





# KOP PERSONAL HEALTH AND MEDICAL SUMMARY

To be filled out by parent or guardian

## IDENTIFICATION

Name: Last \_\_\_\_\_ First \_\_\_\_\_ Date of Birth(mm/dd/yy) \_\_\_\_\_ Age \_\_\_\_\_

Name of parent or guardian \_\_\_\_\_ Telephone \_\_\_\_\_

Home Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_

Business Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_

If person named above is not available in the event of an emergency notify:

Name \_\_\_\_\_ Relationship \_\_\_\_\_ Telephone \_\_\_\_\_

Name \_\_\_\_\_ Relationship \_\_\_\_\_ Telephone \_\_\_\_\_

Name of personal physician \_\_\_\_\_ Telephone \_\_\_\_\_

Personal Health/Accident Insurance carrier \_\_\_\_\_ Policy No. \_\_\_\_\_

In case of emergency, I understand every effort will be made to contact me in the event, I cannot be reached. I hereby give my permission to the physician selected by the adult leader in charge to secure proper treatment which may include hospitalization, anesthesia, surgery, or injections of medication for my son.

Date \_\_\_\_\_ Signature of parent or guardian \_\_\_\_\_

## Medical information past or present (please check)

Asthma Yes\_\_ No\_\_ Heart disease Yes\_\_ No\_\_ Cancer Yes\_\_ No\_\_

Allergies Yes\_\_ No\_\_ High blood pressure Yes\_\_ No\_\_ Leukemia Yes\_\_ No\_\_

Convulsions Yes\_\_ No\_\_ Diabetes Yes\_\_ No\_\_ Hemophilia Yes\_\_ No\_\_

Explanations \_\_\_\_\_

Allergies: Food Yes\_\_ No\_\_ Plants Yes\_\_ No\_\_

Medicines Yes\_\_ No\_\_ Insect bites Yes\_\_ No\_\_

Explanations \_\_\_\_\_

Any reason to restrict full activity including swimming, long hikes, backpacking, strenuous physical games? Yes\_\_ No\_\_

List any conditions limiting full participation (Physical or emotional) \_\_\_\_\_

Any reason for medicines to be taken at camp? Yes\_\_ No\_\_ List medicines and send ample supplies and directions for use \_\_\_\_\_

Any special equipment such as orthopedic or handicap devices, glasses or contacts, dentures? Yes\_\_ No\_\_ What? \_\_\_\_\_

Explain any Yes answers and give all information needed to provide as safe and as full participation as possible:

Immunizations: Date of last Inoculation Date of last inoculation Date of last inoculation

Tetanus Toxoid \_\_\_\_\_ Polio \_\_\_\_\_ Mumps \_\_\_\_\_

Diphtheria \_\_\_\_\_ Pertussis \_\_\_\_\_ Measles \_\_\_\_\_

Rubella \_\_\_\_\_



## Georgia Knights of Pythagoras

### Parents' Contact Information

Knight's Name: Last \_\_\_\_\_, First \_\_\_\_\_ MI \_\_\_\_\_

Knight's Birth date (mm/dd/yyyy): \_\_\_\_\_ Parent's Last Name: \_\_\_\_\_

Mother's First Name: \_\_\_\_\_ Father's First Name: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Home Phone: ( ) \_\_\_\_\_ Cell Phone: \_\_\_\_\_

Work Phone: ( ) \_\_\_\_\_ E-Mail: \_\_\_\_\_

### Health Insurance Company:

\_\_\_\_\_

Policy Number: \_\_\_\_\_

Sometimes it is difficult to reach the parents. Please list two individuals (neighbors, relatives, or friends) and their number so they can be reached in case of an emergency. If we cannot reach the number you listed above, we will attempt to reach the individuals you have listed below.

Name of secondary contact 1: \_\_\_\_\_

Telephone Number: \_\_\_\_\_

Name of secondary contact 2: \_\_\_\_\_

Telephone Number: \_\_\_\_\_

I agree to the following terms and conditions as outlined in the following disclaimer by the submission of this form:

I allow my son/ward to participate in the Knights of Pythagoras Mentoring program and/or summer camp. I understand my son/ward will not leave the KOP mentoring site during program hours and that unauthorized departures from the KOP mentoring meeting site as well as any violation of KOP rules, may result in termination on his attendance in the program. If he is terminated from the program, I agree to pick him up immediately upon notification.

I will not hold the KOP program or staff liable for injury or damage arising from the result of my son/ward's participation in the program. I hereby give permission for my son/ward to receive medical treatment, if necessary.

I approve my son/ward's participation in the KOP program. To the best of my knowledge, there are no physical or other conditions which will interfere with my child's participation.

Note: If there are conditions of which the KOP needs to be aware with regards to your child's participation in the program, please use the below form to elaborate.

\_\_\_\_\_  
Parent Signature

\_\_\_\_\_  
Date