DESPERATION STUDENT CONFERENCE REGISTRATION/MEDICAL FORM

Contact Information:

First Name: _____ Last Name: _____

Church Name: Cornerstone Church Church Address: 2901 N. 8th St.

City: Garden City State: Kansas Zip Code: 67846 Phone: 620-275-5965

Student's Phone: _____

Student's Email: _____

Birth date _____/_____/_____ Age _____ Gender: Male Female

Home Address: _____

City: _____ State: _____ Zip: _____

Parent/Guardian #1 Name: _____ Relationship:_____

Day Phone_____ Night Phone_____

Parent/Guardian #2 Name: _____ Relationship:_____

Day Phone_____ Night Phone_____

Family Physician Name_____ Phone: _____

Dentist/Orthodontist Name: _____ Phone: _____

SECTION II – INSURANCE INFORMATION

Is the student covered by family medical/hospital insurance? Yes No

If yes, indicate Insurance Carrier: _____

Group #_____ Policy #_____

Policy Holder's Name: _____ Relationship to Student: _____

Emergency Contact Name & Relationship _____

Emergency Contact Cell # _____

SECTION VI – HEALTH HISTORY

Please know that we value your privacy. Health History information is available only to the staff. The more info you provide, the better we can do our job. Thanks!

Has the student had a history of or is prone to any of the following (Please circle all that apply).

1. Recent injury, illness or infectious disease	11. Hepatitis	21. Fractures
2. Chronic or recurring illness	12. Bleeding/Clotting Disorders	22. Frequent Headaches
3. Asthma	13. Diabetes	23. Head Injury
4. Homesickness	14. Mononucleosis (in last 12 months)	24. Eating Disorder
5. Frequent Ear Infections	15. Chicken Pox	25. Diarrhea or constipation
6. Seizure Disorder or Convulsions	16. Measles	26. Frequent Stomachaches
7. Dizziness during or after exercise	17. German Measles	27. Wears glasses or contacts
8. Chest pain during or after exercise	18. Mumps	28. Been Hospitalized
9. Heart Defect/Disease	19. Tuberculosis	29. Wears a Medic Alert ID
10. Hypertension	20. Joint problems (knees, ankles)	

Please list the number and provide explanation for any checked items _____

_____

Date of Last Physical Exam _____

Physical Activities to be Limited or Restricted while at Camp _____

_____

SECTION VII – AUTHORIZATION

My child has permission to engage in all prescribed activities except as noted. The information provided on this form is accurate to the best of my knowledge. I have indicated any special health conditions, including required medication and activity limitations which should be known to the staff and medical personnel. I am aware of and accept the risk inherent in the program activity. I give consent in advance for medical treatment at an appropriate facility in case of illness or injury.

Signature of Parent or Guardian: _____

Date: _____