

**KAIROS OUTSIDE CONFIDENTIAL MEDICAL INFORMATION**

Name \_\_\_\_\_

Address/City/State \_\_\_\_\_

Phone \_\_\_\_\_ **Signature:** \_\_\_\_\_

Primary Care Doctor \_\_\_\_\_ Phone (\_\_\_\_) \_\_\_\_\_

Address/City/State \_\_\_\_\_

Insurance Carrier \_\_\_\_\_ Phone (\_\_\_\_) \_\_\_\_\_

Address/City/State \_\_\_\_\_

ID # \_\_\_\_\_ Group# \_\_\_\_\_

In case of an emergency, Please contact: \_\_\_\_\_

Address/City/State \_\_\_\_\_

Relationship \_\_\_\_\_ Phone (\_\_\_\_) \_\_\_\_\_

**Medical History (use back if necessary)**

Blood type (if known) \_\_\_\_\_

Allergies (food, medication, bees, pollen, etc.) \_\_\_\_\_

Medications currently taking \_\_\_\_\_

Dosage \_\_\_\_\_ Date started \_\_\_\_\_

Any current medical problems \_\_\_\_\_

Medical treatment in past 12 months \_\_\_\_\_

Exposure to illness in past 2-4 weeks \_\_\_\_\_

Optional: Religious Affiliations \_\_\_\_\_

Pastor/Priest \_\_\_\_\_ Phone (\_\_\_\_) \_\_\_\_\_

***Your signature on this form, gives Kairos Outside permission to use this form on the weekend, if necessary, due to a medical emergency.***

**PHOTO AND ADDRESS RELEASE FORM**

**Photo Release:**

\_\_\_\_\_ I hereby give me permission to be included in the Kairos Outside Weekend Group Photo

\_\_\_\_\_ I **do not** give my permission to be included in the Kairos Outside Weekend Group Photo

**Address Release:**

\_\_\_\_\_ I hereby give my permission for Kairos Outside to release my name and address to the Kairos National office and the local State Chapter for use on the Kairos Newsletter mailing lists.

\_\_\_\_\_ I **do not** give my permission for Kairos Outside to release my name and address to the Kairos National office and the local State Chapter for use on the Kairos Newsletter mailing lists. I understand that by checking this area, I will not receive local or national newsletters.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date