

Kiamichi Baptist Assembly Health Form

P.O. Box 9
Talihina, OK 74571

Date of camp: _____
Church _____ Phone# _____
Address _____
City _____ State _____ Zip _____
Cabin you're staying in at KBA _____

Camper's name: _____ D.O.B. ____/____/____ Sex: ____ M ____ F
Address: _____ City _____ State _____ Zip _____
S.S.#: ____/____/____ CDIB # _____ (Please, send photo copy)
Home Phone# : _____ Parent/Guardian name: _____ Relationship _____
Emergency Phone#: _____ Emergency Contact Person: _____ Relationship _____

Health Information

Allergies: ____ No ____ Yes If yes, list what you are allergic to: _____
Medicine(s) you are presently taking: _____
Date of last tetanus shot: _____ Are you current on all your shots: ____ Yes ____ No
Are there any special conditions/health problems about that we should be aware of: ____ Yes ____ No
If yes, please explain: (use the back of this paper if necessary) _____
Your physician's name: _____ Office Phone# _____

Permission to receive medical help for camper if needed.

I/we _____, parent/guardian of the above named camper, hereby give consent to provide this camper with emergency care, and/or hospitalization for any accident or illness which occurs while attending Kiamichi Baptist Assembly, and also give permission to transport camper to and from localities where such health services are provided.

Signed: _____ Relationship: _____ Date: ____/____/____

Statement: (must be signed by parent/guardian and camper)

We have read or have had read to us the KBA guidelines, rules and regulations. We agree that the above named camper will follow these rules while camping at KBA. We understand that KBA is not the responsible party for the supervision of the campers, but it is the responsibility of the church or group bringing them to the KBA campgrounds.

Signed: _____ Date: ____/____/____
Parent/Guardian

Signed: _____ Date: ____/____/____
Camper

Health Insurance Information

Camp Ins. Coverage:

American Income Life Insurance
P.O. Box 50158
Indianapolis, IN 46250
1-800-849-4820

Accident coverage limit: \$2,500
Sickness coverage limit: \$750
Dental coverage limit: \$300

Personal Ins. Coverage: (your insurance)

Company name: _____
Address: _____ City _____ State _____ Zip _____
Phone #: _____ Policy# _____

