COVENANT FELLOWSHIP CHURCH
MEDICAL DISCLOSURE FORM

Participant Information (Please PRINT in ink)

Participant's Name: _____ Age: _____ Gender: ☐ M / ☐ F
Address: _____ Height: _____ Weight: _____
City: _____ State: _____ Zip: _____ Date of Birth: _____ / _____ / _____
E-mail Address: (for medical questions) _____ Phone: _____

Emergency Contacts and Information-

Parent or Guardian Name: _____ Work phone: _____ Home phone: _____
Alternate Contact: _____ Work phone: _____ Home phone: _____
Primary Care Physician: _____ Office Phone: _____
Insurance Carrier: _____ Policy Number: _____
Insurance Carrier's Phone Number: _____

Allergies

Medication(s): _____
Bee or Insect Stings: _____ Treatment: _____ Intolerance ☐ Anaphylaxis ☐
Foods: (list) _____ Treatment: _____ Intolerance ☐ Anaphylaxis ☐

Asthma ..... Yes ☐ No ☑

If YES, will your child carry a rescue inhaler during the camp session?..... Yes ☐ No ☐
If YES, does your child need staff help to use that rescue inhaler?..... Yes ☐ No ☐
If YES, what triggers your child's asthma?_____

Activity Restrictions: _____ Physical Handicaps: _____
Date of Last Physical Exam: _____/_____/_____ Date of Last Tetanus: (DPT) _____/_____ Date of Last (MMR) _____/_____
Any limiting fears? _____ Dietary Restrictions? _____

Health History (check conditions and describe below, list the year for each illness)

_____ADD/ADHD	_____Diabetes	_____Joint or Muscle Pain
_____Anemia	_____Diarrhea/Constipation	_____Knee Injury or trouble
_____Appendicitis	_____Dislocations	_____Measles
_____Asthma	_____Eating Disorder	_____Migraine Headaches
_____Back Pain or Injury	_____Emotional/Behavioral Issue	_____Mononucleosis
_____Bedwetting	_____Epilepsy or Convulsions	_____Motion Sickness
_____Bleeding/Clotting Disorder	_____Fainting or Dizziness	_____Pneumonia
_____Blood Pressure (high/low)	_____Fractures (broken bones)	_____Rheumatic Fever
_____Bronchitis	_____Frequent Ear Infections	_____Skin Conditions or rashes
_____Chickenpox	_____Gall Bladder	_____Sleepwalking
_____Colitis	_____Hay Fever	_____Sprains or strains
_____Concussion/Head Injury	_____Heat Stroke or Exhaustion	_____Tuberculosis
_____Corrective Lenses (eyes)	_____Heart Disease or Defect	_____Tumor or Growth
_____Cramps, severe	_____Hepatitis A, B, or C	_____Ulcer
_____Cystitis	_____Hernias	_____Urinary Difficulties
_____Dental Appliances	_____HIV Positive	_____Venereal Disease

Details on above:

_____

Name any injuries, illnesses or disabilities not mentioned and the year of occurrence:

_____

Hospitalization or surgeries (list below or attach on separate paper the dates, reasons, hospital names and locations)

Do you (participant) have any physical, emotional, mental, or physiological limitations that would affect your participation in this event? Yes☐ No☐

If yes, please fully describe such conditions or limitations below: (please use back in needed).

_____

_____

_____

_____

By signing below, I acknowledge that I have completed this Medical Disclosure Form accurately, truthfully, and to the best of my knowledge. I further warrant and represent that if any of the information contained in this form changes *at any time,* I will immediately provide Covenant Fellowship Church with such updated information. I acknowledge that the program will handle medication as described and that information on this form will be shared with staff on a need-to-know basis.

Participant's signature: _____ Date: _____

Parent or Guardian endorsement required if participant is under the age of eighteen (18):

Parent or Guardian Name: _____
(Please print)

Parent or Guardian Signature: _____ Date: _____

Received by: _____ Date: _____
(Authorized CFC staff member)