MEDICAL INFORMATION FORM

The information provided in this form is confidential and will be used solely by authorized staff of King's School of Ministry to ensure the health, safety, and well-being of the student during their time in the program. This form allows staff to respond appropriately in the event of a medical situation, emergency, or ongoing health need. It may be shared with licensed medical personnel only if necessary for treatment. By completing this form, you acknowledge that all information is accurate to the best of your knowledge and that you give permission for KSM staff to act in your best interest in case of a medical emergency.

CONTACT INFORMATION

FULL NAME: _____
DATE OF BIRTH (MM/DD/YYYY): ____ / ____ / _____
PHONE NUMBER: _____
ADDRESS: _____
EMAIL: _____

INSURANCE INFORMATION

INSURANCE PROVIDER: _____
POLICYHOLDER NAME: _____
POLICY NUMBER / GROUP NUMBER: _____
INSURANCE PHONE NUMBER: _____

CURRENT MEDICATIONS

NAME: _____
DOSAGE & FREQUENCY: _____
PURPOSE/REASON: _____
SELF-ADMINISTERED? YES / NO

ALLERGIES

FOOD ALLERGIES: _____
MEDICATION ALLERGIES: _____
ENVIRONMENTAL ALLERGIES: _____
REACTION DESCRIPTION: _____
CARRIES EPIPEN OR INHALER? YES / NO

MEDICAL CONDITIONS/HISTORY (MARK N/A OR EXPLAIN)

ASTHMA? _____
DIABETES? _____
SEIZURE DISORDERS? _____
HEART CONDITIONS? _____
MENTAL HEALTH CONCERNS? _____
PAST SURGERIES OR HOSPITILIZATIONS:
_____
OTHER CHRONIC OR SERIOUS CONDITIONS?
_____

Signature: _____

KSM KING'S SCHOOL OF MINISTRY