



## HEALTH HISTORY FORM NATIONAL ROYAL RANGER TRAINING CAMPS

This **ENTIRE FORM** must be completed and sent in with the application. The National Royal Rangers Ministries office has the prerogative to accept or reject applicants based upon their physical condition.

|                                      |  |                             |   |            |           |
|--------------------------------------|--|-----------------------------|---|------------|-----------|
| Applicant's Name:<br>(Please Print.) |  | Birth Date:<br>(mm/dd/yyyy) |   |            |           |
| Height:                              | Weight:  | Occupation:                 |   |            |           |
| <b>HEALTH HISTORY</b>                | Please answer <b>YES</b> or <b>NO</b> to the following and briefly explain any <b>YES</b> answers under <b>REMARKS</b> below. Use the back of this form, if necessary. |                             |   |            |           |
| <b>QUESTION/CONDITION</b>            | <b>YES</b>   | <b>NO</b>                   | <b>QUESTION/CONDITION</b>   | <b>YES</b> | <b>NO</b> |
| Hearing Difficulties?                |  |                             | Have you had medical treatment in the last year?                          |            |           |
| Lung Condition?                      |  |                             | Have you had surgery in the last year?                                    |            |           |
| High Blood Pressure?                 |  |                             | Have you been exposed to infectious diseases in the last 3 weeks?         |            |           |
| Heart Problems?                      |  |                             | Have you been exposed to Hepatitis in the last 6 months?                  |            |           |
| Asthma/Allergies?                    |  |                             | Do you have any disorders that would prevent strenuous activity?          |            |           |
| Fainting/Dizziness?                  |  |                             | Are you taking any prescription medications?                              |            |           |
| Shortness of Breath?                 |  |                             | Have you had any allergic reactions to any types of drugs or medications? |            |           |
| Vision Problems? Contacts?           |  |                             | Sinus Condition?  |            |           |
| Skin Infections or Problems?         |  |                             | Food Allergy?   |            |           |

**Please use the space below to explain any "YES" answers:**

**If you are currently taking medication, please list them below. (If you need more room, use the back of this form.)**

| MEDICATION | DOSAGE | FREQUENCY |
|------------|--------|-----------|
|            |        |           |
|            |        |           |
|            |        |           |
|            |        |           |
|            |        |           |
|            |        |           |

**\*\*EMERGENCY CONTACT\*\***

NAME \_\_\_\_\_ RELATIONSHIP \_\_\_\_\_

DAYTIME PHONE (\_\_\_\_) \_\_\_\_\_ EVENING PHONE (\_\_\_\_) \_\_\_\_\_

**I know of no physical reason that would restrict me from participation in camp activities.**

Applicant's Signature \_\_\_\_\_ Date \_\_\_\_\_