GENERAL INFORMATION (COMPLETE IN BLACK/BLUE INK ONLY–NOT PENCIL)

Name:______________________________ Date of Birth:____ / ____ / ______ Sex: Male ___ Female ___

Address:______________________________________ Phone: (   ) _____ - _______

City:______________________________ State:________ Zip:______________

Emergency Phone Numbers: MANDATORY

Mother's name: ______________________________ Email: ______________________________

Mother: *(cell)* (   ) _____ - _______ *(wk)* (   ) _____ - _______

Father's name: ______________________________ Email: ______________________________

Father: *(cell)* (   ) _____ - _______ *(wk)* (   ) _____ - _______

Emergency contact person if parents cannot be reached: ______________________________

Relationship to the participant: __________________ Email: ______________________________

Phone: *(cell)* (   ) _____ - _______ *(wk)* (   ) _____ - _______ *(home)* (   ) _____ - _______

Family Doctor/Clinic: ______________________________ Phone: (   ) _____ - _______
(contact info for medical records in case of emergency)

HEALTH HISTORY

To be completed by a parent/legal guardian if Participant **is under 18.** Due to the length and nature of our mission trips, we expect full disclosure in regards to health. If you have questions, please contact Royal Servants.

Do you have a history of: CIRCLE Yes or No *Please explain anything circled yes on the lines below.

1. Hay Fever	Yes No	9. Frequent Upset Stomach	Yes No	17. Birth Defects	Yes No
2. Allergies to Insect Bites	Yes No	10. Frequent Diarrhea	Yes No	18. Diabetes	Yes No
3. Frequent Sinus Problems	Yes No	11. Frequent Constipation	Yes No	19. Blood Disorders	Yes No
4. Frequent Nosebleeds	Yes No	12. Frequent Nausea / Vomiting	Yes No	20. Sleep Disorders	Yes No
5. Ear / Hearing Problems	Yes No	13. Bladder Control Difficulties	Yes No	21. Speech Problems	Yes No
6. Dental Problems	Yes No	14. Kidney Problems	Yes No	22. Bone/Joint Problems	Yes No
7. Frequent Headaches / Migraines	Yes No	15. Heart Problems	Yes No	23. Physical Limitations	Yes No
8. Eye / Vision Problems *(not corrected with glasses/contacts)*	Yes No	16. Previous Surgeries *(when and for what?)*	Yes No	24. Previous Hospitalizations Including Psychiatric Care *(when and for what?)*	Yes No

____

____

____

Please use a separate sheet of paper if you need additional space.

25. Do you have any Drug Allergies? Yes ___ No ___ If yes, to what and describe your reactions:

26. Do you have any Food Allergies? Yes ___ No ___ If yes, to what and when was the last occurrence? Describe your reactions:

    Do you require an Epi Pen? Yes ___ No ___ **If you have a severe allergic reactions, YOU MUST BRING TWO EPI PENS.*

27. Do you have any special food requirements or food restrictions? _______ If yes, what?

    Is this a medical allergy ___ or health preference ___?
    **Please contact Royal Servants to discuss if we are able to accommodate any food restrictions you have.*

28. Do you have asthma? Yes ___ No ___ If yes, when was your last attack? ______

    Do you have any known triggers?

    Have you ever been hospitalized for causes related to your asthma? Yes ___ No ___ Most recent occurrence? ______

    Do you have an Asthma Rescue Plan? Yes ___ No ___ If yes, please describe on a separate page and attach to this document.

    **If you have been prescribed ANY inhalers in the past 5 years, YOU MUST BRING TWO RESCUE INHALERS.*

29. Have you ever had a seizure? Yes ___ No ___ If yes, when was your last seizure? ______

    Do you have any known triggers?

    Do you have a Seizure Rescue Plan? Yes ___ No ___ If yes, please describe on a separate page and attach to this document.

Name (Last, First) ______________

Acct # P00 ________ Trip ________

☐ Reviewed ________

HEALTH FORM

Due within 2 weeks of receiving the Prep Packet

Mail to: Reign Ministries, 5401 W Broadway Ave, Minneapolis, MN 55428

30. Do you have any activity restrictions? Yes ___ No ___ If yes, what? And why?

31. Do you, or have you ever struggled with any of the following:
eating disorder___ anxiety___ depression___ ADD/ADHD___ Bipolar___ learning disability___
self harm ___ suicidal thoughts___ suicide attempt___ alcohol/drug use___ drug/tobacco/alcohol addiction___
Please explain:

32. Have you ever seen a counselor or had psychiatric care? Yes ___ No _____ If yes, explain:

33. Are you currently taking a prescription medication? Yes ___ No ___ If yes, please complete table below.

Medication	Dose	Frequency	Reason	Refrigerated?

34. Girls only: Have you started your menstrual cycle? Yes ___ No ___ If yes, is there anything specific you would like us to know about your cycle?

35. Is there any other information that we need to know about you in regards to your physical or mental health? Such as any developmental or behavioral disorders that could impact your social interactions, ministry engagement, or ability to learn or memorize, etc.? Or family history that may be relevant to participant health or allergies?

*** Please contact Royal Servants if there are any significant changes in your medical health.**

MEDICAL PERMISSION

Required for ALL Participants (Note: guardians of minors required to initial all 3 statements, those over 18 required to initial 1st statement only. Forms filled out incorrectly will need to be returned to be corrected. Please contact Royal Servants with any questions.)

PERMISSION

I verify that this form has been truthfully completed to the best of my knowledge. I hereby give my permission to the physician or dentist selected by Reign Ministries' personnel to hospitalize, secure proper treatment and/or order an injection, anesthesia, or surgery, and disclose protected health information for ____ *(name of participant)* to Reign Ministries' personnel and Royal Servants medical volunteers for the purpose of treating the health and well being of the aforementioned person. I understand that the information used or disclosed may be subject to re-disclosure by Reign Ministries' personnel or Royal Servants medical volunteers receiving it, and would then no longer be protected by federal privacy regulations. I may revoke this authorization by notifying Reign Ministries in writing of my desire to revoke it. However, I understand that any action already taken in reliance on this authorization cannot be reversed, and my revocation will not affect those actions. This authorization begins on arrival to Chicago or Training Camp and expires on August 31, 2021 OR upon the completion of the Royal Servants Mission Trip.

_____ (initial) I give permission for the above named participant or for myself (if 18 or over) to receive medication according to the prescription or parental request for Over the Counter (OTC) drugs, and any special instructions. I understand the information is confidential and only Reign Ministries' personnel, needing to know, have access to this information. I agree to coordinate and work with Reign Ministries and the prescriber if questions arise. *(initials required for guardians of minors or participants 18 and over)*

_____ (initial) I give permission for the nurse or designated Reign Ministries' personnel to administer any OTC non-prescription drug according to the manufacturer's directions. *(initials required for guardians of minors only)*

_____ (initial) I give permission for my son/daughter to self-administer medication, if the nurse or designated Reign Ministries' personnel determines it is safe and appropriate. *(initials required for guardians of minors only)*

Parent/Legal Guardian Signature: ____ Date: ____ / ____ / ______
(required if participant is under 18 years old)

Participant Signature: ____ Date: ____ / ____ / ______
(required for all participants)

Make a photocopy of this form for yourself and send the original to Royal Servants upon completion**
Royal Servants must have this original, signed form**