

KAI CAMP/CLINIC CONFIDENTIAL MEDICAL RECORD

Name of Camp: Jayhawk Golf Camp

This completed form must accompany the camper on their first health center visit. It is essential that consent for treatment of a minor is signed by a parent/guardian.

Camper's Name: _____ Sex: _____
SSN: _____ Birth Date: _____
Parent/Guardian Name: _____
Address: _____

Home Phone: _____ Cell Phone: _____

Person to notify in case of emergency, if other than above:

Name: _____
Home Phone: _____ Cell Phone: _____
Address: _____

Name of Family Physician: _____ Phone: _____

1. Does camper have any significant illness or disability? ☐ YES ☐ NO

If yes, please explain: _____

2. Has the camper ever experienced a heat related injury? ☐ YES ☐ NO

If yes, please explain: _____

3. Please check if camper has or has had any of the following:

☐ asthma ☐ chicken pox ☐ diabetes ☐ epilepsy ☐ kidney problems
☐ polio ☐ rheumatic fever ☐ tuberculosis
☐ other _____

4. Has camper had any other significant illnesses, injuries, or surgeries? ☐ YES ☐ NO

If yes, please explain: _____

5. What routine medications & their dosages and time does the camper take?

6. Date of last tetanus/diphtheria: _____

Date of last MMR: _____

7. Does camper have any allergies, including to any medications? ☐ YES ☐ NO

If yes, please list:

HEALTH INSURANCE BILLING INFORMATION

Insurance Company: _____ I.D. #: _____
Group #: _____

Claim Address: _____

Name of Policyholder: _____ Policyholder Date of Birth: _____

Address of Policyholder: _____

I hereby authorize Student Health Services to disclose to the above named insurance company, information from the camper's medical record as needed in presenting my claim for benefits.

Camper Signature

Date

Parent/Guardian Signature

Date

CONSENT FOR TREATMENT OF A MINOR

I hereby give my consent for treatment of:

Last Name First Middle Date

This authorization covers any procedure, which may be deemed advisable by the attending staff physician.

Parent/Guardian Signature Relationship to Camper Date