

Outreach Application



(please list outreach applying for)

PERSONAL INFORMATION:

FULL NAME: _____ Preferred: _____
 ADDRESS: _____
 CITY: _____ STATE: _____ ZIP CODE: _____
 PARENT'S NAMES: _____
 HOME TELEPHONE: _____ WORK TELEPHONE: _____
 FAX: _____ EMAIL: _____
 AGE: _____ SEX: _____ BIRTHDATE: Year: _____ Month: _____ Day: _____
 CHURCH / PASTOR: _____
 DRIVER'S LICENSE NUMBER: _____ CLASS: _____ STATE: _____
 PASSPORT NUMBER: _____ EXPIRE: _____
 T-SHIRT SIZE: _____ LANGUAGES (In order of fluency): _____
 Previous King's Kids Experiences (Dates/Type/Location/Leaders): _____

GENERAL INFORMATION

Pray about your involvement with this outreach. Please share any direction that the Lord has given you. List scripture or share anything else that you would like us to know about how He has been guiding you. Use a separate sheet if necessary.

My decision to apply is: all mine mostly mine mostly my parents' mostly my friends' half & half other

PROGRAM SKILLS

COMMUNICATION:

Have you ever spoken in front of a large group? Yes No
 Do you have any fear of speaking or performing in front of people? Yes No

MUSIC

Do you play any musical instruments? Yes No
 If yes, which ones and for how long have you been playing? _____
 Do you sing? Yes No

RELATIONSHIP WITH GOD

Describe your relationship with God; _____

Do you spend time with God everyday? _____ If not, how often? _____
 Do you find sharing your faith: Awkward Natural Exciting Challenging
 Do you have any idea what God has planned for your future? _____

If you could change one thing about your relationship with God, what would it be? _____

Church you attend: _____ Pastor's name: _____ Phone: _____

KING'S KIDS DENVER

7754 HOLLAND CT. ARVADA, CO 80005

(303)-424-8493

kingskidsdenver@aol.com

HEALTH FORM

IN CASE OF EMERGENCY, CONTACT:

NAME: _____ RELATIONSHIP: _____

HOME PHONE: _____ WORK OR CELL PHONE: _____

ADDRESS: _____ CITY: _____ STATE: _____ ZIP: _____
OR

NAME: _____ RELATIONSHIP: _____

HOME PHONE: _____ WORK OR CELL PHONE: _____

ADDRESS: _____ CITY: _____ STATE: _____ ZIP: _____

DO YOU HAVE MEDICAL INSURANCE?

NAME OF INSURER: _____ INSURANCE NUMBER: _____

PERSONAL HISTORY: Please answer all questions. Comment on all positive answers in the space below or on a separate sheet. Have you ever, or do you have, any of the following:

