# KIDDIE KRAFTS HEALTH FORM
# (ONE FORM PER CHILD)

This form must be completed and signed by the participant's legal guardian. The information we ask you to provide is necessary in the event your child needs medical treatment while camp is in session. **This form will be returned to you if it is incomplete**. Please type or print in **black ink.**

**PARTICIPANT INFORMATION**

Participant's Name ________________________________________

Permanent Address ________________________________________Date of Birth _______Sex___

City/State/Zip ____________________________________________Home Phone _____________

**MEDICAL EMERGENCY CONTACT INFORMATION**

| Person to contact first: | Backup contact (relative or friend): |
|---|---|
| Name________________________________ | Name______________________________ |
| Relation______________________________ | Relation_____________________________ |
| Daytime Phone_________________________ | DaytimePhone________________________ |
| Evening Phone ________________________ | Evening Phone_______________________ |

**INSURANCE POLICY INFORMATION**

The above-named child is covered by health insurance: Yes No

If yes, provide the following information which is required by Medical City Hospital of Dallas to expedite treatment and to facilitate the billing process.

Policy Holder's (P.H.) Name_____________________________P.H.'s Date of Birth_____

Address ___________________________________________________

Relation___________________________________________________

City/State/Zip _____________________________________________

Occupation ________________________________________________

P.H.'s Employer ____________________________________________________________________

Employer's Address _________________________________________________________________

Insurance Company _________________________________________________________________

Insurance Company's Address _________________________________________________________

Policy # ___________________________________________________

Plan # ____________________________________________________

**MEDICAL TREATMENT CONSENT**

I, the legal guardian of the above-named camper, authorize the Kiddie Krafts staff to seek medical treatment for the camper as they see necessary at Medical City Hospital of Dallas or another nearby facility. I consent to any x-ray, anesthetic, medical or surgical diagnosis or treatment and hospital care subsequently deemed necessary by a licensed health care provider during the participant's session. I understand that this authorization is given in advance of any

specific diagnosis, treatment or hospital care, and that it is given to provide the program staff authority to seek medical treatment, and to provide a licensed health care provider the authority to administer this treatment as s/he judges necessary to the above-named child. I accept responsibility for payment of all services rendered; I authorize any medical facility which renders services to release medical information necessary for the processing of insurance claims; and I authorize the payment of insurance claims directly to the medical facility. I understand that whenever possible, the Program staff will make a good faith effort to contact me or the above-named person(s) before seeking treatment. If this is not possible, I understand that the Program staff will notify me or my designee as soon a possible of any and all diagnoses and treatments.

______________________________ ______________________________ ______________

Legal Guardian's Signature Print Name Date

**DOES THE PARTICIPANT CURRENTLY HAVE ANY OF THE FOLLOWING?** (if yes, please describe)

Drug allergies:_______________________________________________________

Food allergies:_______________________________________________________

Allergies to insect bites: ______________________________________________

Special dietary needs: ________________________________________________

Asthma:____________________________________________________________

Frequent headaches: _________________________________________________

Dizziness or seizures: ________________________________________________

**LIST:** Other health problems:_________________________________________

_____________________________________________________________

Limitations of Activities: _______________________________________

_____________________________________________________________

Medications the camper is currently taking: ______________________

_____________________________________________________________

_____________________________________________________________

Will your son/daughter require any specific treatment for a medical/emotional condition while participating in our program? If yes, please explain. ___yes no

_____________________________________________________________

_____________________________________________________________

**THIS PORTION TO BE COMPLETED BY A PHYSICIAN OR ATTACH IMMUNIZATION RECORDS:**

**MEDICAL HISTORY**

IMMUNIZATION DATES:

Measles ___________________

Mumps ___________________

Date of last medical check-up:_______

Hospitalizations in the past 5 years: Describe

_________________________________

Rubella ___________________ ________________________________
*OR* MMR_____________________ ________________________________
Last Tetanus _______________ ________________________________
*(DPT, TT or TD)* ________________________________
Polio Series completes ______ ________________________________

**PHYSICIAN'S INFORMATION** *(to be completed by physician)* Please **PRINT** the following information:

Physician's Name:_______________________________________________________

Address:________________________________________________________________

City/State/Zip ___________________________________________________________

Telephone ______________________________________________________________

*I have examined the above named participant and found she/he to be able to participate in all activities of the Kiddie Krafts Program.*

_______________________________ _______________________________ ______________

Physician's Signature Print Name Date