KAIROS OUTSIDE CONFIDENTIAL MEDICAL INFORMATION

Name: _____

Address/City/State: _____

Phone: _____ Signature: _____

Primary Care Doctor: _____ Phone (___) _____

Address/City/State: _____

Insurance Carrier: _____ Phone (___) _____

Address/City/State: _____

ID #_____ Group# _____

In case of an emergency, please contact: _____

Address/City/State: _____

Relationship:_____ Phone (___) _____

Medical History (use back if necessary)_____

Blood type (if known) _____

Allergies (food, medication, bees, pollen, etc.):

_____

Medications currently taking: _____

Dosage: _____ Date started: _____

Any current medical problems _____

Medical treatment in past 12 months:_____

_____

Exposure to illness in past 2-4 weeks: _____

Optional: Religious Affiliations: _____

Pastor/Priest: _____ Telephone: _____

Your signature on this form, gives Kairos Outside permission to use this form on the weekend, if necessary, due to a medical emergency.

Updated 2/27/16