| YES | NO | | YES | NO | | YES | NO | |
|--------------------------|--------------------------|-----------------------------|--------------------------|--------------------------|------------------------|--------------------------|--------------------------|----------------------|
| <input type="checkbox"/> | <input type="checkbox"/> | Skin Conditions | <input type="checkbox"/> | <input type="checkbox"/> | Heart trouble | <input type="checkbox"/> | <input type="checkbox"/> | Jaundice |
| <input type="checkbox"/> | <input type="checkbox"/> | Eye trouble | <input type="checkbox"/> | <input type="checkbox"/> | High blood pressure | <input type="checkbox"/> | <input type="checkbox"/> | Hepatitis |
| <input type="checkbox"/> | <input type="checkbox"/> | Ear trouble | <input type="checkbox"/> | <input type="checkbox"/> | Low blood pressure | <input type="checkbox"/> | <input type="checkbox"/> | Intestinal troubles |
| <input type="checkbox"/> | <input type="checkbox"/> | Head injury | <input type="checkbox"/> | <input type="checkbox"/> | Rheumatism / Arthritis | <input type="checkbox"/> | <input type="checkbox"/> | Recurrent diarrhea |
| <input type="checkbox"/> | <input type="checkbox"/> | Recurrent headaches | <input type="checkbox"/> | <input type="checkbox"/> | Back problems | <input type="checkbox"/> | <input type="checkbox"/> | Diabetes |
| <input type="checkbox"/> | <input type="checkbox"/> | Epilepsy | <input type="checkbox"/> | <input type="checkbox"/> | Dislocation of joints | <input type="checkbox"/> | <input type="checkbox"/> | Kidney disease |
| <input type="checkbox"/> | <input type="checkbox"/> | Fainting spells | <input type="checkbox"/> | <input type="checkbox"/> | Broken bones | <input type="checkbox"/> | <input type="checkbox"/> | Anemia |
| <input type="checkbox"/> | <input type="checkbox"/> | Mental or nervous disorders | <input type="checkbox"/> | <input type="checkbox"/> | Stomach/Duodenal ulcer | <input type="checkbox"/> | <input type="checkbox"/> | Venereal disease |
| <input type="checkbox"/> | <input type="checkbox"/> | Weakness | <input type="checkbox"/> | <input type="checkbox"/> | Gall bladder problems | <input type="checkbox"/> | <input type="checkbox"/> | Tumor : cancer |
| <input type="checkbox"/> | <input type="checkbox"/> | Paralysis | <input type="checkbox"/> | <input type="checkbox"/> | Surgery | | | FEMALES ONLY: |
| <input type="checkbox"/> | <input type="checkbox"/> | Insomnia | <input type="checkbox"/> | <input type="checkbox"/> | Appendectomy | <input type="checkbox"/> | <input type="checkbox"/> | Irregular periods |
| <input type="checkbox"/> | <input type="checkbox"/> | Shortness of breath | <input type="checkbox"/> | <input type="checkbox"/> | Tonsillectomy | <input type="checkbox"/> | <input type="checkbox"/> | Severe cramps |
| <input type="checkbox"/> | <input type="checkbox"/> | Hay fever, asthma | <input type="checkbox"/> | <input type="checkbox"/> | Hernia Repair | <input type="checkbox"/> | <input type="checkbox"/> | Excessive flow |
| <input type="checkbox"/> | <input type="checkbox"/> | Allergies | <input type="checkbox"/> | <input type="checkbox"/> | Other (specify) | <input type="checkbox"/> | <input type="checkbox"/> | Are you pregnant? |

Are you presently under a doctor's care for any condition? (specify) : no yes _____Are you taking any medication at this time? (specify) : no yes _____Are you allergic to any drugs? (specify) : no yes _____Do you have a history of emotional instability or psychiatric treatment? (specify) : no yes _____Do you have any physical impairments, handicaps, or health conditions which require special attention?
(specify) : no yes _____

Weight: _____ lbs Height: _____ft_____in Blood Type: (O,A,B,AB,+ or -) : _____

Have you ever had any of the following:

| Yes | No | | Yes | No | | Yes | No | |
|--------------------------|--------------------------|-------------|--------------------------|--------------------------|---------------|--------------------------|--------------------------|------------------------|
| <input type="checkbox"/> | <input type="checkbox"/> | Chicken pox | <input type="checkbox"/> | <input type="checkbox"/> | Tuberculosis | <input type="checkbox"/> | <input type="checkbox"/> | Measles (Rubella) |
| <input type="checkbox"/> | <input type="checkbox"/> | Mumps | <input type="checkbox"/> | <input type="checkbox"/> | Scarlet fever | <input type="checkbox"/> | <input type="checkbox"/> | Other (Specify: _____) |

FAMILY HISTORY

Have any of your relatives had any of the following: (if so please identify his/her relation to you)

| Yes | No | | Yes | No | | Yes | No | |
|--------------------------|--------------------------|----------------|--------------------------|--------------------------|------------------------|--------------------------|--------------------------|------------------------|
| <input type="checkbox"/> | <input type="checkbox"/> | Tuberculosis | <input type="checkbox"/> | <input type="checkbox"/> | Arthritis | <input type="checkbox"/> | <input type="checkbox"/> | Epilepsy / Convulsions |
| <input type="checkbox"/> | <input type="checkbox"/> | Diabetes | <input type="checkbox"/> | <input type="checkbox"/> | Stomach disorder | <input type="checkbox"/> | <input type="checkbox"/> | Heart disease |
| <input type="checkbox"/> | <input type="checkbox"/> | Kidney disease | <input type="checkbox"/> | <input type="checkbox"/> | Asthma / hay fever | <input type="checkbox"/> | <input type="checkbox"/> | Hypertension |
| <input type="checkbox"/> | <input type="checkbox"/> | Cancer | <input type="checkbox"/> | <input type="checkbox"/> | Other (specify): _____ | | | |

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