INDIVIDUAL MEDICAL FORM

Health, History, and Medical Permission form

PLEASE PRINT

Name _____

Address _____

City, State, Zip _____

Home Phone (_____) _____

Email_____

Ranger Outpost # _____D.O.B.____/____/____

Section _____

Church Name_____

To be completed by the applicant's guardian or a physician.

Check all boxes that apply and briefly explain all checked boxes under remarks.

IN CASE OF EMERGENCY
PLEASE NOTIFY

Name

_____

Email Address

_____

Phone

(_____)_____

Phone

(_____)_____

Relationship

_____

- ❑ Sinus Condition
- ❑ Ear Problem
- ❑ High Blood Pressure
- ❑ Shortness of Breath
- ❑ Any Medical Care Within the Past Year
- ❑ Any Disorder preventing Strenuous Activities?
- ❑ Any Reactions to Drugs or Medication of Any Type?
- ❑ Bad Eyesight
- ❑ Lung Problem
- ❑ Allergy-Asthma
- ❑ Skin Infection
- ❑ Any Surgery Within The Past Year
- ❑ Do you wear contacts
- ❑ Fainting or Dizzy Spells
- ❑ Hearing Difficulty
- ❑ Taking Prescription Medicine
- ❑ Exposed to Infections?
  - A. Disease Past three weeks
  - B. Hepatitis Past Six months

Remarks and medical facts we should know in case of emergency. Use additional paper if necessary.

_____

_____

Give Latest Date of Inoculation of Vaccination Against the Following:
Tetanus _____ Small Pox _____ Measles _____ Typhoid _____ Diphtheria _____ Polo _____

In the event hospitalization is needed, please fill in:

Name of insured _____
Policy Holder

Medical/Hospital insurance company: _____
Policy or certificate number: _____
Employer _____ Employer's group number: _____

In case of an emergency, I hear by give permission to the physician at hand to render treatment. Should the physician deem it necessary, I authorize hospitalization, anesthesia, surgery, or injection of medication.

_____ _____
Parent or Guardian's Signature Date