLUDED Contract # ________________

Health Insurance Company ___________________ Policy/ Group # ______________________
Emergency Contact _________________________________ Relationship _________________
Address ____
Street City State Zip

Telephone _________________ Work ______________________ Cell ___________________
Primary Physician _________________________________ Phone _______________________