

Individual Medical Form

HEALTH HISTORY AND MEDICAL PERMISSION FORM
One Form per Person (Must have a copy of this on every boy when you register at event/camp)

PLEASE PRINT

NOTIFY IN AN EMERGENCY:

Name _____

Name _____

Address _____

Address _____

City _____

City _____

State _____ Zip _____

State _____ Zip _____

Phone (____) _____

Emergency Phone (____) _____

Date of Birth _____

Relationship _____

Ranger Outpost # _____

Church Name _____

City _____

PLEASE Provide additional information about any items (checked Yes) to Right Following?

Have You Ever Been Treated For Any Of (If Yes Check)

- | | |
|--|-------------------------------------|
| <input type="checkbox"/> Heart disease | <input type="checkbox"/> Asthma |
| <input type="checkbox"/> Seizures | <input type="checkbox"/> Allergies |
| <input type="checkbox"/> High Blood pressure | <input type="checkbox"/> Bronchitis |
| <input type="checkbox"/> Diabetes | |

Please Identify Any Physical Impairments or Limitations:

Date of Last Tetanus Booster _____

Do You Wear: (If Yes Check)

- | | |
|---|----------------------------------|
| <input type="checkbox"/> Contacts | <input type="checkbox"/> Glasses |
| <input type="checkbox"/> Dental appliance | |

Please list any medications being taken

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 Hereby Give Permission to the Physician to Render Treatment. Should The Physician Deem it Necessary, I Authorize Hospitalization, Anesthesia, Surgery or Injection of Medication.

Signature (Parent, if Minor)

Date

Name of Person to Contact (Commander or Adult) on Premises for Information:
